

**Probation hostels:
Control, Help and Change?**

*A Joint Inspection of
Probation Approved Premises*

March 2008

Foreword

In the Probation Inspectorate's report in 2007 focusing on hostels in Bristol, *Not Locked Up but Subject to Rules*, the point was highlighted that supervision in the community is not, and cannot be, 'prison in the community'. Yet of all the interventions available to probation, a condition of residence in a hostel makes the greatest demands in the work to 'Punish, Help, Change and Control' each offender in accordance with the individual needs of each case. (The words of the official Offender Management Model – in this context, 'Punish' here simply refers to the need to ensure that offenders comply with the requirements of their order or licence.)

In this report, a year later, the joint inspection team has visited a wider and more representative sample of hostels across England and Wales and we have found that they are generally doing a good job in carrying out the increasingly exacting role that they have been expected to undertake in recent years. In addition to ensuring that residents comply with their orders and licences properly, all the hostels we visited carried out their 'Control' function to a good standard, thereby keeping to a minimum their residents' Risk of Harm to the public. With the more constructive aspects of the hostel work, the 'Help' and 'Change' functions, provision was more patchy, though we found some examples of very good work. Residents were also in general treated decently and fairly, and experienced acceptable living conditions, with a proper standard of health and safety.

Our specific recommendations for improvement should be seen in the light of this overall assessment.

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Glossary of abbreviations

ACCT	Assessment, Care in Custody and Teamwork
ACT	Assessment, Care and Teamwork
CAB	Citizen's Advice Bureau
CCTV	Closed Circuit Television
DIY	Do It Yourself
ETE	Employment, Training and Education
GP	General Practitioner
HDC	Home Detention Curfew
HMI Constabulary	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
IT	Information technology
LiHMO	Living Here, Moving On
MAPPA	Multi-Agency Public Protection Arrangements
MAPPP	Multi-Agency Public Protection Panel
NAPA	National Approved Premises Association
NHS	National Health Service
NOMS	National Offender Management Service
NPS	National Probation Service
OASys/eOASys	Offender Assessment System/electronic Offender Assessment System
PPO	Prolific and other Priority Offender

1. SUMMARY

1.1 National Strategic Context

1) Summary:

1.1.1 From 2004, there had been a significant amount of activity at national and local levels in relation to hostels. This work was designed to support the implementation of the strategy to develop probation hostels as a resource for managing offenders who posed a high Risk of Harm to the public. However, some developments, including those addressing the level of funding required to deliver such a regime, had been delayed pending decisions about commissioning and contestability. Nevertheless, hostels had recently been the subject of an Approved Premises Service Review⁴ within NOMS, the outcome of which was being positively anticipated by probation areas.

1.1.2 We collected evidence from a number of sources about the Facilities Management contract⁶ which appeared to have had a detrimental impact on the ability of many areas to manage their hostel estate efficiently and safely. The particular needs of hostels had been lost in this major reorganisation in 2001. As the first element of the probation service's responsibilities to be contracted out to the private sector, it was to be hoped that these negative lessons would not be repeated.

2) Key Findings:

1.1.3 The creation of new hostels, to meet the level of assessed need, had proved to be impossible in recent years due to local opposition.

1.1.4 Development of existing provision had been hampered by a change to the admissions policy in 2006² which reduced the capacity of the probation service to contribute to public protection as certain hostels could no longer admit some sex offenders.

1.1.5 The Approved Premises Service Review was due to be published. In draft, it had given a steer on funding arrangements and the development of a regime of purposeful activity amongst other matters. We were not aware of what recommendation would be made in respect of future commissioning arrangements.

1.1.6 Most hostels had not been well served by the national Facilities Management contract. The decision not to take the provision of certain services back in-house at the end of the current contract appeared to have been an opportunity missed.

1.2 The Regional Contribution to the Development and Management of Approved Premises

1) Summary:

1.2.1 The regional role in hostel development was limited. Cooperation between areas was sometimes triggered by the needs of those without hostels. Several regions had reached the conclusion that the merger of their whole hostel estate and management would be an effective and efficient arrangement but, so far, had drawn back from taking the work forward due to estimated short to medium term costs. As we said in our report, *Not Locked Up but Subject to Rules*³, we support the concept of regional collaboration within a national framework as the best way of promoting public protection. In this inspection, we found that there was scope for improvements to regional cooperation that would enhance the effective use of the national hostel estate in protecting the public.

2) Key Findings:

- 1.2.2 Regional collaboration was essential, both to manage those cases which could not be placed locally due to their high Risk of Harm and to address the shortfall in bed spaces for both men and women.
- 1.2.3 Probation areas in several regions had worked together to explore the extent to which hostel provision could be managed regionally in order to maximise the potential of the available estate. Progress varied widely.

1.3 Local Strategic Arrangements

1) Summary:

- 1.3.1 Even those areas with positive relationships with Supporting People were unable to influence the local housing authority to address the effective resettlement of offenders from Approved Premises. Although they might deal with the accommodation of offenders generally, none of the strategies that we saw developed by any local authority or probation area addressed the need to move on from a hostel to suitable accommodation. Generally speaking, local housing authorities and Supporting People failed to recognise that hostel residents had specific needs in that they were required to live where directed for a limited period of time as part of a planned process of resettlement.
- 1.3.2 There was an impressive amount of liaison and joint work with the police at different levels in relation to probation hostels and to individual offenders. This was organised differently everywhere but with the same core activities. The police view about the management of their local probation hostel in the eight areas visited and the part they played in protecting the public was universally positive.
- 1.3.3 Funding levels for hostels were no longer sufficient to support the required development of a hostel regime with a full programme of purposeful activity and probation areas with hostels had had to invest significant amounts from their

main service budgets to make up for the shortfall in the central grant. This had been sufficient to ensure appropriate restrictive measures were in place everywhere. Voluntary management committees, who tended to have fewer resources to draw on than probation board managed hostels, were particularly affected by the shortfall. Nevertheless, the voluntary management committee added value to the strategic management of its hostels through the range of skills and experience of its members and had developed a very positive interface with the local community.

2) Key Findings:

- 1.3.4 In most areas, local housing authorities had failed to recognise the need to establish joint working arrangements to ensure the effective resettlement, including housing of offenders residing in probation hostels, under section 17 of the Crime and Disorder Act 1998¹⁶.
- 1.3.5 All the hostels we visited were well supported in their work by the police from the local area and those working in public protection teams.
- 1.3.6 No probation area had a written protocol about information sharing with the police. They each relied upon MAPPA procedures which was inadequate as not all residents were subject to these. We found examples of how the absence of a clear formal agreement with the police could have a negative impact on cooperation. Such a protocol, to be effective, needed to be hostel and locality specific.
- 1.3.7 Most areas did not have a sufficiently detailed contingency plan against the need to evacuate the premises and re-locate the residents. The police were unable to locate a copy of any of the plans we were shown.
- 1.3.8 Probation areas subsidised their hostel(s) from the main service budget. Voluntary management committees were less likely to be able to do so as they were smaller charitable organisations with fewer reserves to draw on.
- 1.3.9 Arrangements had been made to ensure that the voluntary managed hostels adopted the same approach to the role and purpose of hostels as the probation board managed hostels.
- 1.3.10 Some areas felt that they subsidised others that had no hostel as they accepted significant numbers of their offenders as residents. Arrangements for managing these cases were satisfactory on the whole but costly to the receiving area.
- 1.3.11 We found a significant level of under-occupancy in one of the hostels with restrictions on admissions.

1.4 Hostels for Women Offenders

1) Summary:

1.4.1 Due to its geographical distribution, much of the current provision for women offenders in hostels did not meet their needs. As a consequence, the hostels for women were often under-used and were in danger of being eroded to cope with the rising demand for places for men. There was a need for a national strategy to ensure that appropriate provision was made for the small but significant number of women who continue to pose a risk to the public on their release from prison. The recent national review of hostels did not make recommendations that would support this need.

2) Key Findings:

1.4.2 There were sufficient numbers of women posing a high Risk of Harm and who needed an enhanced level of supervision to justify provision within the hostel estate.

1.4.3 Hostels for women were located in only a few places. They were not easily accessible for the majority of potential residents, particularly those with children.

1.4.4 Given the abusive nature of many male residents and vulnerability of some female residents, we strongly questioned both the effectiveness and the viability of requiring women to live in mixed gender hostels.

1.5 Hostel Management

1) Summary:

1.5.1 Overall, residential staff were making a good job of managing safely a group of residents who could include at any one time some of the most damaged and potentially dangerous offenders in society. We found that the quality of the manager made the greatest difference to the performance of the hostel. Their management style and approach to defining staff roles were crucial. How staff then interpreted what their job was meant to be had a significant impact on how well this was done. At one end of the spectrum, we saw an emphasis on restriction, rules and security to the detriment of creating a positive atmosphere. At the other end, staff were modelling positive behaviour towards residents and dealing openly with them, within rules aimed at staff and resident safety, about the level of risk they presented to the public.

2) Key Findings:

1.5.2 There was no apparent link between the level of financial investment in a hostel and the quality of its regime. It was the quality of leadership that made a difference.

1.5.3 All hostels had a satisfactory level of restrictive measures in place and staffing levels were sufficient to maintain a safe environment.

- 1.5.4 Whilst all hostels provided some activities during the week, only three could demonstrate that they were on target for delivering a constructive regime of purposeful activity.
- 1.5.5 Shift patterns were not always set in a way that maximised the potential for hostel management of staff development.
- 1.5.6 Hostel work was very demanding of staff and took its toll. Staff were not always given sufficient support and direction and responded by retreating into their office rather than mixing more freely with residents.
- 1.5.7 Some of the hostels visited underestimated the importance of the handover meeting at shift change and did not share information about residents as fully as they should have done.
- 1.5.8 Hostels were well supported by probation areas' health and safety arrangements.
- 1.5.9 Room checks at the start and end of curfew were intrusive but necessary to ensure the security of the hostel and welfare of its residents.

1.6 Living in the Hostel

1) Summary:

- 1.6.1 All the hostels visited were able to provide at least a minimum standard of basic decent accommodation. Although the highest priority was given to the protection of the public, staff and residents, within the necessary restrictive conditions, residents were treated with respect by staff. The level of engagement with residents varied a great deal from hostel to hostel; those hostels that demanded most from their residents got the greatest level of cooperation from them. These were hostels where staff spent more time, both formally and informally, with residents.

2) Key Findings:

- 1.6.2 All of the hostels visited were fit for purpose and provided a decent standard of clean accommodation.
- 1.6.3 The national smoking ban meant that residents were less likely to use the residents' lounge and participate in informal activities with staff.
- 1.6.4 All residents consulted said that they felt safe in the hostel.
- 1.6.5 Insufficient use was made of residents' meetings as a method of consultation and of gaining ownership of hostel life.
- 1.6.6 Overall, staff treated residents with respect and were fair and courteous.
- 1.6.7 Only two hostels supported the active promotion of diversity through locating and advertising resources for different faiths and minority groups.

- 1.6.8 The quality of the main meal was good but it was often served far too early, resulting in considerable waste.

1.7 Offender Management

1) Summary:

- 1.7.1 The likelihood of achieving sustainable outcomes including rehabilitation and attaining suitable accommodation was enhanced by a period of residence in a hostel. All the hostels were able to demonstrate that they contributed positively to public protection through their work with offenders who posed a high Risk of Harm and we saw some very impressive work undertaken with residents with a history of serious offending and complex needs. The liaison between hostel key workers and offender managers was very productive.

2) Key Findings:

- 1.7.2 The probation service was clear that the role and purpose of hostels was to provide a period of enhanced supervision to offenders assessed as posing a high Risk of Harm to the public.
- 1.7.3 The Risk of Harm presented by residents was contained and managed during their stay in the hostels we visited and in a number of cases actively reduced. The public was therefore better protected.
- 1.7.4 In most cases, the quality of work undertaken with residents was good and in some very impressive.
- 1.7.5 The relationship between the offender manager and key worker was pivotal in achieving a successful outcome.
- 1.7.6 There were insufficient hostel places to meet the demand.
- 1.7.7 Few offenders actually wanted to live in a hostel and were often only informed that they had to do so shortly before release from prison.
- 1.7.8 Offenders' period of residence in a hostel was not always supported by a plan outlining the objectives of their stay; hostel plans, where written in addition to OASys, did not always link to the sentence plan.
- 1.7.9 Careful attention was paid to the diverse needs of individual residents that had contributed to their offending.
- 1.7.10 There was insufficient suitable move on accommodation to meet the needs of hostel residents and continue the process of protecting the public.

