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“Enhanced Support for High Intensity Users of the Criminal Justice System” – an evaluation of mental health nurse input into Integrated Offender Management Services in the North East of England.

Abstract

The current UK Government’s focus on the development of services to manage and support offenders with mental health problems has resulted in a number of innovative project developments. This research examines a service development in the North East of England which co-located Mental Health nurses with two Integrated Offender Management teams. While not solving all problems, the benefits of co-location were clear – although such innovations are now at risk from government changes which will make Integrated Offender Management the responsibility of new providers without compelling them to co-operate with health services.

Key Words: *offender mental health, Integrated Offender Management, co-location, Criminal Justice Liaison and Diversion.*

Introduction

This article reports on the findings of an evaluation of a new Integrated Offender Management-Mental Health (IOM-MH) service developed in the North East of England. The initiative aims to provide support for repeat offenders with mental health problems who frequently come into contact with the Criminal Justice System (CJS) and is based on two policy developments: the Bradley Report (Bradley, 2009) and the creation of Integrated Offender Management (IOM) teams (Home Office and Ministry of Justice, 2009).

Background

The Bradley Report (2009) was an independent review to determine to what extent offenders with mental health problems or learning disabilities could be diverted from prison to other

services and what were the barriers to such diversion. A number of issues prompted the review including continued concerns that the numbers of prisoners with mental health problems remains high and that prison can itself have a detrimental impact on mental health (Singleton et al, 1998; Birmingham, 2003; Rickford and Kimmett, 2005; Loucks, 2007; HM Inspectorate of Prisons, 2007; Prison Reform Trust, 2009). There were also arguments that public protection and reducing re-offending might be better served by addressing the multiple problems that many of the most persistent offenders face, such as poor health (Social Exclusion Unit, 2002). The Centre for Mental Health, Rethink and the Royal College of Psychiatrists (2011) argued that increasing evidence from international experience and from local schemes in this country suggested that well-designed interventions can reduce re-offending by 30% or more.

Bradley recommended the development/redevelopment of Criminal Justice Liaison and Diversion Services (CJLDS). Originally established at the beginning of the 1990s following publication of Home Office Circular 66/90, the Reed Report (1992) and Home Office Circular 12/95, the Bradley report refocused attention on CJLDS aimed at the management and support of offenders with mental health problems so that more offenders can be treated more effectively in the community. Bradley's recommendations were recognised by the Government in 'Breaking the Cycle' (Ministry of Justice, 2010), the governments Green Paper, along with the cross-government strategy 'No Health Without Mental Health' (HM Government and Department of Health, 2011), both of which described the intention to continue the development of CJLDS. While there now exists a standard draft 'Service Specification' (NHS England Liaison and Diversion Programme, 2014) and 'Operating Model' (NHS England Liaison and Diversion Programme, 2014) for core diversion services, the post-Bradley period has also seen the development of a variety of regional and local responses to service design and delivery across the whole offender health pathway from

arrest and police custody, through the courts, to prison and community sentence and resettlement.

One such approach developed in the North East of England by the Offender Health Commissioning Unit (now 'Health and Justice (North East & Cumbria), NHS England') – responsible for planning and purchasing healthcare services to meet the needs of those in contact with the CJS – focuses on repeat offenders and aims to provide “enhanced support for high intensity users who frequently come into contact with the Criminal Justice System.” (PID IOM High Intensity Users, 2012).

Health and Justice (North East & Cumbria) appointed the Revolving Doors Agency to review activities and make associated recommendations to shape the future development of liaison and diversion services and support care pathways for offenders with mental health problems in the North East region (Revolving Doors Agency, 2012a). Key findings from the review included the identification of a group of people who are in repeat contact with the CJS who have multiple, often complex needs but yet their individual needs alone do not meet eligibility thresholds for services. As a result this client group consistently ‘falls through the net’.

