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Partnership with probation hostels

A step forward in community forensic psychiatry

With every serious incident of violence involving a person with current or past mental health problems we hear the cry 'community care has failed'. While an increase in resources for in-patient psychiatric care will be welcomed, the reality is that many individuals with mental health needs, some of whom commit criminal offences, will be living in the community. The probation hostels are an example of such an interface, and offer an opportunity for inter-agency working.

Statutory provision relating to probation and bail hostels is made by Sections 7 and 27 of the Probation Service Act 1993 and the Rules made under that Act (National Association of Probation and Bail Hostels, 1995). Hostels can offer residence to offenders who are subject to a Probation Order and defendants on bail. They can also take offenders who have completed a prison sentence, but who are subject to post-release supervision on licence and prisoners who are subject to a temporary licence.

There are four Approved Hostels in Northumbria: St Christopher's and Ozanam House (managed by the Society of St Vincent De Paul), and Cuthbert House and Pennywell House (managed by the probation service). St Christopher's Hostel in Newcastle accommodates up to 15 residents at any given time. They also provide two cluster flats within the community, which are useful in providing a graduated move towards independent community living. The staff at the Hostel comprises of a Manager and Deputy Manager, five project workers, three project support workers, administrative and domestic support staff.

Community forensic psychiatry services have worked closely with the probation service by, for example, holding out-patient clinics in probation offices (Bowden, 1978; Collins *et al*, 1993). Currently, there is only one bail hostel facility (in Birmingham) within the criminal justice system specifically for mentally disordered offenders (Snowden, 1995). However, we are not aware of any established services providing psychiatric input to probation hostels. Hence, an attempt was made by the Forensic Psychiatric Department, St Nicholas' Hospital and St Christopher's Bail Hostel, Newcastle in 1997 to develop a partnership providing specialist psychiatric services at the point of contact within the hostel. This paper will describe the contract, and the outcome of one year's work. A contract was drawn regarding the partnership agreement; a brief version is reproduced below.

Contract

Statement of aims

(a) To assist in identifying and achieving a comprehensive mental health assessment for current and potential service users with such needs.
(b) To provide direct access to mental health support for hostel residents and to increase staff awareness and knowledge of mental health issues.

Description of service

(a) The forensic psychiatric department will provide one medical session (three hours) per fortnight of psychiatric input.
(b) If an assessment is carried out on a resident, the resident's general practitioner (GP) and the hostel should be informed in writing of the outcome.
(c) The input of the forensic psychiatry department will not replace psychiatric treatment or follow-up that a service user may be receiving from other sources but may act as a facilitator in some cases.
(d) The psychiatric assessments will not be used in court proceedings without the express agreement of the writer.
(e) The overall service will be carried out within the policy statements (confidentiality, equal opportunities etc.) of both St Christopher House and the forensic psychiatry unit.

It was agreed that the contract would be evaluated and reviewed at six monthly intervals.

Description of first year of service

The hostel had 149 residents over a period of one year (15 April 1997–14 April 1998). Twelve residents were referred

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to the forensic psychiatry service during this period. The median age of those referred was 26 years.

The majority of the referrals were for complaints of depression and concerns regarding self-harm. Ten residents satisfied the criteria for a substance use disorder, of which four had mental health problems directly, related to their alcohol or illicit drug misuse. Two residents satisfied the criteria for a depressive episode, whereas one satisfied the criteria for adjustment disorder according to ICD–10 (World Health Organization, 1992). One resident was diagnosed as suffering from an acute psychotic episode and was subsequently transferred to a local in-patient psychiatric unit. Two residents satisfied criteria for a personality disorder, such as emotionally unstable and dissocial personality disorder. Of the 12 referrals, the specialist registrar saw one resident on a regular basis until his discharge into the community. Psychotropic medication was prescribed for four residents as part of their treatment plan through their GP. Two individuals continued to have psychiatric contact from local services following their discharge into the community. Four residents were successfully discharged to the community whereas one was transferred to a local psychiatric unit. Four residents either breached their conditions of residence or bail and two were re-bailed to another hostel. One resident absconded from the hostel.

Training workshops

Over the course of the year, two mental health training workshops were conducted. The first workshop, held in October 1997, aimed at providing an overview of the role of professionals, basic concepts in mental illness and mental health legislation. The feedback demonstrated that the participants were satisfied with the training, finding it interesting and well organised.

The second workshop was conducted in April 1998. The topics of this workshop included psychopathology in schizophrenia and crime and dangerousness in offenders with mental illness. The feedback from the participants showed that they found the training exercise interesting, relevant and well organised. They were satisfied with the overall content of the exercise, although some felt that they were overloaded with information. Suggestions for improvement were made such as use of hand-outs, more case studies and workshops. All the participants felt that they had developed useful insights in working with mentally disordered offenders.

Discussion

Resource implications

The resource implications for developing this partnership were minimal. The health authority are aware of community initiatives by the department, including probation hostel liaison, although there is no separate funding identified. The specialist registrar served as the link between the forensic psychiatry department and the hostel and utilised one medical session (three hours) in a fortnight. Over a period of one year, 12 residents were referred out of a total of 149 (8%). A factor influencing this finding could be the high turnover and frequent moves between hostels, community and prison. Perhaps a mental health screening tool could be of use in screening those with mental health needs during the initial period of their residence. Four residents were prescribed psychotropic medication after liaising with their GP. Hospital admission to the local psychiatric unit was arranged for the resident who presented with an acute psychotic episode. One resident was followed up on a regular basis during his stay in the hostel until his discharge into the community.

Partnership with hostel staff

The liaison benefited the hostel staff in increasing their awareness about mental health problems in offenders. It similarly benefited the forensic psychiatry trainees in gaining useful insights into the functioning of probation hostels dealing with the care and supervision of offenders within the community. Feedback from training exercises suggested that hostel staff had perceived substantial benefits, which could be applied in practice towards managing mentally disordered offenders and assessing risk.

Effectiveness

We do not draw any conclusions towards the effectiveness of this service in managing and rehabilitating offenders with mental health problems into the community as the small number of cases seen limit the generalisability of the findings. Future longitudinal research with larger samples should be carried out to address these issues. Discussions with probation staff, however, suggest that some of the service users who may have mental health needs are reluctant to attend a psychiatric clinic for reasons such as stigma. Mental health presence in a hostel assists in overcoming such barriers, and contributes to dealing with unmet need.

Comment

We are not aware of any study of the prevalence of mental disorder in this population. However, given the rates of mental disorder in remand prisoners, it would be expected that psychiatric morbidity in hostels would be in excess of that in the general population (Birmingham *et al*, 1996).

We suggest that the development of similar partnerships is within the guiding principles of the Reed Report which state that mentally disordered offenders should be cared for as far as possible within the community, rather than in institutional settings; in such a way as to maximise rehabilitation and their chances of sustaining an independent life (Department of Health & Home Office, 1992).

We believe that such partnerships constitute another step within the ever expanding remit of community forensic psychiatry. It is proactive in its

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approach in providing specialist psychiatric input at the point of contact within the hostels. We would suggest that each district might usefully develop their services, perhaps as an adjunct to Court Diversion, and, consistent with this model, a general psychiatry team including members with an interest in forensic psychiatry could take the lead.

We believe that while the need for specialist hostel facilities for mentally disordered offenders cannot be discounted the vast majority of existing probation hostels could benefit from a partnership such as ours with minimal cost and resource implications.

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