1.8 Health

1) Summary:

1.8.1 Staff in hostels were dealing with high numbers of residents with physical and mental health problems. On the whole they did this well, although conditions in the hostels made it difficult to maintain confidentiality about medical issues. They were often supported on site by mainstream health professionals, including services for substance misuse. The trend towards accommodating elderly and infirm residents who had been unable to get proper access to social or nursing care was worrying and suggested a lack of cooperation with local authorities.

2) Key Findings:

1.8.2 Staff would need to develop a more proactive approach to resident supervision in some hostels to implement the changes proposed under the *Medication in Possession* pilot.

1.8.3 There were few services for alcohol misuse in any of the hostels inspected despite the high level of prevalence.

1.8.4 It was unclear why certain hostels were required to pay for GP services.

1.8.5 None of the areas visited had a satisfactory written protocol about sharing information between the hostel and healthcare professionals.

1.8.6 In addition, prisons often did not respond to requests for hostels or GPs for information to ensure continuity of care.

1.8.7 None of the hostels visited had drawn up procedures about what their response would be to the potential outbreak of a contagious disease. No reference was made to this eventuality in any of the contingency plans examined.

1.8.8 Not all of the hostels were following national guidance for testing for the use of illegal drugs. All did, however, adopt a harm reduction approach.

1.9 Suicide and Self-Harm

1) Summary:

1.9.1 Hostel staff were acutely aware that the resident group was vulnerable to attempts at suicide and self-harm. This applied to women in particular but also to men. Staff dealt sensitively but realistically with those they assessed to be at risk and carried out frequent and potentially intrusive monitoring to try to minimise the risk of self-harm. Nevertheless, significant improvements were required in the assessment and recording of vulnerability, including in respect of room sharing.

2) Key Findings:

- 1.9.2 We were impressed by the depth of staff knowledge about their residents in most hostels and by the level of care demonstrated.
- 1.9.3 However, procedures around self-harm and suicide prevention needed urgent improvement in all of the hostels visited. They were applied inconsistently and recording was poor.
- 1.9.4 Assessments of the risk of self-harm, by both hostel staff and offender managers, tended to be inadequate. Offender managers and hostel staff did not routinely seek information about potential residents from prisons.
- 1.9.5 Most staff had had a limited amount of health related training but needed more. They also needed specific guidance on what to look for as potential triggers in individual cases.
- 1.9.6 Some were well supported by the mental health care professionals who provided a regular service to the hostel.
- 1.9.7 Care planning was weak and, with the exception of one area, there was no evidence that the plans were reviewed in most of the cases we examined.
- 1.9.8 Staff carried out room checks at the start and end of curfew to check on the presence and welfare of residents. Where necessary, this process was carried out more frequently and, in general, was undertaken satisfactorily. We saw evidence of staff dealing calmly and appropriately with residents experiencing crises that could, in a few instances, have been fatal.

RECOMMENDATIONS:

National Strategic Context

- In order to enable an effective national strategy for public protection, the hostel estate should be managed nationally rather than regionally.

Local Strategic Arrangements

- The probation service should in all areas work within Supporting People commissioning bodies to establish appropriate supported housing resources to effect the planned move on from hostels of offenders who pose a high Risk of Harm to others.
- Each area should have a clear formal agreement with the police about information sharing and other aspects of liaison and cooperation. These should include contingency arrangements outlining in detail:
 - who should do what in the event that a hostel has to be evacuated and its residents re-located
 - what risk assessments have to be carried out and specify which police officers have been consulted.

Hostels for Women Offenders

- Probation areas that still have mixed gender hostels should comply with the national directive that they should be converted to single sex establishments with immediate effect.
- Adequate and appropriate provision for female offenders meeting the national target profile for hostel accommodation is established within each probation region in the short-term and plans drawn up by NOMS to ensure reasonable access from all major centres of population by 2011.

Hostel Management

- Probation areas should review the roles and deployment of their hostel staff to determine whether existing staff can be freed up to engage further with residents and develop purposeful activities for them.

Living in the Hostel

- Each hostel should develop and implement a strategy for promoting equalities and diversity; the strategy should be monitored and regularly reviewed.

Offender Management

- Offender managers should draw up a sentence plan for offenders residing in hostels which is supplemented within OASys or in an additional plan with details of the contribution that the hostel is intended to make. It should identify the proposed outcomes of the hostel stay, and include:
 - a move on plan
 - how Risk of Harm to others will be managed and
 - what the offender needs to achieve.

Health

- NOMS should discuss with the Offender Health Unit the necessity and propriety of paying for GP services where no extra services are provided.
- Probation areas should seek advice from the local communicable disease consultant (public health) about what to do in the event of an outbreak of a contagious disease. This should be included in the hostel contingency plan.
- Where it is not current practice, local authorities should play a part through MAPPA in the assessment and planning for those aged 65 and over with social care and nursing needs who require residential accommodation but also have a criminal history and pose a Risk of Harm to others. They should add a variation to their contracting and commissioning arrangements in order to ensure access to achieve this.

Suicide and Self-Harm

- Hostels should have clear written guidance on the procedures for the assessment of risk of self-harm and suicide. These should include:
 - where there is a history of self-harm, information should be sought actively from any recent prison sentence and/or medical practitioner to inform the current assessment
 - the development of a care plan that is accessible to all staff, is followed, recorded and reviewed
 - the exchange of information about the status of the level of risk and plan at handover meetings.

2. THE STRUCTURE OF THE INSPECTION AND REPORT

2.1 Structure of the inspection

2.1.1 The terms of reference for this inspection were:

to assess the effectiveness of the contribution of Approved Premises to the management of offenders in the community who pose a high Risk of Harm to others and to examine the treatment of residents in such establishments.

2.1.2 At the heart of the methodology was the inspection of eight Approved Premises and the management of a representative sample of their residents. In addition, we examined national, regional and local strategies relating to offender management and public protection in so far as they impinged on the work of the hostels.

2.1.3 The individual hostels were located in eight probation regions to give a wide spread of practice. The choice of hostels in metropolitan as well as smaller areas gave us access to those serving both ethnically diverse and rural populations. Five of the hostels were managed by probation boards and were for men only and therefore represented the majority of Approved Premises. We also selected hostels with the following spread of characteristics:

- ▶ one managed by a voluntary committee
- ▶ one female
- ▶ one mixed gender
- ▶ one that had participated in the late Approved Premises Pathfinder programme¹
- ▶ two that were on the list of those premises not permitted to accommodate offenders who had been convicted of sexual offences against children²
- ▶ three that were routinely expected to take referrals from neighbouring areas that did not have their own Approved Premises.

2.1.4 The probation board managed hostels inspected were in London, Bedfordshire, South Wales, Lincolnshire, Northumbria, Staffordshire and Cheshire. The voluntary managed hostel was in West Yorkshire.

2.1.5 We adapted elements of HMI Prisons' *Expectations* (prison inspection criteria) and HMI Probation offender management criteria and included specific references to MAPPA and the police to create a framework for each inspection. We then spent three days in each of the Approved Premises, ensuring that we were present in each on one evening, at the start of a night curfew and hostel check, and then on one morning, for the hostel check at the end of the curfew.

- 2.1.6 A sample of ten cases was read in each area and offender managers and key workers interviewed; the offenders were also interviewed if they still resided in the hostel and were available. The case file assessments focused on their period of time in the hostel and the outcomes of their stay. The sample was made up of five offenders living in the hostel approximately nine months prior to the inspection, most of whom had moved on, and five who had been admitted only a few weeks before it started. As far as possible, the sample included a range of cases in terms of age, ethnicity, gender and seriousness of offending; outcomes included both recall and move on to independent accommodation.
- 2.1.7 We also interviewed police officers with responsibility for public protection and for the neighbourhoods in which the hostels were situated. Interviews with the police generally took place away from the hostel unless an officer was visiting staff or residents. Senior probation managers, middle managers and board members were interviewed in groups, as were the voluntary management committee; these discussions were informed by evidence submitted in advance about supporting strategies and other information. Hostel managers were all very helpful in setting up meetings for us with regular visitors including drugs workers, GPs, ETE partnership staff, health and safety advisors and community representatives.
- 2.1.8 We deliberately allowed ourselves a significant amount of time to observe what was going on, to examine hostel documentation in situ and check out the operation of written procedures. We met informally with all the staff in each of the hostels who were in work on the days we were there and as many residents as were prepared to speak to us. We had tested out this methodology during our inquiry into the allegations made in a *Panorama* programme in November 2006 and found that it gave us the information and experience we needed to inform our assessment. Our report on this inspection, *Not Locked Up but Subject to Rules: an inquiry into managing offenders in Approved Premises (hostels) following the Panorama programme broadcast on 8 November 2006*³, was published in March 2007.
- 2.1.9 Our aim in this inspection was to see whether hostels were operating as intended and having the desired impact on behaviour and Risk of Harm. As residents were now unlikely to apply to live in a hostel, but were required to do so as a mandatory condition of their release from prison on licence, we also wanted to be reassured that residents were treated with respect and provided with decent living conditions.
- 2.1.10 At the end of our visit to each area we gave verbal feedback to senior and hostel managers, signposting areas for improvement, which we confirmed in writing within two weeks.

2.2 Terminology

- 2.2.1 The hostels we refer to in this report are now formally called Approved Premises. Previously they had been referred to as Approved Probation and Bail Hostels, having been 'approved' by the Home Secretary for the purpose of

accommodating those offenders subject to bail conditions or under the supervision of the probation service.

2.2.2 In the interests of being understood by the general public, in this report we use the term 'hostel' to refer to Approved Premises.

2.3 Structure of the report

2.3.1 In our report, *Not Locked Up but Subject to Rules*, we included a significant amount of background information about the work of the NPS, aspects of the prison system and about hostels. Having watched the *Panorama* programme and undertaken our inquiry, we decided that we needed to consider what the public could fairly expect of the criminal justice agencies in terms of public protection. In order to address this issue, we felt that we had to explain the context. As information in that report is still relevant, we do not need to repeat all of it here. However, some detail about the evolution of the hostel estate and current position is included.

2.3.2 This inspection was conducted during a dynamic period for the development of the hostel estate in England and Wales. More broadly, the context of change also included the move from probation boards to Trusts to be piloted from April 2008 and decisions about commissioning generally. Accordingly we spent time examining the current position and potential impact of plans, where they were known, in relation to:

- ▶ the NOMS Approved Premises Service Review⁴
- ▶ work to address the recommendation in the *Review of the protection of children from sex offenders*⁵ that there should be a mandatory amount of purposeful activity in hostels
- ▶ the new Facilities Management contract⁶
- ▶ progress in regionalising the management of hostels.

We used the information we collected from hostels about their residents to draw conclusions about the use of the hostel estate. We decided to include female provision in our inspection as we were concerned that it was being eroded to accommodate the growing number of men requiring hostel accommodation. In order to address the issues around the female estate, we also drew on wider sources of information.

2.3.3 The core sections in this report, which address directly the terms of reference, are: Hostel Management, Living in the Hostel and Offender Management. These are followed by two detailed chapters – Health, and Suicide and Self-Harm – that illustrate both who hostel residents are and aspects of their treatment that dominate hostel life.