IOM was introduced in 2009 (Home Office and Ministry of Justice, 2009) to provide a multi-agency integrated approach to the management of repeat offenders, including those with mental health problems as identified by Revolving Doors. It is not yet available across all areas in England and Wales as a recent IOM survey reported 79 per cent of Community Safety Partnerships considered their IOM arrangements to be fully established, and 21 per cent said their arrangements were partially established (Home Office, 2013); and of those available there is no common model (Senior et al, 2011), which means it is not currently feasible to calculate the proportion of offenders managed by IOM services. However the

broad aim of IOM was to “bring together the management of repeat offenders into a more coherent structure” (Home Office and Ministry of Justice, 2009, p.3), including accounting for the needs of particularly vulnerable offenders such as those with mental health problems (p.10). This original IOM Government Policy Statement specifically recognises the importance of Lord Bradley’s review of offender mental health needs (Bradley, 2009), however although the original policy statement describes “better working between criminal justice agencies, government departments, the NHS, local authorities and partners in the private and third sector” (Home Office and Ministry of Justice, 2009 p.5), the IOM survey (Home Office, 2013 p.4) reported a minority of arrangements involved NHS commissioning boards (23 per cent) or NHS England local area teams (17 per cent). Many IOMs talk about having ‘links’ with mental health services, without being very clear about what this means (Ministry of Justice and Home Office, 2011; Criminal Justice Joint Inspection, 2014).

Health and Justice (North East & Cumbria) represents one of the small number of NHS commissioning units which has recognised the importance of a mental health component to IOM services and, based on the work carried out by the Revolving Doors Agency, have introduced a ‘Complex Needs Consultancy Service’ to two IOM teams (one urban and one semi-rural). The aim of this new IOM Mental Health (IOM-MH) service is to identify ‘frequent users’ of the CJS with associated mental health, learning disability or drug and alcohol issues, and devise a strategy to reduce their contact with the CJS. Service specifications were developed by the two North East NHS Mental Health Foundation Trusts to provide the IOM-MH service which importantly would co-locate MH nurses within existing IOM teams to provide specialist knowledge and clinical input.

Project - an evaluation of mental health nurse input into Integrated Offender Management Services in the North East of England.

This evaluation was commissioned by the two NE NHS Mental Health Foundation Trusts responsible for delivering the IOM-MH service, and describes progress made in relation to aims and objectives, including the identification of strengths of the IOM-MH service, continuing issues and recommendations for service improvements.

Method

This study used a qualitative exploratory design, including a literature review to contextualise the research and to provide a benchmark for subsequent findings, and repeat semi-structured interviews and focus groups with 23 key staff responsible for the development and delivery of the IOM-MH service during November 2012 and June 2013. Interviewees worked in a variety of roles and included IOM Team Managers, Probation Offender Managers, Police Officers, Advanced Mental Health Practitioners, Housing Officers, Drug and Alcohol Recovery Workers, Area Safer Partnership representatives, and the IOM-MH nurses. In addition six service user representatives were also interviewed – identified using a mixture of convenience sampling and those approached by the IOM-MH nurses who indicated willingness to be involved in the evaluation. The interviews explored service provision and activity; previous issues experienced prior to delivery of the IOM-MH service; the benefits of the new service; and continuing issues, concerns and recommendations for future developments. Interviews and focus groups were conducted face to face or by telephone. All interviews were recorded, transcribed and analysed for common themes and patterns using NVIVO to code a-priori issues as derived from the study's main research questions, as well as issues raised by the respondents themselves, and unexpected views/experiences that occurred in the data (Braun and Clarke, 2006).

Case studies selected by the IOM-MH nurses were also used to describe typical activities, outcomes and challenges associated with the IOM-MH nurse role in more detail – staff were

specifically directed to select and describe cases which represented ‘success’ and cases which illustrated common problems and challenges.