3. THE ROLE AND PURPOSE OF PROBATION HOSTELS

3.1 Historical development

- 3.1.1 A few years after the creation of the probation service in 1907, legislation⁷ was passed allowing a condition of residence as part of a probation order. The first hostels were exclusively managed by the voluntary sector and were intended to accommodate young offenders only. They focused on the provision of stable accommodation and support, encouraging boys and young men into employment as a route out of crime. In 1948⁸, the arrangements for hostels were put on a statutory footing and the Home Secretary was empowered to approve and regulate hostels. The age range for residents remained as 15 to 21 years. When the minimum age for probation orders was raised to 17, following the implementation of the *Children and Young Persons Act (1969)*⁹, access to hostel places was opened up to all adults.
- 3.1.2 From the 1970s, the probation service began to open and manage its own hostels. Specific ones for people on bail also began to be established as an alternative to a custodial remand. It was soon decided that bailees could also be accommodated in probation hostels. Most became known as Probation and Bail Hostels although some specialised. A few began to take women, either exclusively or as a mixed hostel. A few of the women's hostels also accommodated their children. Whilst growth was slow, often due to local opposition, 27 new hostels were established between 1988 and 1994.
- 3.1.3 In 1998, HMI Probation published a report on a thematic inspection of hostels¹⁰. By this time, hostels had come a long way from housing petty young offenders and there was a growing emphasis on tackling both offending behaviour and criminogenic need, particularly for convicted residents. The first finding was: *'Hostels, including those managed by voluntary committees, unquestionably demonstrated their ability to accommodate and work successfully with some of the most difficult, damaged and potentially dangerous defendants and offenders within the criminal justice system, in a manner which gave due regard to public safety'*.
- 3.1.4 The majority (65%) of residents at the time were, however, bailees, who were mainly unconvicted, and most hostels took the view that it was inappropriate to require them to undertake offending behaviour work. As bailees, they had been placed in a hostel to provide reassurance to a court that they were more likely to answer their bail than if left at home or because they had committed offences that rendered them homeless. In other words, it was the provision of monitored accommodation that was required, not supervision. Having seen how positive an impact a period of residence could have on offending behaviour, we queried

whether this was the best use of an expensive resource capable of delivering an enhanced level of supervision.

- 3.1.5 Whilst many examples of good practice were then found, the overall picture was one of inconsistency, with current provision and hostel regimes based on historical local initiatives. Nine of the then 54 probation services did not have a hostel. We advised that the time was right for a national strategy to determine what form of provision was needed, how it should be provided and where it should be located.

3.2 National developments

- 3.2.1 The NPS came into being in 2001 and created an opportunity to bring consistency to work with offenders. Responsibility for hostels was located within the Public Protection Unit. A thorough review was undertaken and the approved premises strategy was published with ministerial approval in 2004¹¹. It endorsed the trend towards the use of probation hostels for the management of offenders who had been convicted of serious offences and who posed a high Risk of Harm to the public. By then, the characteristics of the population of hostels had changed significantly since our inspection in 1998 and the majority of residents were now those released from prison on licence. Hostels were already established as an essential resource in the management of offenders posing a high Risk of Harm to others; they were well used by probation officers supervising such offenders and within MAPPA.

- 3.2.2 The strategy contained wide ranging recommendations aimed at developing this approach further. On a practical level, they included the introduction of double waking night cover and the end of mixed gender hostels. Both these changes were already in the process of being implemented; the closure of mixed gender hostels was almost complete. Probation areas were required to work together regionally to research and evaluate further need. A set of quality standards was to be drawn up and work undertaken to define what enhanced supervision should look like.

- 3.2.3 An Approved Premises Pathfinder programme¹ was established in eight hostels in 2002 and ran for two years. It was designed to address the need for a constructive regime to support the rehabilitation of residents. Its main features were staff training to develop a team based pro-social and motivational approach for work with residents and the development of a Pathfinder group work programme, LiHMO. This programme was designed to assist residents to respond positively when confronted with difficulties and to develop problem-solving skills but had mixed success and, by the time it was evaluated in 2006, a decision had already been taken not to roll it out nationally. Views about the values of LiHMO varied: some former prisoners, who had been through accredited programmes, were said to have found it repetitive whilst others described it as useful. However, it was still the only hostel specific programme and we found several probation areas during this inspection still using it, or training staff and planning to do so. The training had been developed over a number of years and was acknowledged as good.

- 3.2.4 Other developments within the probation service during this period supported the changes proposed by the strategy, including the introduction of OASys as the tool to be used by all probation areas when assessing offenders. It was hoped that the introduction of OASys would bring greater consistency into the assessment process, particularly in relation to Risk of Harm.
- 3.2.5 Linked developments were the creation of MAPPA (by the Criminal Justice and Court Services Act (2000)¹² updated in the Criminal Justice Act (2003)¹³ and the introduction of the Supporting People programme in 2003 as the means by which supported public housing was commissioned and funded. MAPPA placed a responsibility on the police, probation and prison services to establish panels and supporting mechanisms to assess and manage violent and sexual offenders in England and Wales. At the same time, a duty was imposed on a number of other agencies within the local authority, including health, housing and social services, to cooperate in this process. The link between the two was that some offenders who posed a Risk of Harm to the public needed supported accommodation, often after a period in an approved probation hostel, to address needs linked to their offending. These developments had the potential to establish a joined up approach: entry into the hostel estate for those who required such structured support and oversight, followed by transfer to a suitable alternative when their level of risk diminished.
- 3.2.6 The national strategy was implemented through Probation Circular 37/2005: *The Role and Purpose of Approved Premises*¹⁴. In summary, it stated: '*the core purpose of Approved Premises is the provision of enhanced supervision as a contribution to the management of offenders who pose a significant Risk of Harm to the public. Admissions criteria and referral processes need to reflect this focus on public protection. The delivery of enhanced supervision encompasses security, staffing arrangements, restrictive measures and rehabilitative components.*'
- 3.2.7 A period of residence in a hostel could still properly be used for the purposes of bail or as a condition of a community order, but was now more commonly seen as a requirement in a licence. Offenders assessed as posing a medium Risk of Harm could be accepted as residents if the other conditions applied, i.e. they would benefit from the enhanced level of supervision, management and oversight provided by an approved hostel regime and they did not take up a place to someone assessed as high risk. In the draft report on the *Approved Premises Service Review 2007*⁴, it was proposed that, from April 2008, there would be a new performance measure that 70% of residents in each hostel should be assessed as posing a high Risk of Harm. We were not aware, at the time of writing, whether this proposal had been accepted.
- 3.2.8 The proposed change of use was achieved at the expense of hostel places for bailees. This, coming at a time when the prison population was rapidly increasing, was a cause for concern amongst sentencers and probation staff alike. As a consequence, the *Bail and HDC Accommodation and Support Service*¹⁵ was commissioned, with ClearSprings Management Services chosen as the provider from June 2007. This service would also accommodate prisoners released on HDC who did not need a place in a probation hostel.

3.3 Current position

- 3.3.1 NOMS came into being in 2004 as the overarching body with responsibility for both prison and probation services. Changes included the introduction of a regional focus and preparation for commissioning of services at this level. Potentially, probation areas would have to win contracts to provide services. Developments in some elements of service, including hostels, had been delayed pending decisions about which aspects were to be the first to be subject to contestability. However, there had been a significant amount of progress made during 2007.
- 3.3.2 During the fieldwork phase of this inspection in October and November 2007, there were 100 'mainstream' probation hostels in England and Wales. In addition, there was one joint probation and prison project for 18-25 year olds on licence and four for offenders with a substance misuse problem. Whilst these projects were funded by NOMS, they were regarded as pilots and outside of the scope of this inspection.
- 3.3.3 Of the 100 existing hostels, 12 were still managed by voluntary committees. Seven were for women only and four were mixed. (By December 2007 one of these had changed to male only and another had decided to do so from April 2008.) Between them, they provided 2,200 bed spaces, 160 of which were for women. They ranged in size from ten to 41 beds apiece. Five out of the now 42 probation areas did not have a hostel and as all recent attempts to establish new ones had failed, due to local opposition, they were unlikely to get one. Most therefore were probation board managed hostels for men.

3.4 The prison – hostel – community continuum

- 3.4.1 It is an important point that most offenders were released from prison at some stage. Only those serving life or detained in secure psychiatric units are detained indefinitely, should they be assessed as posing a continuing very high Risk of Harm. This applies to very few cases. The majority of prisoners serve determinate sentences and will be released at the halfway point of the custodial element of their sentence.
- 3.4.2 Most prisoners are released without supervision, but with the threat of a return to prison to serve the remainder of their sentence should they reoffend before the expiry of their original sentence period. All young offenders and those aged 21 and over serving sentences of 12 months or more are released on licence to the supervision of the probation service or, if aged under 18, to the local youth offending service. The minimum length of licence is three months and the maximum life. In most cases the length of licence is known at the time of release.
- 3.4.3 We were told that a period of residence in a hostel could feel more restrictive to an offender subject to licence than their last period in prison. This would clearly not be the case for someone released from a closed prison where they would have been locked up at all times either in their own cell or within the prison walls. However, there are ten open prisons where prisoners are allowed a range

of freedoms. Some of the prisoners would have been transferred to one of these open prisons towards the end of a long sentence as part of their preparation for release. Prisoners in such establishments can go out to work each day, be released on temporary or 'home leave' for a variety of reasons connected to resettlement and are not locked up during the day.

- 3.4.4 Being required to live in a probation hostel is a serious undertaking. All hostel residents have to conform to a minimum curfew from 11pm to 6am; individuals are then usually subject to one or more further conditions from a range of standard restrictions. These include extra curfews, prohibitions from visiting certain places or people, refraining from alcohol use or whatever is deemed necessary and proportionate to contain or manage the assessed level of Risk of Harm. Hostel residents can not receive visits from children which is a sensible precaution. We found that each hostel had its own rules about admitting adult visitors; one permitted no visitors at all which we thought was unnecessarily restrictive.
- 3.4.5 In addition, the length of stay in a hostel is usually not set. Depending on the period of licence, the offender is likely to be told that they are to remain at the hostel until their offender manager or MAPPA is satisfied that their level of Risk of Harm has been reduced. This can be achieved by successful completion of an accredited programme aimed at reducing offending behaviour or stabilisation of some risk related factor, e.g. mental health problems. All probation hostel residents have to live where directed. Licencees risk a return to prison by administrative recall; bailees and those subject to community orders with a residence requirement face a return to court and by implication a period of imprisonment, either on remand or as an alternative sentence.
- 3.4.6 The restrictive conditions are only one part of the picture; hostels also have to provide a positive regime of constructive interventions for residents to address and reduce the factors linked to their offending. The planned outcome for a period of residence is positive change brought about by a programme of rehabilitation addressing whatever factors are linked to offending and the assessed level of Risk of Harm. This should be driven by the offender manager on the outside and the key worker or offender supervisor in the hostel. The period of residence is an opportunity to move an offender towards resettlement so that they can eventually take their place safely and independently in the community.

3.5 What can the public expect?

- 3.5.1 The developments described at the start of this section took place against a backdrop of growing public interest in the hostels. This was due in part to a small number of high profile cases involving serious reoffending by residents and to concerns expressed about who might be living in hostels that were situated in residential areas. We return to this in the next section but reproduce here an extract from the inquiry³ into the allegations made in the *Panorama* programme: *'the Home Office and individual agencies often find themselves portrayed in the public eye as responsible for some aspect of public policy that has been seen to*

go wrong. The implicit expectation continues to grow that risk to the public can be eliminated if only supervision in the community can be made effective enough. The linked expectation has grown that if an offender under supervision has reoffended the supervisor must in some way necessarily be at fault.'

- 3.5.2 It will be clear from this report, and our other reports, that we take a different view. We say that when supervising an offender in the community it is simply not possible to eliminate risk to the public, and we do not criticise staff for failing to achieve the impossible. But it is right for the public to expect that public servants will do their job properly. By that we mean that probation officers and others involved in the supervision of offenders must take all reasonable action to keep to a minimum each offender's Risk of Harm to others. If it can be shown that they have done that, then they will have 'achieved the possible'.
- 3.5.3 At the time of this inspection residents in probation hostels were primarily offenders released on licence from a custodial sentence. As the definition of purpose implies, they were also most likely to be assessed as people who would pose a high Risk of Harm to the public if they were not resident in a hostel and subject to the rules and restrictions imposed therein. There is no such thing as no risk. OASys uses the term 'low' risk which effectively means that there is no known evidence to suggest a risk. Some offenders will continue to pose a high level of Risk of Harm even when in a probation hostel, to staff, other residents or members of the public. In this report we identify what measures can realistically be expected to be put in place to minimise this risk.

4. NATIONAL STRATEGIC CONTEXT

4.1 Limitations on further developments

- 4.1.1 A coherent national strategy, giving direction about hostel development and use, was issued to all probation areas in 2004¹¹ but its implementation was limited by the shortfall in hostel places and their uneven spread. The creation of new hostels to address this problem had since proved impossible due to local opposition. The situation was then exacerbated further by the fact that 14 out of the 100 mainstream hostels were prohibited from accommodating offenders convicted of sexual offences against children aged under 16 years. This pronouncement had originally been made by the Home Office in June 2006 in respect of 12 hostels in response to a national newspaper campaign about child sex offenders; three more hostels were subsequently added to the list and one removed.
- 4.1.2 The decision to admit someone to a hostel has always been based on an assessment of Risk of Harm that included the location of the hostel. However, it is the individual who is risk assessed and not the premises. Given that most hostels have been private homes, it is inevitable that many are located in residential areas and that some are close to schools or nurseries. At least one hostel on the list has never admitted sex offenders as it is literally next door to a nursery. Others have worked positively with schools, nurseries and nearby local groups to ensure the safety of children and has been supported by them in their disapproval of the prohibition. The original Probation Circular 26/2006 *Changes to admission policy for Approved Premises*² indicated that the prohibition would apply to those 'immediately adjacent to schools or nurseries'. Most of those on the list, however, are not so situated.

4.2 Approved Premises Service Review 2007

- 4.2.1 It was decided that hostels would be the subject of one of the NOMS Approved Premises Service Reviews in 2007⁴. This was an exercise commencing in June, owned by both the Commissioning and Partnerships and the Performance and Improvement Directorates. A draft report was circulated in November 2007, which we commented on, informed by the findings from this inspection. Some of the elements of the recommendations in the draft report are discussed in more detail in the body of this report and include the issues addressed below. We were not aware of the final outcome in relation to this draft at the time of issuing our own report for consultation in January 2008.
- 4.2.2 There continued to be a significant amount of investment from the centre in improving standards in hostels. A set of performance standards had been introduced in 2006 for areas to audit themselves against; it addressed progress

against achievement of an enhanced constructive and restrictive regime. The only hostel funding related performance target was dropped during 2007/2008 whilst the Performance Improvement Unit undertook a quality assurance exercise against the second audit, completed in 2007. Having undertaken this exercise, it was intended that the self-audit scores would feature in the new performance measures in the Integrated Probation Performance Framework.

- 4.2.3 In addition to the Approved Premises Service Review, the *Review of the protection of children from sex offenders*⁵ had recommended that guidance should be drawn up about the development of compulsory programmes of purposeful activity for residents in Approved Premises. The recommendation was an acknowledgement of the fact that there was often little such activity in the hostels and that the lack of occupation for sex offenders could increase the likelihood of reoffending. As such, it was accepted by ministers. A team of hostel managers, under the leadership of NAPA, had been considering the content of compulsory programmes.
- 4.2.4 It was acknowledged in the NOMS Approved Premises Service Review that the current funding arrangements were no longer adequate. Chief officers and boards had complained that, whereas the national grant had previously been adequate to fund the running of their hostel, it was now insufficient. Dropping the 90% occupancy target had, almost perversely, had a negative impact on budgets as occupancy over target could attract significant funds in the following year. (As an example, one hostel in the sample had previously achieved a £12,000 bonus.) The national job evaluation scheme, together with the introduction of double waking night cover, where implemented, had had a more significant impact on hostel budgets than other parts of the service. The fact that 12 out of the 100 hostels were owned and/or managed by voluntary management committees was another complicating factor as they tended to have fewer, if any, other resources to draw on to make up any shortfall.
- 4.2.5 In 2006, an assessment of the potential shortfall in hostel provision had been published. The data had been generated by a standard formula, using information, supplied by regions and areas, on the number of offenders who met the criteria for admissions to Approved Premises. Information about the length of stay was included. The returns suggested a shortfall of between approximately 100 and 300 bed spaces for men. Even allowing for these figures to be estimates, this was a significant gap. There was also an estimated shortfall in provision for women, but the position here was less straightforward as there was an acknowledgement that existing resources were too widely dispersed.
- 4.2.6 At the draft stage, the Review Group did not make a recommendation about whether future commissioning arrangements should be on a regional or national basis. Given that the primary purpose of the hostel estate was the protection of the public and it was unlikely that the shortfall in provision would be resolved, we strongly believe that there should be a national approach to commissioning, as we had already said in our report *Not Locked Up but Subject to Rules*³. Any potential disruption to protocols around case transfers and admissions should be avoided. We believe that this can only be achieved with a commissioning approach that has public protection as its highest priority.

4.3 Facilities management

- 4.3.1 There had been acceptance at all levels in the probation service including officials that hostels had not been well served by the national Facilities Management contract⁶. It was acknowledged, during the consultation phase before the recent re-tendering exercise, that there had been problems with what was referred to as the 'soft services', i.e. contracted staff's interface with residents, the amount and quality of food, cleaning and furnishings. Prior to 2001 and the creation of the NPS, each area had managed its own estate and services. This first contract had been due to end in the spring of 2007 but was extended to March 2008. During 2005, consideration had been given to returning responsibility for 'soft services' to areas or regions, in light of the unhappiness with existing arrangements, but this was not followed through. The reasons for this were not clear.
- 4.3.2 The original contract had been let by the NPS. The new one was now the responsibility of the newly created Home Office Property General Group which had responsibility for the whole of the Home Office estate. Within this arrangement, the probation service was a small player and the 100 hostels made up a very tiny portion of what was a massive contract. The tendering process took place during the autumn of 2007. There were few changes to the new contract: the main ones were that instead of one contract for the whole hostel estate six 'regions' would be created plus an independent helpdesk.
- 4.3.3 Unless there was to be a change of direction which would entail paying the penalties attached to any decision to opt out of elements of the new contract, it would operate until 2013 with up to two years extension.
- 4.3.4 There was bound to be a tension between a service driven by cost and economy of scale and the needs of one small element of the operation, particularly as these needs were probably different to those of the rest of the Home Office estate. The other obvious residential facilities, i.e. the prison estate and other custodial establishments, had their own arrangements for 'soft services'.
- 4.3.5 Only the minimum level of service in the Facilities Management contract was funded. Areas told us that economies of scale achieved at the centre were outweighed by the cost of managing them. As far as some areas and hostel managers were concerned, there was a lack of transparency about certain aspects of the contract. Only one of the hostels we visited had no complaints to make about its operation. This was the purpose-built hostel which was kept in good repair and was well furnished and comfortable. Otherwise, the state of repair varied significantly, suggesting a differential approach on a regional basis to the operation of the contract.
- 4.3.6 A number of the complaints that we heard appeared to be the result of paring back costs by the contractor and providing a service below the minimum required. Two hostels reported ongoing problems in getting essential repairs done, to the point where it felt like a battle. The inadequate response to requests suggested that those responsible for repairs had no concept that this was someone's home rather than an office and that leaking water and holes in

bedroom windows were not acceptable. We were shown evidence of the state of disrepair which, in the largest hostel, meant showers almost constantly out of use and in another what we considered to be hazardous stair covering. This had a negative effect on one hostel's ability to obtain cooperation from residents who told us that they could not respect the authority of managers who could not even get a shower fixed.

- 4.3.7 Instead of a swift response from local staff to small problems, things, e.g. leaks, were allowed to escalate until they became large expensive ones. What might be a source of bemusement in an office, e.g. a broken light that has to be fixed by someone who has to travel for several hours to get there, only to find on arrival that they do not have the correct kit, can be a real hazard in a probation hostel with its resident mix. All but one of the probation board managed hostels commented with frustration about the large amounts of management time wasted in trying to get work done. One had undertaken an exercise earlier in the year and had found that the deputy manager spent over 40% of her time in chasing contractors in relation to repairs or cooking and cleaning staff. Savings at the centre achieved through this contract were costing individual hostels dear.
- 4.3.8 The Facilities Management contract applied to the probation board managed premises only. The contrast with the voluntary managed hostel we visited was stark. Here it shared a handyman and gardener with its sister hostel and was in control of its own building. It was able to keep on top of repairs, etc with the minimum management input.
- 4.3.9 This hostel also employed its own cooks and cleaner who had worked for it for a number of years. We came across cooks and cleaners in other hostels who had previously been employed by the probation area and had been transferred across and stayed in their posts. The long-standing permanent day time staff were not 'just' cooks and cleaners but full members of the hostel's staff who contributed to the management of offenders. We saw them taking the time to get to know and talk with residents, adding to the positive atmosphere. On another level they would sometimes be the ones, particularly the cleaners, to spot warning signs of escalating risk. Weekend and relief staff, newly employed by the contractor, were generally not part of hostel life in the same way and tended to do what they were paid to do and no more.

Summary:

From 2004, there had been a significant amount of activity at national and local levels in relation to hostels. This work was designed to support the implementation of the strategy to develop probation hostels as a resource for managing offenders who posed a high Risk of Harm to the public. However, some developments, including those addressing the level of funding required to deliver such a regime, had been delayed pending decisions about commissioning and contestability. Nevertheless, hostels had recently been the subject of an Approved Premises Service Review within NOMS, the outcome of which was being positively anticipated by probation areas.

We collected evidence from a number of sources about the Facilities Management contract which appeared to have had a detrimental impact on the ability of many areas to manage their hostel estate efficiently and safely. The particular needs of hostels had been lost in this major reorganisation in 2001. As the first element of the probation service's responsibilities to be contracted out to the private sector, it was to be hoped that these negative lessons would not be repeated.

Key Findings:

- The creation of new hostels, to meet the level of assessed need, had proved to be impossible in recent years due to local opposition.
- Development of existing provision had been hampered by a change to the admissions policy in 2006 which reduced the capacity of the probation service to contribute to public protection as certain hostels could no longer admit some sex offenders.
- The Approved Premises Service Review was due to be published. In draft, it had given a steer on funding arrangements and the development of a regime of purposeful activity amongst other matters. We were not aware of what recommendation would be made in respect of future commissioning arrangements.
- Most hostels had not been well served by the national Facilities Management contract. The decision not to take the provision of 'soft services' back in-house at the end of the current contract appeared to have been an opportunity missed.

RECOMMENDATION:

- In order to enable an effective national strategy for public protection, the hostel estate should be managed nationally rather than regionally.

5. THE REGIONAL CONTRIBUTION TO THE DEVELOPMENT AND MANAGEMENT OF APPROVED PREMISES

5.1 Regional collaboration

- 5.1.1 In several regions, there had been a high degree of collaboration to explore the extent to which hostel provision could be managed regionally to achieve the maximum potential of the available estate. The London Probation Area had the advantage of being a region in itself and had invested in ensuring a consistent approach to hostel development. One senior manager had responsibility for all of its approved premises and a central referral unit was used to manage referrals. At the other extreme, one senior management team in another area referred to their regional approach to approved premises as having a 'light touch', although there was evidence of some practical collaboration between areas.
- 5.1.2 A number of probation areas had agreed in principle that further collaboration, ranging from the harmonisation of procedures to full regionalisation of the management of the regional estate, was desirable. Most regions assessed themselves as having a shortfall in bed spaces for men. All agreed that provision for women was a problem; two had been prepared to follow the national recommendation that regions should convert one of their mixed hostels into an all female facility to act as a regional resource but thereby reducing the beds available for men. (It should be noted that all of the other 26 former mixed hostels that had converted since the end of 2005, or planned to do so, had changed to an all male population.)
- 5.1.3 Senior managers in several regions had agreed that, in principle, they would support merging resources to form a regional hostel estate, managed by one assistant chief officer on their behalf who would work to a nominated chief officer. This full approach would require a range of substantial changes from the creation of a central referral system at one level to centralising human resources functions and rationalising staffing at another. Regions that had pursued this option had all predicted savings in due course that made it affordable. However, the start-up costs would be considerable and the changes would take several years to take full effect. With difficult financial settlements ahead, most had settled for a more modest shift although two areas were waiting for the publication of the Approved Premises Service Review before making a decision about their options.
- 5.1.4 It was positive to see, however, that a number were actively considering changes at little or no cost that would make referrals, in particular, more efficient. At least two software programmes had been developed in-house in areas that were capable of supporting a regional vacancy database. They could also be used to monitor and report on aspects of performance. Regional forums

had been used to harmonise approaches to managing their hostels that had had a positive impact on regime development.

5.2 Transfers between areas

- 5.2.1 In the meantime, there continued to be a number of offenders who could not be accommodated in local hostels. This was obviously the case where areas had no hostel or nowhere to refer some sex offenders. On one level, offender managers in these areas were disadvantaged by the inequitable distribution of provision and had to work harder to find appropriate hostels that would take their cases. What was more important, however, was that regional cooperation was essential for public protection. There would also be cases which could not be accommodated in their home area in order to protect their victim and cases with a high media profile who needed to be placed out of their home county.
- 5.2.2 It was still normal for assistant chief officers to negotiate these moves informally with their counterparts in neighbouring areas. This was not always easy or even possible when bed spaces were over-subscribed internally. In addition, areas were required to accommodate the 'critical few' who posed such a high level of risk that the Public Protection Unit took responsibility for ensuring they were found an appropriate hostel bed.