The Liaison and Diversion Minimum Dataset was analysed to measure project activity and outcomes for adults referred to the NE IOM-MH services. The Liaison and Diversion Minimum Dataset is a national dataset funded by the Department of Health (DH) and devised in July 2012 by the ‘Criminal Justice Liaison and Diversion Service (CJLDS) Offender Health Research Network (OHRN) Consortium’. The adult and youth minimum datasets (MDS) are aimed at measuring CJLDS activity and outcomes for adults and young people, including those with multiple needs and problems. While at the time of this evaluation there were a number of accuracy and reliability issues, the MDS was used to provide a summary of data for the NE IOM-MH project.

The triangulation of the three types and sources of data – qualitative interviews/focus groups, case studies, and quantitative MDS – allowed for cross-checking emergent themes for convergence and the exploration of new lines of enquiry (Bryman, 2004).

Ethics approval for this study was obtained in line with the University of Northumbria’s ethics approval process, including approvals from the two Mental Health Trusts, the Regional Psychologist, and Health and Justice (North East & Cumbria).

Findings

Characteristics of Cases

Analysis of the MDS described, between December 2012–May 2013, the IOM-MH service had received a combined 67 referrals (40% of the overall IOM caseload, which fits with research which suggests that 39% of offenders supervised by probation services have a current mental health condition (Centre for Mental Health, 2012)), with an average age of 30 years (18-48 years), majority male (81%; n=54), and all ‘white British’. Reflecting the

characteristics of those referred to IOM services, clients had committed frequent and/or acquisitive crime. The majority had over 10 previous convictions (82%; n=55); 60% (n=40) had served two or more prison sentences and the majority were subject to existing licence or supervision requirements (88%; n=59) for offences such as theft (39%; n=26) or violence against the person (24%; n=16). They were likely to misuse drugs (72%, n=48) and/or alcohol (39%, n=26) and presented with a range of current mental health issues including depression, anxiety and personality disorder (81%; n=54). They were also likely to have had previous or current contact with MH services (73%; n=49) but a poor record of engagement.

Strengths

A number of advantages to the co-location of mental health nurses were described during interviews with staff including increased identification and awareness of mental health issues on the part of other staff. IOM-MH nurses were working in collaboration with other members of the IOM teams to identify, manage and support offenders who had complex mental health and social care needs. All IOM cases were screened for previous contact with mental health services by the IOM-MH nurses and a number of screening and assessment tools were used for those specifically referred to the nurses including: the Mental Health NHS Trusts Care Co-ordination Documents, the FACE Risk Assessment Package (FACE, 2014), the Historical Clinical Risk Management-20 (Douglas et al, 2013), the Patient Health Questionnaire-9 (Spitzer, 1999), the Generalized Anxiety Disorder-7 (Spitzer, 2006), interview and discussion with the client, and access to specialist input such as Learning Disability nurse screening.

Prior to MH nursing input the issues faced by the NE IOM teams when attempting to access support and treatment for offenders with mental health problems mirrored those facing services generally as reported in a number of publications (Anderson, 2011; Stevenson et al,

2011; Yakeley et al, 2012; Campbell and Abbott, 2013), including lack of interagency cooperation and communication, and an unwillingness to intervene or offer a timely service:

“I can recall offenders over the last two or three years where the lack of health information and engagement has meant that they’ve gone on to re-offend, some quite seriously...we’ve had people that we would describe with acute mental health needs that haven’t been dealt with...hasn’t been recognised through mental health routes, with them getting into a crisis before there’s been an intervention”.

(Safer Area Partnership)

In order to meet these challenges the IOM-MH service was designed to focus on early intervention and prevention through the provision of comprehensive, intensive and consistent MH support – rather than being crisis focused. The service provided a MH nurse co-located full-time with each of the two IOM teams. The MH nurses described their core activities included: screening and assessment; liaison with other services to organise referral and appointments; information sharing within the IOM team; direct primary care-level interventions with clients prior to their engagement with specialist services including solution focused interventions and Cognitive Behavioural Therapy (CBT); and the delivery of practical support to clients including advocacy at services appointments, and advice and referral for finance, benefits and housing issues.

This first case study provides an example of how initial contact with the IOM-MH nurse lead to the service user receiving a diagnosis and engaging with services for the first time, resulting in behaviour changes and apparent impact on recidivism:

Case Study 1 – M: M was an 18 year old, unemployed male. His criminal record included convictions for criminal damage, endangering life, possession of cannabis,

possession of an offensive weapon and assault. M was referred to the IOM-MH nurse by his Probation Officer because they were concerned that he was unable to engage appropriately with staff at his Probation appointments, becoming defensive and agitated and being unable to properly appreciate the impact of his crimes on his victims. The MH nurse completed a comprehensive assessment, which raised concerns that M might have Attention Deficit Hyperactivity Disorder (ADHD). The assessment process revealed that M had previously been referred to the Child and Adolescent Mental Health Services (CAHMS), but had not engaged. Indeed, he had refused all previous mental-health related interventions offered. Following his assessment, M was referred to the adult ADHD service where he attended an appointment and was diagnosed as having adult ADHD and a possible Personality Disorder. The MH nurse also attended this appointment to ensure his attendance and to act as an advocate if required. Based on these diagnoses, M was referred to the Affective Disorder Service for care co-ordination and for shared care with the adult ADHD team. In addition to assessment and referral, the MH nurse also gave M advice about alcohol and cannabis intake. As a result of his initial engagement with the MH nurse, M had for the first time engaged with services and had not re-offended.

The benefits of the IOM-MH service model were unanimously described by those interviewed, including increased awareness of mental health issues; a readily available, timely resource to better identify, intervene and manage clients; improved information sharing between different agencies and practitioners; improved referral of clients onwards to other services (although on occasion still problematic); and a reduction in the likelihood of client disengagement because of the provision of short-term ‘bridging’ interventions and support which helped to stabilise behaviour and therefore potentially reduce the risk of re-offending:

“It’s good having [the MH nurse] based here because this guy [name] came in one day and he was making all kinds of threats against people. [The MH nurse] was just able to come in and sit with him and talk to him. That’s really good having that access to [the MH nurse] here rather than having to ring and wait for people. It’s continuity as well...it’s not a different worker each time...they trust [the MH nurse]. A lot of our clients struggle to build up rapport”.

(IOM Team)

“The difference is now, having [the MH nurse] as part of the team is that you can do that outreach before someone hits that crisis point by home visits with different members of the team”.

(IOM Team)

Although at this early stage it was not possible to analyse the impact on reoffending, anecdotal evidence from clinicians, other service providers and service users was hopeful:

“My attitude towards people has changed...on normal occasions when I would’ve kicked off and later regretted, I’ve thought about it logically. I’ve thought to myself there’s too much to lose. Controlling my temper. I feel like it’s turning me into a better person...that’s what I wanted from it”

(IOM-MH Service User 1)

“I was kind of glad to get an opportunity to speak to somebody after what had already happened with being knocked back. [The IOM-MH nurse] pinpointing where I’d gone wrong and letting me know where I’d gone wrong and showing me and telling me ways to right the wrong”.

(IOM-MH Service User 2)

“[The IOM-MH nurse] asked me what problems I had and I went through in detail about the anger, my thoughts...irrational thoughts and then [the IOM-MH nurse] took me back and got me to start from my childhood and we worked all the way through...school years, leaving school, prison, through everything. You know what, I’d never put my life out in front of me like that to actually see where I had went wrong”.

(IOM-MH Service User 3)

“I was in a mess, I couldn’t even speak to anyone, but I’ve pulled myself up the ladder a bit. I’m starting to do jobs in my house and looking a lot cleaner...my mind’s changing slowly. I definitely think if I hadn’t have seen [the IOM-MH nurse] I would’ve hung myself by now”.