Summary:

The regional role in hostel development was limited. Cooperation between areas was sometimes triggered by the needs of those without hostels. Several regions had reached the conclusion that the merger of their whole hostel estate and management would be an effective and efficient arrangement but, so far, had drawn back from taking the work forward due to estimated short to medium term costs. As we said in our report, *Not Locked Up but Subject to Rules*, we support the concept of regional collaboration within a national framework as the best way of promoting public protection. In this inspection, we found that there was scope for improvements to regional cooperation that would enhance the effective use of the national hostel estate in protecting the public.

Key Findings:

- Regional collaboration was essential, both to manage those cases which could not be placed locally due to their high Risk of Harm and to address the shortfall in bed spaces for both men and women.
- Probation areas in several regions had worked together to explore the extent to which hostel provision could be managed regionally in order to maximise the potential of the available estate. Progress varied widely.

6. LOCAL STRATEGIC ARRANGEMENTS

6.1 The position of hostels in the move from prison to community

- 6.1.1 The extent to which areas had worked successfully as members of their Supporting People commissioning bodies varied. Some probation areas had not understood their power within the Supporting People commissioning body, as established by section 17 of the Crime and Disorder Act 1998¹⁶ and had therefore failed to persuade the other agencies of the merits of supporting offenders in different forms of accommodation as against perceived 'deserving' groups. Others had been successful in commanding the inclusion of offenders into strategic plans and had been able to assert the notion that offenders were a cross-section of citizens with supported housing needs; also that accommodation and support needs were so closely linked to offending for many that the failure to provide appropriate access put the public at risk of further reoffending. Crime reduction was not just the responsibility of criminal justice agencies and did not end with locking people up.
- 6.1.2 Even those areas with positive relationships within Supporting People were unable to influence the local housing authority to address crime reduction in relation to effective resettlement of offenders from Approved Premises as required by the crime and disorder legislation.
- 6.1.3 All the areas we visited resorted to the commonly used approach in the community of issuing a 28 days notice to quit as evidence of impending homelessness. It put the hostels in an invidious position as the criminal justice system and/or MAPPAs had required an offender to live in the probation hostel, usually against their will and sometimes causing them to lose their own accommodation. The hostel then, as a way of proving impending homelessness, (which in turn increased the number of points awarded to the offender and their level of priority with the housing authorities) promised through its power to direct to evict the resident with nowhere to go. We did not find any examples of Approved Premises and authorities working together to develop a joint and effective resettlement plan which included planned moves into mainstream or supported housing without this expedient.
- 6.1.4 Despite these problems at a strategic level, several areas had established good supported accommodation schemes for high Risk of Harm offenders; alternatively, they were able to make referrals to other hostels providing a less restrictive regime and often specialist support, e.g. regarding mental health or substance misuse.

GOOD PRACTICE EXAMPLE

The Heanton Housing Association operated in the West Midlands region. It provided a public protection liaison service and had the equivalent of one full-time worker in the Staffordshire area. The public protection liaison officer participated in the work to broker move on accommodation with area accommodation workers on behalf of offenders assessed as posing a high Risk of Harm. They supported residents into their new tenancy, addressing issues around Risk of Harm as well as needs. They assisted with resettlement, including after the end of the licence if necessary; liaised effectively with other agencies, e.g. CAB, and provided support with learning to budget and cook, etc. as required.

6.2 Partnership in public protection

- 6.2.1 We interviewed senior and operational police officers in the eight areas inspected. There was an impressive amount of liaison and joint work at different levels in relation to probation hostels and to individual offenders. It was organised differently everywhere but with the same core activities. The police view about the management of their local probation hostel and the part they played in protecting the public was universally positive. They were clear about the role of the hostel as primarily a link between prison and full liberty in the community and saw it as part of the resources available to MAPPA. They welcomed the opportunity to monitor the individual's behaviour as an indication of how they were likely to get on after they had moved. We also saw examples of where through MAPPA and inter-area agreements, the police had been prepared to accept the temporary transfer of cases, creating significant extra work for them, provided that the offender was required to live at a probation hostel.
- 6.2.2 It was surprising to find that no area had developed a written protocol with the police about information sharing or other routine activity. Given the extent to which intelligence was shared in both directions, we considered this was a gap. All relied upon their MAPPA procedures; this was not satisfactory as not all residents were subject to MAPPA. There were some written agreements relating to procedures for individual hostels, e.g. police responses in emergency out of hours recall, but even these were not consistently available. Procedures relied upon the relationships built up between the relevant post holders over time and, as such, were vulnerable at times of change, especially out of normal office hours. Such a protocol, to be effective, needed to be hostel and locality specific.
- 6.2.3 In a similar vein, most areas did not have a satisfactory contingency plan for evacuation of the hostel in the event of an emergency. The plan needed to address how staff would go about re-housing all of the residents, which would be based on an assessment of the Risk of Harm posed at the time. Plans presented to us tended to be unspecific. The more practical ones identified which hostels to approach and which police forces. Unfortunately, the relevant police officers, when consulted, were unable anywhere to locate the plans.

- 6.2.4 Police officers commented on how impressed they were at the vigilance of hostel staff who, they felt, clearly had the risks presented by individuals at the front of their mind and worked proactively to manage them. Staff in several hostels were prepared to share OASys with the police so that the latter could see precisely what the risk management plan entailed and how the hostel placement contributed to it. Hostel staff had the advantage of spending time every day with offenders and of information gathered through routine and random room searches. They were therefore in a position to monitor closely any changes in behaviour that could indicate reoffending or a change in the level of Risk of Harm.
- 6.2.5 The police officers that we met made a clear distinction between probation Approved Premises and other types of hostel providing lower levels of supervision. None of them reported any problems to the neighbourhood or individual members of the public caused by probation hostel residents, although several spoke of ongoing problems with other types of hostel.
- 6.2.6 The local police forces were involved in existing community consultation or liaison arrangements in four of the eight hostels visited. All probation areas had considered the extent to which there would be any benefit in establishing, or continuing, such arrangements. Depending on the local political climate, they could be fraught and time-consuming for senior managers as well as the hostel manager. We thought that each area had made a sound pragmatic decision about what kind of local profile it wanted. Accordingly four restricted their local liaison to the police.

6.3 Investment in hostels

- 6.3.1 All probation areas in the sample subsidised their hostels from the main service budget. The extent to which they did this varied considerably and was not necessarily reflected in the quality of hostel management. The level of investment could have a significant impact on their ability to fund other core work, particularly in areas that had several hostels. The contribution in respect of most of the hostels in the eight areas was approximately £60,000 each which we understood was an average nationally; two contributed more than twice this amount, to no advantage as far as we could see.
- 6.3.2 The reduction in value of the grant from NOMS had greatest direct impact on the voluntary managed hostels, as we had discovered during our inquiry in 2006. They were not assisted financially by probation areas and were less likely to have reserves to draw on. The voluntary hostel included in this inspection was one of two managed by the same charitable body. It had been particularly affected by the loss of the occupancy bonus and had gone from a £9,000 surplus at the end of 2004/2005 to a projected overspend of £22,000 for this financial year.
- 6.3.3 It was acknowledged by the voluntary managed hostel that the probation area also invested significantly in benefits in kind through management support, some staff training, etc. This could be a significant cost to those areas with several voluntary managed hostels and was a hidden cost in respect of the bed spaces

gained. The voluntary hostels also benefited financially as well as practically from not being tied to the Facilities Management contract.

- 6.3.4 All of the hostels visited had implemented the double waking night cover requirement and other restrictive measures, e.g. CCTV. One was having some problems with security; it was not clear at the time of the inspection whether this was the responsibility of the Facilities Management contractor or NOMS. Despite requests being made, communication about progress was, we were told, difficult to obtain. This situation was not acceptable.

6.4 The voluntary management committee

- 6.4.1 Whilst we inspected only one voluntary managed hostel, there were several more in the areas we visited. Their managers tended to be part of local hostel managers' groups and worked cooperatively with their colleagues across the area. We were extremely encouraged to find that, in all of the eight areas, the voluntary and probation board managed properties shared an approach to hostel and offender management that was consistent with national policies.
- 6.4.2 The voluntary management committee of the hostel included in the inspection was made up of people with an interest in the hostel; some were linked to the umbrella charitable body that owned the building and also managed another hostel in the same city. Others had a criminal justice background, e.g. as magistrates and/or relevant professional skills in healthcare or teaching. A probation board member acted as the link with the area. The committee bought-in a number of services, e.g. human resources and health and safety. There was a written protocol with the probation area covering management, liaison and monitoring arrangements for all of the three local voluntary managed hostels. In this particular hostel, the manager was employed directly by the management committee but the deputy had been seconded to the hostel by the area. It also employed all other staff directly, including a bursar.
- 6.4.3 The committee members were clear that theirs was a strategic role and we were impressed by the breadth of knowledge and experience that they brought with them. Some had been members for many years and were clearly committed to its development. It had had a change of chair during the year and we could see that practical plans for improvement were in hand.
- 6.4.4 Whilst three of the other hostels inspected had some form of community liaison activity, which was to be commended, the voluntary committee was able to engage with local residents in a way that the statutory run hostels were unlikely to be able to achieve. We do not suggest that every hostel could or should do this but it was an example in our view of how the public can be better informed about the work of approved hostels and be better protected as a consequence.

GOOD PRACTICE EXAMPLE

One member of the committee was a local resident and had been a member for ten years. She took responsibility for a proactive approach to keeping the people living nearby informed about the hostel. This included approaching new residents to inform them about the existence and purpose of the hostel. She also organised an annual open day, inviting everyone from around the neighbourhood.

6.5 Dealing with out of area referrals

- 6.5.1 Three of the areas inspected were in regions where there was no hostel in one or more neighbouring area. Whilst they accepted referrals from their neighbours, there was obviously a tension as, by so doing, the receiving area incurred the cost of the hostel place during the period of residence. One area was effectively providing hostel places for three areas. It was making use of the permission in Probation Circular 25/2007 *Case transfers – community orders, suspended sentence orders and licences*¹⁷ to accept offenders for up to three months provided the referring area retained responsibility for their order or licence. This practice ensured that there was a move on plan agreed at the start of the period. There were some concerns with this approach, however, as no offender manager was appointed by the area in which the hostel was located to supervise the offender. The level of information sharing could not therefore be as good as where the offender manager and the key worker came from the same area and could each contribute to the same case record.
- 6.5.2 The hostels sent us two snapshots of their residents, approximately nine months apart. In these, all but the smallest had had cases transferred in from other areas. This hostel did not accommodate those convicted of sex offences against children under the age of 16 and worked in collaboration with its sister hostel so that between them they could accommodate all types of male offender. It was not the case that it did not accept referrals from outside. We were unable to tell how many cases in the London hostel came from outside of the borough but few came from outside of London. Overall, 49 of the 312 cases included in the sample had been transferred in. Not surprisingly, by far the greatest out of area cases (12) were found in the all female hostel as they actively sought such referrals as did the other hostel with a restricted admissions policy who had accepted nine. Two areas that routinely accepted referrals from neighbours with no hostel had taken seven each.
- 6.5.3 Despite accepting external transfers, the occupancy rate of the larger of the two hostels that we visited, which was not able to accommodate sex offenders, had been significantly affected by the national change to the admissions policy. As the only hostel in the probation area, it had been needed to be able to accommodate all types of male offender. Now, managers were unable to 'trade' one type of referral for another so were unable to fill their bed spaces as a consequence. This was an example of where systematic regional cooperation was required, to eliminate waste and provide the maximum protection for the public.

- 6.5.4 Most hostel residents returned to their home area; only those who were rootless through long periods of imprisonment, or whose offending meant that they could not return home, actually re-located. Without taking the final step towards regionalising the management of hostels, areas could work together better, with their MAPPA, to provide the kind of approach seen in the area referred to in 6.5.1. There needed to be a national approach to funding to support such initiatives so that there was no financial barrier to their implementation.

Summary:

Even those areas with positive relationships with Supporting People were unable to influence the local housing authority to address the effective resettlement of offenders from Approved Premises. Although they might deal with the accommodation of offenders generally, none of the strategies that we saw developed by any local authority or probation area addressed the need to move on from a hostel to suitable accommodation. Generally speaking, local housing authorities and Supporting People failed to recognise that hostel residents had specific needs in that they were required to live where directed for a limited period of time as part of a planned process of resettlement.

There was an impressive amount of liaison and joint work with the police at different levels in relation to probation hostels and to individual offenders. This was organised differently everywhere but with the same core activities. The police view about the management of their local probation hostel in the eight areas visited and the part they played in protecting the public was universally positive.

Funding levels for hostels were no longer sufficient to support the required development of a hostel regime with a full programme of purposeful activity and probation areas with hostels had had to invest significant amounts from their main service budgets to make up for the shortfall in the central grant. This had been sufficient to ensure appropriate restrictive measures were in place everywhere. Voluntary management committees, who tended to have fewer resources to draw on than probation board managed hostels, were particularly affected by the shortfall. Nevertheless, the voluntary management committee added value to the strategic management of its hostels through the range of skills and experience of its members and had developed a very positive interface with the local community.

Key Findings:

- In most areas, local housing authorities had failed to recognise the need to establish joint working arrangements to ensure the effective resettlement, including housing of offenders residing in probation hostels, under the Crime and Disorder Act 1998.
- All the hostels we visited were well supported in their work by the police from the local area and those working in public protection teams.

- No probation area had a written protocol about information sharing with the police. They each relied upon MAPPAs which were inadequate as not all residents were subject to these. We found examples of how the absence of a clear formal agreement with the police could have a negative impact on cooperation. Such a protocol, to be effective, needed to be hostel and locality specific.
- Most areas did not have a sufficiently detailed contingency plan against the need to evacuate the premises and re-locate the residents. The police were unable to locate a copy of any of the plans we were shown.
- Probation areas subsidised their hostel(s) from the main service budget. Voluntary management committees were less likely to be able to do so as they were smaller charitable organisations with fewer reserves to draw on.
- Arrangements had been made to ensure that the voluntary managed hostels adopted the same approach to the role and purpose of hostels as the probation board managed hostels.
- Some areas felt that they subsidised others that had no hostel as they accepted significant numbers of their offenders as residents. Arrangements for managing these cases were satisfactory on the whole but costly to the receiving area.
- We found a significant level of under-occupancy in one of the hostels with restrictions on admissions.

RECOMMENDATIONS:

- The probation service should in all areas work within Supporting People commissioning bodies to establish appropriate supported housing resources to effect the planned move on from hostels of offenders who pose a high Risk of Harm to others.
- Each area should have a clear formal agreement with the police about information sharing and other aspects of liaison and cooperation. These should include contingency arrangements outlining in detail:
 - who should do what in the event that a hostel has to be evacuated and its residents re-located
 - what risk assessments have to be carried out and specify which police officers have been consulted.

7. PROFILE OF HOSTEL RESIDENTS

- 7.1.1 Each of the eight hostels sent us details of their resident group on two dates; one around December 2006 and one around September 2007. We aggregated these figures as we considered that they represented a reasonable snapshot of the national picture.
- 7.1.2 The data related to 312 people – 25 women and 287 men. One of the interesting facts was that only three hostels had, between them, just 15 residents who had been resident for the period covered by the two samples.
- 7.1.3 In Lincolnshire, South Wales and Cheshire, between 93% and 97% of the population were white and British. Bedfordshire, Staffordshire and Northumbria ranged between 83% and 89%. 25% of the West Yorkshire population was of a black or minority ethnic origin as was 52% in the London hostel.
- 7.1.4 The age range within the two samples was very wide: 19 to 78 and 20 to 78 respectively. There was a fairly even spread of ages within each decade up to 60.

7.2 Risk of Harm profile

- 7.2.1 The Risk of Harm profile varied considerably. Caution needed to be exercised, however, when considering the difference between high and medium Risk of Harm. There were residents whose cases we read who were classified as presenting a medium Risk of Harm. Their level of Risk of Harm may have legitimately been reduced due to the work undertaken during their period of residence. Often, the assessment was based on the fact that they were in a hostel and that aspects of the Risk of Harm were being contained. By implication, should this latter group leave the hostel without improvement, then they would, once again, be classified as posing a high Risk of Harm. This approach was not compatible with the OASys approach to Risk of Harm classification for serving prisoners where it is clear that this should be made on the basis that they could be released imminently back into the community. Although clarification had been issued about this subject, we still found some confusion amongst offender managers in particular.
- 7.2.2 There was only one hostel where we criticised the referral and admission of several inappropriate cases. This was one of those where the restrictions applied to its admissions meant that it had been unable to maintain its former high levels of occupancy. Whilst low Risk of Harm cases were not taking up bed spaces currently required by more appropriate referrals, such offenders were potentially vulnerable to the risk posed by others.

- 7.2.3 Over 70% of the residents in five hostels were assessed as high or very high Risk of Harm. In three, the figure was over 90%, including one where the proportion was 96%.
- 7.2.4 In two hostels only 42% and 65% of residents respectively were classified as high Risk of Harm. However, when we read some of the files during the inspection and looked into the current resident mix, we were confident that the level of risk had been reduced in a significant proportion of cases by living in the hostel.

7.3 Type of supervision

- 7.3.1 In six of the hostels the profile was as intended, i.e. mainly licencees. The proportion ranged from 81% to 91%.
- 7.3.2 Two of the hostels visited had no bailees on either date and most had only single figures. Two, however, had over 20% of their population on bail. In the case of the women's hostel, these referrals were mainly women undergoing bail assessment and, with one exception, were appropriate. The other hostel was the one we criticised in 7.2.2 for accepting inappropriate cases.
- 7.3.3 Five hostels had residents subject to community orders in single figures. There was one that fitted the national profile for Risk of Harm and licencees but also had 17% of its residents subject to community supervision. This was due to their participation in a sex offender treatment programme.
- 7.3.4 Only seven out of the 312 cases were PPOs.

7.4 Moving on

- 7.4.1 There were 142 residents in the first snapshot who had left the hostel. The largest group (58%) had had a planned move on and most were given their own independent tenancy. Others either obtained a supported tenancy or went to live with family or friends. Given the obstacles to finding appropriate accommodation for offenders, these would seem to be very positive outcomes.
- 7.4.2 The next largest group was the 30% who found themselves in prison after a period in a hostel, either on recall or after conviction for a new offence or following a period on bail. This figure illustrated how volatile managing this group of offenders could be.
- 7.4.3 It was difficult to pick out a pattern in any hostel to describe the length of stay before moving on. All had a very wide range, with one or more residents remaining for over a year but many leaving after six months. For instance, 24 of the 25 residents who had moved on in one hostel had stayed for six months or under whilst one had lived there for a year. Some of those who left within the six month period had stayed for a few days only or one or two months.

8. HOSTELS FOR WOMEN OFFENDERS

8.1 Acknowledging a problem

- 8.1.1 There are too few probation hostels, a situation that is likely to continue due to the public's successful opposition to the creation of new ones. As a consequence, the female hostel estate has been diminishing for some time to the benefit of the men's estate. This is an understandable strategy from the national perspective, achieving increases without cost in the politically demanding arena of managing dangerous offenders as, with certain notable exceptions, the public perceive dangerous offenders to be male. It is not an acceptable strategy, however, from the point of view of those women who meet the national criteria for hostel admission or those who have to manage their supervision. Nor is it compatible with equalities legislation.
- 8.1.2 Approximately 11% of the adult offenders under supervision by the probation service in 2007 were women. Of the 2,200 bed spaces available in approved hostels, 141 were in women only hostels or 6.4%. As the female prison population represents approximately 6% of the total (*What Works with Women Offenders*¹⁸) and most hostel residents are on licence following a prison sentence, this could be seen to be fair. Our view, however, was that, in terms of successful rehabilitation and integration back into the community, location was probably more important than the number of beds available and that, therefore, the current provision was inadequate. There had been 28 mixed gender hostels in late 2005, only two of which had converted to female only. At the end of 2007, only 18 beds for women remained in three mixed hostels; one of these was due to convert to male only by April 2008 and there was increasing pressure, which we supported for reasons given below, on the remaining two areas to do the same.
- 8.1.3 The number and location of hostels for women perpetuated the discrimination experienced by women in prison in that a higher proportion than men were forced to stay a long way from home. For women, in particular, enforced separation from their families and support networks compounded the problems associated with their offending, e.g. relationships and mental health. Seven of the 100 mainstream hostels were for women; four of which were managed by voluntary committees. They were located in: Bedford, Birmingham, Greater Manchester North, Leeds, Liverpool, London North and Reading. Wales had no provision for women and the North East Probation Region would have none from April 2008 when its mixed hostel was due to convert to male only. The East Midlands and South West Regions had female beds in mixed hostels only, provision that we considered unacceptable. There was only one hostel in the other six regions, with the exception of the North West, where there were two. Whilst there might be a women's hostel in six out of the ten regions and

inadequate but still existing provision in a further two, most female offenders would have to move a long way from home to be placed in a hostel. From April 2008, there would be no provision further north than Leeds.

- 8.1.4 Nevertheless, in October 2007, eight months later, both of the new women's hostels were still operating at around 50% occupancy. Conversely, the six bed female unit in the mixed hostel inspected had been operating at around 100% occupancy on most months over the past 18. In the latter, the residents were either from within the area itself or areas nearby as these were large centres of population and could sustain a small number of beds. The all female hostel that we inspected was intended to serve a very large region whose centres of population were far distant from each other, had no natural links or, in some cases, direct transport. We speculated that this would have had an impact on referrals despite the decision to establish the hostel as a regional resource being based on solid research about need.
- 8.1.5 Occupancy levels in six of the seven hostels for women were significantly lower than across the hostel estate as a whole. Over half of all hostels had 90%+ occupancy in the first half of 2007/2008, with 73 achieving over 85% occupancy. Whilst one women's hostel realised over 90% during this period, in five occupancy was less than 70%. Three of the four hostels with the lowest occupancy figures (59% to 66%) were in the voluntary managed premises. The inspection findings therefore mirrored the position nationally.
- 8.1.6 The research referred to in 8.1.2 found that women in prison tended to be the primary carers of children and were often single parents. It estimated that two-thirds of women prisoners were mothers. Only a small proportion of male prisoners had primary care of children. The main element of discrimination against female prisoners and by extension against female hostel residents was the distance between their family and community and where they were located during the custodial and licensed supervision elements of their sentences. Unless they were prohibited by court order from having contact with their children, they were likely to want to see them and to work towards re-establishing a full relationship with them.
- 8.1.7 Given the location of the seven hostels, it followed that many potential residents would face several hours of travel to visit their children. Travel was expensive, unlikely to be direct, given the geography, and slow. In addition, as most hostel residents had lost their own accommodation, regaining suitable accommodation for themselves and their children in a different part of the country could seem or actually be insurmountable. We thought that this was a likely explanation for many women either not being referred to a hostel a long way from home.

8.2 Mixed gender hostels

- 8.2.1 Following our fieldwork, we were very clear that mixed gender hostels could not be the solution to this problem. The mixed hostel that we chose to inspect was very well run but graphically illustrated the inherent problems.

- 8.2.2 The women residents in the two hostels we inspected (one mixed and one female only) were as likely as the men to fit the profile of serious offending; they presented a high Risk of Harm and needed a regime of enhanced supervision to resettle safely following a period of imprisonment. In addition, however, most had experienced some form of abuse either as an adult or during childhood. Many suffered from mental health problems and their offending was clearly linked to these factors plus, often addiction to alcohol or illegal drugs. As well as presenting a significant risk to the public, known adults or children, they were themselves vulnerable.
- 8.2.3 Many of the male residents in mixed gender hostels had a history of violent or sexual abuse as perpetrators and could be skilfully manipulative. We read cases where women, who were struggling with life after prison, were separated, sometimes permanently from children, and were being targeted by male residents and pressurized into forming yet another abusive relationship. Whilst staff were able to prevent unacceptable contact on the premises, and worked closely with local police, they were unable to stop relationships forming that were conducted outside of the hostel. We gained the impression that, even in a small unit, there would always be concerns about at least one or two such potential relationships. Clearly, there will be vulnerable residents in single sex hostels who suffer similarly. In our view, however, despite the impressive work seen during the inspection by staff with women under their supervision, those placed within the mixed gender hostels were particularly at risk.
- 8.2.4 Recognising these issues, the senior management team in Northumbria, where the mixed hostel we visited was located, had taken the decision to convert the hostel to an all male resource from early 2008. Whilst they were acutely conscious that their action would end all Approved Premises provision for women in their region, we found it difficult to see how they could have acted otherwise. It was not sufficient to separate sleeping areas. In a mixed facility, even where women had the opportunity, as in Northumbria, of living and eating separately, there would always be communal areas. Some activities or facilities would always be mixed. Typically a mixed hostel would have half a dozen beds for women and between 12 and 20 for men. The regime was therefore likely to be dominated by men's issues. In addition, economies of scale would dictate that many of the group programmes, as in the hostel we inspected, would be for men and women together.