(IOM-MH Service User 4)

Continuing issues

During interviews staff described clients as presenting with ‘chaotic lifestyles’, limited or problematic family and social relationships, accommodation needs, ‘maladaptive coping strategies’, and be reluctant to give service providers an honest account of their offending, lifestyle and other issues:

“Most of the clients who’ve come onto my caseload have had failed appointments previously...because they’re chaotic, they don’t turn up to appointments, they don’t value the appointments”.

(IOM-MH Nurse)

‘Access to mental health services’ and ‘client disengagement or non-engagement’ are two issues where, while there has been improvement following the co-location of MH nurses with the IOM teams, difficulties still remain.

The following case study describes an example where client disengagement was not effectively tackled, partly due to lack of co-operation from other agencies, in this instance the courts. It illustrates the difficulties of engaging those with multiple needs and the challenges facing the IOM-MH nurse (and the wider IOM team) in their attempts to manage and support their clients. Despite issues with the outcome, this case study does also illustrate the value of collaborative working and information sharing to enable all service providers to offer appropriate services, jointly plan their responses to clients and to have an accurate and timely picture of an offender’s circumstances:

Case Study 2 – P: P was a 20 year old, unemployed (long term sick) female. She had never been to prison but had convictions for theft and criminal damage. She was previously referred for Psychiatric Liaison input, but failed to engage. P was referred to the IOM-MH nurse by her Probation Officer for assessment. The assessment identified symptoms of moderate mood issues, poor self-esteem and poor coping skills. All agencies involved in this case met together regularly to share information, with regular follow up emails and telephone calls to update all services on P’s situation. Working together the IOM MH nurse, her GP, the Police, a sexual health worker, the Leaving Care team, Probation and a Housing Association, managed to locate and engage P, and she was referred to the Affective Disorder team. However following assessment, P disengaged with all services and her behaviour became chaotic and problematic. She superficially self-harmed and was evicted from her temporary accommodation. She also became verbally aggressive and threatening with

service providers and was arrested for criminal damage in an Accident & Emergency Department. As a result of this deterioration in her situation including breaches of her Probation terms, risk taking behaviours, non-engagement with services and drug taking, all agencies agreed it was appropriate for P to be detained in custody and worked together to have her suspended sentence revoked. However, despite being provided with the relevant information, the court decided otherwise and she was instead given a six month supervision order.

The non-engagement and disengagement of clients was described as one of the main challenges facing the IOM-MH nurses and IOM teams generally. The IOM-MH nurses expressed concern about the non-engagement of potential clients because of their ‘chaotic lifestyles’ and the stigma still associated with a diagnosis of mental health problems. One IOM-MH nurse estimated that approximately 25 per cent of their potential clients fail to engage with or subsequently disengage from mental health-related support. Attempts had been made to minimise this problem by proactively meeting with clients in prison, at home or on the street.

Research supports this experience that the engagement and retention of clients with multiple and complex needs is problematic. However, although there is a tendency to point the finger of blame at this group of clients and what is often described as their ‘chaotic’ lifestyle, research which seeks the opinions of service users themselves suggests engagement and retention problems often lie with the services themselves (Dean, 2003; Jeal & Salisbury, 2004; Rosengard et al, 2007; Anderson, 2011) including: difficulties accessing services; a range of systemic barriers that impede access or are detrimental to care and can lead to repeated experiences of service rejection or delays in receiving help; and poor experiences of services following access (Anderson, 2010; Rosengard et al, 2007).

The second challenge facing the IOM-MH nurses, IOM teams, and CJLDS more generally concerns just such a lack of cooperation from other services, particularly wider MH services. Rather than lack of cooperation from the CJS and Court (as described in Case Study 2), problems experienced by the NE IOM-MH service were more likely to involve delayed responses or rejection of referrals by wider MH services, including services provided by the same Mental Health NHS Trusts which employed the IOM-MH nurses. Although evidence indicated that the NE IOM-MH service had improved referral pathways for many clients, there were still concerns that some MH services remained reluctant to accept referrals. The IOM teams described clients could be ‘bounced’ between different services before securing an appointment with an appropriate provider, which again impacted on the likelihood of non-engagement and disengagement. Whilst it is difficult to determine the precise causes of this problem the IOM-MH nurses suggested, based on their clinical experience, that it was due to a majority of their clients having a dual-diagnosis and complex needs, and a reluctance on the part of some services to offer input to ‘offenders’ based on assumptions that they are difficult client group.