8.3 The need for women's hostels

- 8.3.1 It was not within the terms of reference for this inspection to examine the treatment of women within the criminal justice system in England and Wales. However, there were women who posed a Risk of Harm to the public and required the restrictive and enhanced regime provided in a probation hostel setting. Although the current Approved Premises Service Review within NOMS addressed the needs of women, it confined itself in its draft recommendations to restricting further growth and proposing a review of the needs of women in relation to Approved Premises.

- 8.3.2 There were several current sources of information about women offenders to draw on to compare against the women that we met and whose cases we read. These included Baroness Corston's report *A Review of Women with Particular Vulnerabilities in the Criminal Justice System*. March 2007¹⁹ and the HMI Prisons report *Women in Prison Literature Review*. 2005²⁰ were also helpful.
- 8.3.3 The women included in this inspection reflected the profiles in these publications. Whilst, overall, women's offending was less common and less serious than men's, the hostel residents were both serious offenders and extremely needy. In the women only hostel, that was struggling to fill its bed spaces, staff had resisted the temptation (with one exception as far as we were aware) to go outside the target population. They did take more bailees than others because they had more spaces; these women tended to be there on bail assessment for suitability for a community order with a condition of residence rather than 'straight' bail. Index offences also tended to be of violence including manslaughter, wounding and robbery plus offences against children. The victims of their offending were often their partners or children. All of the female residents in the mixed hostel were licencees and had served sentences of between two years and life.
- 8.3.4 One of Baroness Corston's recommendations in relation to women's prisons was to replace existing prisons with geographically dispersed, small, multi-functional custodial centres. Whilst the Government had responded positively to the report overall, its response to this particular suggestion was to imply that it would be a long-term goal if adopted. Part of her argument was that: *'Equality does not mean treating everyone the same. The new gender equality duty means that men and women should be treated with equivalent respect, according to need. Equality must embrace not just fairness but also inclusivity. This will result in some different services and policies for men and women.'* Our findings supported this approach.

Summary:

Due to its geographical distribution, much of the current provision for women offenders in hostels did not meet their needs. As a consequence, the hostels for women were often under-used and were in danger of being eroded to cope with the rising demand for places for men. There was a need for a national strategy to ensure that appropriate provision was made for the small but significant number of women who continue to pose a risk to the public on their release from prison. The recent national review of hostels did not make recommendations that would support this need.

Key Findings:

- There were sufficient numbers of women posing a high Risk of Harm and who needed an enhanced level of supervision to justify provision within the hostel estate.
- Hostels for women were located in only a few places. They were not easily accessible for the majority of potential residents, particularly those with children.
- Given the abusive nature of many male residents and vulnerability of some female residents, we strongly questioned both the effectiveness and the viability of requiring women to live in mixed gender hostels.

RECOMMENDATIONS:

- Probation areas that still have mixed gender hostels should comply with the national directive that they should be converted to single sex establishments with immediate effect.
- Adequate and appropriate provision for female offenders meeting the national target profile for hostel accommodation is established within each probation region in the short-term and plans drawn up by NOMS to ensure reasonable access from all major centres of population by 2011.

9. HOSTEL MANAGEMENT

9.1 Approach to management

- 9.1.1 The arrangements for managing hostels in the areas we visited varied. Most of the managers were integrated within the probation area's management team, which meant that they were able to keep up with developments in offender management, etc. They were all probation officer grades and mostly, but not exclusively, senior probation officers. Three had wider and more strategic roles relating to offender accommodation across their area. One managed two hostels with a deputy in each. Where there was more than one hostel in an area, the managers and deputies were clearly expected to cover for one another. In one, the manager post was currently vacant and was being covered by the deputy.
- 9.1.2 The role of the deputy, where there was one, was less well defined than that of the manager. In two, we found an old fashioned approach that did not sit well with the offender management model and the role of the offender supervisor (hostel residential staff or key worker). For example, the offender manager would write the sentence plan and the deputy then wrote a hostel management plan that the key worker would address with the offender – or not.
- 9.1.3 Neither the Lincolnshire nor Northumbria hostels had a deputy manager. Where there was a deputy, it was their job normally to manage the staff. They would also tend to deal with the Facilities Management contractor. As both of these responsibilities were time consuming, the singleton managers would be stretched to carry out all of their duties fully. The largest hostel had two deputies.
- 9.1.4 We found that the role and titles for staff varied significantly. We use 'residential staff' as an umbrella term to denote those whose primary job was interaction with residents and those who provided security only or were cooks, managers, etc. All hostels had at least two grades of residential staff: some undertook key work sessions whilst others assisted in the day-to-day tasks. A number also worked with residents on specific tasks, working alongside the key worker. These were sometimes called supervisors to distinguish them from key workers. The staff mix during the night shift could be different again and consisted of the supervisor role, as described above, together with someone who was meant to have little to do with residents. They would support the supervisor or residential officer in their role, which at night was mainly monitoring. Whilst many staff worked nights only, others undertook a mixture of shifts. Some areas employed security staff whose role was simply, as the title implied, to provide back up to residential staff; they had little to do with residents other than keeping a watch on them.
- 9.1.5 The key workers were arguably the most important members of staff as they carried out much of the day-to-day work with residents. In the board managed

hostels they were probation service officers, employed extensively by the probation area, traditionally non probation officer staff doing face-to-face work with offenders. In the voluntary managed hostels pay and conditions had not kept up so these staff were not graded as probation service officers. The inspection was carried out after this group of staff had experienced a difficult couple of years. On the negative side financially, double waking night cover had been introduced in most areas and had taken away the opportunity to sleep in as overtime on top of normal shifts. More recently and positively, the results of the national job evaluation scheme had been implemented in probation areas and whilst it had proved financially challenging for most, it had significantly increased the salaries and status of all hostel staff. To be able to afford these changes, however, a number of areas were still considering downgrading some roles so there were continuing uncertainties around. At least two more regions were costing the appointment of security staff to work alongside residential staff.

9.2 Staff development and training

- 9.2.1 As might be anticipated, the approach to staff development varied. In the best examples, the manager put a positive emphasis on team meetings as a vehicle for communication and development. Shifts were organised so that most staff could attend meetings by the simple expedient of having it towards the end of one shift and requiring the next shift to come in slightly early. Each hostel had its own pattern. In one, there were no team meetings, ostensibly because of the way the shifts fell. This was not a defensible reason and it was probably not a coincidence that this was one of the hostels where staff seemed to be demoralised.
- 9.2.2 The amount of training undertaken by staff also varied widely. Unlike most probation settings, the costs of training hostel staff doubled as the majority of staff had to be replaced if absent on courses; for night staff, training could be disruptive for days either side of an event. Nevertheless, in several of the hostels visited, we thought that staff were well trained. Most had undertaken the national Approved Premises training including Risk of Harm work and handling aggression. From being the Cinderella of the probation service up to a few years ago, hostel staff were now often as well trained as their probation service officer counterparts in the rest of the service. This change had been brought about in recognition of the demanding job undertaken by hostel staff.
- 9.2.3 The stress experienced by workers was, however, not always well supported, either by training or supervision and appraisal. Many residents, and in particular many female residents, could be both challenging and demanding, much more wearing for staff than in an office setting.
- 9.2.4 Some hostel residents posed a threat to staff who needed to be constantly vigilant, looking for signs of risk to themselves and to other residents. Where staff were well trained and supported, and confident in role, these potentially difficult situations were managed pragmatically, without creating unnecessary alarm.

- 9.2.5 Staffing levels were sufficient to maintain a safe environment. In the best run establishments, there was little need to use relief staff but, when used, were often from a pool including people who had worked at the hostel before or elsewhere in the probation service. Other hostels needed to make more extensive use of relief staff which used up a significant amount of management time as well as providing a reduced service. Relief staff tended not to have access to the IT systems, which was of concern given the importance of good communication and recording. In a hostel, it was essential that staff were absolutely up to date with even small developments in relation to individuals.

9.3 The constructive regime and purposeful activity

- 9.3.1 We could not detect a direct link between the level of funding, availability of staff and the extent to which each hostel had established a constructive regime of purposeful activity. It was difficult to make direct comparisons due to the different models operating across the hostels we visited. Two received a significantly higher level of subsidy from their local probation area than the others. One of these only provided key working and one partnership activity, supported by external funding. The other had no additional activities beyond ETE until the week of the inspection. Those that achieved the most had managers who had a clear view of the hostel environment, as one which promoted positive change and who organised job roles and shift patterns to maximise the time available to staff to spend with residents.
- 9.3.2 Hostels were busy places during the day, particularly in the morning. There was often insufficient space for activities or interviews to take place comfortably or safely. The hostel day at each location was punctuated by the same events: the end of the morning curfew, bedroom check, breakfast, medication issue, etc. and so on until the final room check at the start of the night time curfew. Each had its own method of ensuring that residents knew what appointments they had that day. In some hostels, these regular events might be all that happened on that day, apart from individual key worker sessions, and residents were otherwise left to their own devices.
- 9.3.3 Each of the hostels did, however, provide some activity during the week. Most had partnership agencies visiting to carry out assessments for basic skills or other elements of ETE. Others provided the subsequent teaching in the hostel. All had some elements of health, mental health or substance misuse assessment or provision in-house. A few periodically ran the hostel skills programme, LiHMO; one had access to an outward bound programme and one a healthy living programme. Some could obtain housing advice through the probation area or partner organisations. Positive though these activities were, where they were all that was available, we saw them as individual events that punctuated the hostel week rather than as a coherent approach to a hostel regime.
- 9.3.4 We observed some of the activities provided by hostel staff that were mandatory for those not in employment or education unless they had other acceptable reasons for absence. Whilst residents tended to complain about attending, most participated and when spoken to individually said that they had benefited

through learning a new skill or having the opportunity to examine aspects of their life constructively.

GOOD PRACTICE EXAMPLES

Staff in Bedfordshire had each taken responsibility for putting together an activity. This could be reflective, e.g. problem solving, leisure based or practical. The DIY and gardening activities were particularly popular as residents learned skills that they would take with them into their next home.

A similar approach had been adopted in Staffordshire. One member of staff involved residents in restoring an old windmill that was a local landmark. They learned practical skills and had benefited from a restorative justice approach, as did the charitable organisation restoring the windmill. The fact that hostel residents were contributing to the project had been publicised positively.

- 9.3.5 The importance of the role of managers in promoting this positive approach cannot be underestimated. In three of the hostels visited, staff had been required by 'can do' managers to come out from behind their desk and work actively and positively with residents. Despite the fact that they had often been in post for many years, during which time they had been required to interpret their role in a very different way, they had been successful and both staff and residents had benefited. The first two were well on the way towards providing a reasonably full and mandatory regime of programmes and activities; the third had a number of regular activities, both on and off site.
- 9.3.6 All had created a positive environment and had separated out the work that needed to be done in the office from constructive contact with residents. Whilst it was not absolutely possible to compare like with like, these hostels did not appear to have more staff than the others, they just used them differently. Instead of two or three staff sitting in the office, one would be out either mixing informally with residents or running an activity which they had often developed themselves. They were also more likely to put on evening and weekend activities, e.g. a quiz or planned discussion about a DVD they had watched. Two other hostels were, we thought, working positively towards developing their regime but had not yet done enough.
- 9.3.7 Whilst there were positive aspects in all the hostels inspected, in the remaining three we saw some staff (but by no means all) behaving as if under siege. Whilst their individual work as key worker was satisfactory they sought the company of colleagues rather than engage with residents and left their office only to undertake specific duties. Many of these staff were demoralised; they felt overwhelmed with tasks and did not feel valued as workers. As in the positive examples cited above, some had had years of experience and could probably achieve more but were not encouraged to do so. We did not see the need for there to be constantly two people in the general office. No-one continuously monitored the CCTV nor were they expected to do so.