Anderson (2011) provides a review of the literature and analysis of contributing factors that lead to poor frontline service response to adults with multiple needs. Issues identified confirm the concerns of the IOM-MH nurses including: the stigmatisation of clients with multiple labels such as ‘offender’, ‘drug user’, ‘mentally ill’, ‘personality disordered’ and ‘dangerous’; systemic attitudes within an organisation to ‘risk/risk aversion’ and an unwillingness to work with clients assumed to pose a greater level of challenge; and organisational barriers such as rigid screening and assessment requirements which mean services are denied altogether “because adults with multiple needs were not considered to have sufficient depth of need, while the damaging implications of the breadth of their need were ignored” (Anderson, 2011

p.28). These challenges have also been re-emphasised by the ‘Bradley Report five years on’ (Durcan et al, 2014):

“poor mental health and learning disability [does] not occur in isolation and particularly not in the offender population that tends to have complex and multiple problems by default. This multiplicity of need makes it particularly difficult for such people to engage with services or for services to engage with them, as often services are mono problem focussed. Further to this, Lord Bradley recognised that services often set the entry thresholds high and do not recognise complexity.” (p.8)

Recommendations

At a regional and local level the agencies involved with the commissioning and provision of the NE IOM-MH service have acknowledged the challenges associated with providing a service for clients with multiple and complex needs including accessing services, and engagement and retention issues. Issues around lack of cooperation from other services have been noted and referral source, related activity and outcomes will be monitored in order to identify ‘good’ pathways and relationships, including any gaps or issues. Referral rates and rates of failure to engage or disengaging will be monitored to identify key client characteristics associated with disengagement, with a view to using this information to inform on-going service delivery to reduce attrition rates. Development and innovation in relation to engaging and retaining engagement with clients will be encouraged and good practice shared between IOM projects and MH services.

Discussion

The challenges facing the NE IOM-MH service are not new. In particular, the issue around wider mental health service cooperation - the ‘diversion to what?’ question – has been well documented but is yet to be resolved (James, 2010; Dyer, 2012; Scott et al, 2013; Fengea,

2014). Despite these challenges overall findings described a very positive picture. The specialist knowledge and clinical input provided by co-locating MH nurses with IOM teams were unanimously welcomed by all those interviewed.

While these findings were not entirely unexpected, what is perhaps more unexpected is that co-located, dedicated MH input is not core to all IOM teams. IOM services were established to bring together criminal justice and other agencies to deliver a local response to crime, targeting those offenders most at risk of reoffending or committing offences that might cause serious harm to others. It was envisaged that those targeted would have committed multiple offences and have multiple and complex levels of need so that while police and probation would be at the heart of IOM, success would also depend upon ‘positive engagement’ by the local authority, health service providers and a range of other service providers (Home Office and Ministry of Justice, 2009, 2010; Ministry of Justice and Home Office, 2011; Revolving Doors Agency, 2012b). However a recent IOM survey reported that the NHS was least likely to be involved from a list of agencies reported to be involved in local IOM arrangements (Home Office, 2013 p.4). The Home Office survey makes no attempt to explain why the NHS has limited involvement – has it simply not crossed anyone’s mind, were invites sent but declined, or despite significant evidence to the contrary (Robinson and Cottrell, 2005; Bradley, 2009; Williams, 2009; Hean, et al, 2011; Yakeley et al, 2012), do agencies continue to assume that some vague nod towards ‘inter-agency cooperation’ means that those who need it will be referred to and consequently receive mental health service input? The challenges of partnership working particularly across the care-control divide, including: models of understanding, roles, identities, status and power, and information sharing; are generally well documented but according to Williams (2009) had not been addressed by government interventions. This continues to be the case so that despite reports which suggest for example that co-location is important to the success of achieving ‘joined-up’ working:

“co-locating staff facilitated cultural change, case management processes, knowledge transfer and information sharing” (Ministry of Justice and Home Office, 2011 p.3), there were no reports of health services co-located on the same premises with IOM teams (Home Office, 2013 p.5). Instead, IOM service inspections and evaluations make claim to largely unspecified ‘partnerships’ or ‘relationships’ or ‘links’ with health (Ministry of Justice and Home Office, 2011; Senior et al, 2011; Criminal Justice Joint Inspection, 2014). Findings from the evaluation of the NE IOM-MH service point to the problems facing the IOM teams prior to the input of the MH nurses, when they had to rely on these unspecified ‘partnerships’ or ‘relationships’ or ‘links’ with health, including lack of interagency cooperation and communication, and an unwillingness to intervene or offer a timely service. Although some problems with access and retention persist, having a MH nurse as an integral part of the IOM team has introduced many benefits including overcoming barriers between health professionals and their colleagues, strengthening team cohesion, and improvements in referral pathways and client engagement.

The current UK Coalition Government’s ‘Rehabilitation Revolution’ described in ‘Transforming Rehabilitation: A Strategy for Reform’ (Ministry of Justice, 2013a) aims to drive down reoffending rates by focusing on “the broader life management issues that often lead offenders back to crime” (p.6), including mental health problems and substance misuse. Attention is given to the good work of IOM services who work together to manage offenders in the most effective way and whose “dedication and pooled expertise...has served to control the impact of the worst offenders in local areas” (p.29). However whilst the need to work with other local partners to sustain and develop networks is recognised, including Community Safety Partnerships, safeguarding boards and Youth Offending Teams, no specific reference is made to mental health service input.

Under the new arrangements changes to the Probation Service means that IOM will become the responsibility of newly commissioned providers (35 Probation Trusts will be replaced by 21 'Community Rehabilitation Companies' (CRCs)). The strategy suggests:

“It will be in providers’ interests to work with other partners [including IOM arrangements] to achieve the best results and our payment mechanism, which will reward reductions in reoffending, will incentivise them to do so” (p.30),

although the built-in “flexibility to do what works” (p.8) means that it is not yet clear how and in what format IOM teams will continue, or what, if any, role mental health services will have.

According to Wong (2013) there is a presumption that the CRC contract holders will want to maintain IOM in some form, in particular given the steer to do so within the Target Operating Model documentation and the financial incentive to reduce re-offending built into the payment structure for the CRCs (Ministry of Justice, 2013b). However, there are risks associated with this including: reduced investment, added complexity of the information sharing arrangements for offenders arising from the separation between the CRC and National Probation Service, and disruption to cooperation between local agencies (e.g. because of the introduction of competition between successful and unsuccessful bidders):

“cooperativeness between agencies and individuals is a defining element of IOM. Co-operation between local agencies following the bidding process for the CRC contracts, during and after the implementation of Transforming Rehabilitation has to some extent been presumed. Arguably, this should not be taken for granted. This cooperativeness may be disrupted by Transforming Rehabilitation.” (Wong, 2013, p77)

Despite the focus of the DH and NHS England on CJLDS and the acknowledgement by Chris Grayling, Lord Chancellor and Secretary of State for Justice, in the ministerial foreword to ‘Transforming Rehabilitation’ (MoJ, 2013a):

“nothing we do will work unless it is rooted in local partnerships and brings together the full range of support, be it in housing, employment advice, drug treatment or mental health services” (p.3),

Government departments continue to miss the opportunities for a national joined-up approach to the management and support of offenders with multiple and complex needs. Co-location of MH nurses has brought benefits, while not solving all problems, but these benefits are at risk from government changes which will make IOM the responsibility of new providers and does not specifically require them to co-operate with health services.

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