- 9.3.8 Residents in these three hostels complained about staff. Not about their key worker, which suggested that this could still be a positive relationship, but about staff in general. What they told us confirmed what we saw: they themselves suggested that there should be 'office' staff and staff whose job was to spend time with them. They (the residents) told us that many residents needed help to resettle after prison but that staff just left them to get on with it themselves. The atmosphere in these hostels was more institutional, even though these were not the worst buildings. Overall, it did not feel as if anyone cared about the overall environment. In these hostels, residents were more likely to be out all day as there was no reason to stay in. They complained of boredom – a factor specifically mentioned in risk management plans as an element potentially escalating Risk of Harm linked with a return to offending.
- 9.3.9 Some senior managers defended the lack of activities provided as appropriate, stating that it was not their intention to run an establishment where residents continued to be institutionalised. Once released from prison, offenders needed to integrate back into the community and participate in activities as they would when they no longer lived in the hostel. Considering the prison – hostel – community continuum, there was a logic to this line of reasoning. However, we would argue that, in hostels that provided very little beyond the restrictive regime, the end of that continuum was reached too early. How could hostel staff ensure that the enhanced regime of supervision a resident needed to address their offending behaviour and to protect the public was being delivered if they were out unsupervised from 7am to 11pm?
- 9.3.10 Towards the end of a stay in a hostel, however, it might be appropriate for residents to decide for themselves what they did each day as they ought to be more prepared for independent living by then. As it was, as many of the hostel residents often either disappeared for the whole day or spent their time on their own in their bedroom. These were both potentially worrying approaches to hostel life and contributed to the impression of the hostel as a warehouse rather than as a venue for positive change.
- 9.3.11 We welcomed the recommendation in the draft Approved Premises Service Review⁴ that all hostels should deliver a mandatory programme of purposeful activity, scaled down for those in employment. Options for inclusion were being developed by a national working group. A note of caution, however, may be necessary at this stage. Whilst we were convinced of the benefit of organised and mandatory activity, hostels should be very careful not to try and replicate the type of learning that an accredited programme seeks to make; nor should they be taking the accredited programme material and dropping elements into a module and calling it offending behaviour work. A return to the piecemeal approach to group work with offenders that preceded the *What Works* movement should be avoided.

9.4 Restrictive measures

- 9.4.1 We were satisfied that there were sufficient measures in place everywhere to manage residents and to protect the public.

- 9.4.2 Each hostel imposed the mandatory curfew from 11pm to 6am. For some residents, this was extended either by court order, licence requirement, or a decision by their offender manager or MAPPA to manage the level of risk presented. Typically, someone convicted of predatory sexual offences against children might have to be in the hostel around the start and end of the school day. Someone whose offending was linked to alcohol and pubs might be required to stay in the hostel after 6 or 7pm. We found that such restrictions were proportionate to the level of risk presented by the individual.
- 9.4.3 External doors were alarmed as were a number of internal doors. All staff carried personal alarms that could sound in the hostel alone for one level of incident or direct to the police call centre for another. Alarms were tested daily. Arrangements were made for checking who was coming in and leaving. This also related to the need to know who was in the hostel in case of fire.
- 9.4.4 All of the hostels were covered by CCTV internally in the public areas and externally. There were multi-screened monitors in the office that could zoom in on particular screens. Hostels took different approaches to monitoring. Some took the view that there had to be one person in the office at all times to keep an eye on the CCTV, whilst others felt that it was more important to spend time with residents, particularly in the evenings when there were no pressing office tasks to complete. We agreed that there needed to be a balanced approach that could respond flexibly to the dynamic of the current resident mix.
- 9.4.5 There were gaps in security that were to do with staff not following their own guidelines, e.g. in one of the no-smoking hostels, staff allowed residents to go out with them to smoke at the door after curfew. We drew this to the manager's attention and understood that this practice was stopped. Of more concern, was one hostel that could not be secured for want of a gate. Residents were able to get out at night and members of the public were able to get in. The hostel had made requests of the estates contractor for one but had been turned down. This was not defensible and resulted in security staff having continually to check the perimeter to maintain security.
- 9.4.6 In all but one hostel, residents were not allowed to go into one another's rooms. We thought that was a sensible precaution. Room sharing had to be agreed following a risk assessment. Spending time alone with another resident created the opportunity for bullying.
- 9.4.7 There was a full room check in all but one hostel at the start of curfew after residents had to go to their room and after the end of curfew in the morning. The latter sometimes doubled as a wake up call or opportunity to remind residents of the day's appointments. These checks involved staff knocking on the door to alert the resident that someone was about to come in; staff were often not of the same gender as the resident so this practice allowed both resident and worker to avoid embarrassment. All required the resident to speak to them or for the worker to be able to see that they were breathing and, in one hostel, the resident was required to sign that they were there. There was no night time room check in only one of the hostels visited, staff just made sure who was in before the curfew; this was unsatisfactory. It was generally acknowledged that

room checks were intrusive and disruptive for people who were asleep by 11pm or 12 midnight. However, there was no other way of being satisfied that everyone was in and that they were alive.

9.4.8 With the gradual change in purpose of hostels to primarily for the management of potentially dangerous offenders, they had been required to change their night time arrangements so that two staff were on duty and awake at all times. Previously there had been one member on duty at night and one sleeping-in in the staff flat who could be called on in an emergency. Double waking night cover was in place in all eight hostels inspected but had not been implemented everywhere due to the increased cost. Some areas had declared their intention not to implement the requirement, on the basis of having undertaken a 'risk assessment' that demonstrated it was not necessary. We thought it was hard to justify having only one member of staff awake to deal with 12 to 20 plus residents whilst maintaining that a probation hostel offered an enhanced level of security and supervision. As one member of night staff put it to us, calling someone out of the staff flat when the problem was between the flat and the office could be dangerous in itself. As this person normally also had a 'day job' and was likely to be fully asleep during the night, how quickly were they likely to be able to respond to an emergency?

9.4.9 Certainly, the night shift did not fully occupy two people, although on the night when we were in one hostel where two residents were on half hourly checks, because of their state of health, staff were fully occupied. In some, staff were asked to use the quiet night hours to prepare activities to be delivered during the day.

9.5 Health and safety

9.5.1 There was a comprehensive national health and safety manual that covered all aspects of probation work including hostels. Each area had customised this and submitted it for approval to the centre. After three years, it was thought to be working well.

9.5.2 We found universally that hostels and staff were well supported by the probation area's health and safety arrangements. In all but one, there was an advisor who visited regularly and gave advice. In the eighth, a committee had responsibility for the issues and was equally effective. There were regular audits and an annual inspection; local advisors met quarterly with the national lead advisor and we saw the evidence that outstanding actions were followed up.

9.6 Good communication and recording

9.6.1 Communication and recording were essential elements of all aspects of offender management. In cases presenting a high Risk of Harm to the public, it followed that they become even more important so were crucial to the safe running of a hostel. Hostel staff were acutely aware of the process but, in most cases, we found significant room for improvement in systems. Typically, information was stored in an incomplete form in several places and was not accessible to all who

needed it. The offender manager, for instance, held key information but was not privy to the hostel record and could only routinely see what was on the area's electronic case record or other electronic system. We found staff (mainly relief staff but some permanent staff) who did not have access to electronic systems. We found paper-based files, including the risk of self-harm documentation, for individual residents in each of the hostels visited. As a result, there was not one place to go to get the full picture on any individual resident. We read and cross-checked the log, handover notes where there were any, paper files and electronic files. In most, we were satisfied that key information from the hostel daily log tended to be transferred to the case file in a planned way and vice versa but there were gaps everywhere.

GOOD PRACTICE EXAMPLES

Bedfordshire had established a rolling electronic log that was accessible to everyone and updated constantly throughout the day. It had the advantage of retaining information for a whole week at a time making it very easy to check back on incidents. It was easy to use as the basis for the handover.

London also used their electronic case record to ensure prompt recording accessible to all in both individual notes and the hostel log.

Cheshire had developed a systematic approach to the handover note. It used an electronic format that ensured that the same issues were addressed each time; it was also printed off and stored for reference during the day.

In Staffordshire there was a weekly meeting between the manager and residential staff member specifically to review the Risk of Harm posed by residents. We thought that this approach was to be commended as it ensured that all available information was brought into one place.

- 9.6.2 In all of the hostels there were three or four handovers during the day, from one shift to another. Managers tended to work office hours Monday to Friday (though they were also on call), as did administrative staff, cooks and cleaners. In Northumbria, the probation service officer staff also worked a day shift only. All the staff known as supervisors, where in post, and night staff worked shifts with one member of a two or three person team staying for an hour into the next shift. It was clear from the handovers that most of the staff knew the residents well. This was reassuring. In most, one member of staff informed all incoming staff of the events of the last shift. They considered each resident and shared factual information and opinions about how the person had been that day. It was worrying though that this process was undertaken less thoroughly in one hostel and, in another, not all residents were mentioned at each handover, only those where the member of staff considered that something 'significant' had happened. We were concerned that staff and managers did not appreciate that it was important to pass on small details about comings and goings to flesh out the bigger picture. If there were no concerns about residents, why were they there?

Summary:

Overall, residential staff were making a good job of managing safely a group of residents who could include at any one time some of the most damaged and potentially dangerous offenders in society. We found that the quality of the manager made the greatest difference to the performance of the hostel. Their management style and approach to defining staff roles were crucial. How staff then interpreted what their job was meant to be had a significant impact on how well this was done. At one end of the spectrum, we saw an emphasis on restriction, rules and security to the detriment of creating a positive atmosphere. At the other end, staff were modelling positive behaviour towards residents and dealing openly with them, within rules aimed at staff and resident safety, about the level of risk they presented to the public.

Key Findings:

- There was no apparent link between the level of financial investment in a hostel and the quality of its regime. It was the quality of leadership that made a difference.
- All hostels had a satisfactory level of restrictive measures in place and staffing levels were sufficient to maintain a safe environment.
- Whilst all hostels provided some activities during the week, only three could demonstrate that they were on target for delivering a constructive regime of purposeful activity.
- Shift patterns were not always set in a way that maximised the potential for hostel management of staff development.
- Hostel work was very demanding of staff and took its toll. Staff were not always given sufficient support and direction and responded by retreating into their office rather than mixing more freely with residents.
- Some of the hostels visited underestimated the importance of the handover meeting at shift change and did not share information about residents as fully as they should have done.
- Hostels were well supported by probation areas' health and safety arrangements.
- Room checks at the start and end of curfew were intrusive but necessary to ensure the security of the hostel and welfare of its residents.

RECOMMENDATION:

- Probation areas should review the roles and deployment of their hostel staff to determine whether existing staff can be freed up to engage further with residents and develop purposeful activities for them.

10. LIVING IN THE HOSTEL

10.1 Use of the building

- 10.1.1 A probation hostel is home for its residents for however long they stay there. In order for offenders to feel motivated to stay, they need to be treated with respect and live in decent conditions. They have to pay a service charge for their accommodation and food, on a sliding scale depending on benefits or other income. Given that they are made to live in the hostel, this fact often comes as a shock to residents and is resented as it constitutes a significant amount of their disposable income.
- 10.1.2 Only one of the hostels inspected had been purpose built which was probably typical of the national hostel estate. Most had been large private homes that at some stage had been converted to multiple-occupancy then, usually in the 1970s or later, had become a probation hostel. All were located in residential areas. Several were in areas of general multiple-occupancy, close to hostels, student accommodation or other non-probation hostels.
- 10.1.3 They ranged in size from a semi detached property with 12 beds in just five shared bedrooms to a very large hostel with 41 beds. The rest had between 18 and 26 beds in a mixture of single and double rooms with a few self-catering flats for two or three people. Single rooms predominated.
- 10.1.4 All of the buildings were fit for purpose, although some would have benefited from changes to their layout to make better use of the space. Certain aspects of some of the buildings, such as bathrooms, needed improvement. They were all clean and provided a decent standard of accommodation for residents. The smallest was rather cramped but was well run and, despite its limitations, provided a positive atmosphere. There was sufficient access to showers and toilets in all but one. Most had adequate utilitarian furniture in bedrooms and some attempt at comfort in at least one communal room by way of settees. There was one exception to this, which was the only hostel to feel like an institution. It made no attempt to be welcoming and was scruffy with curtains hanging off rails around the building. This was one of the three where residents complained about staff attitudes to them. All but one had a pool table; curiously the eighth considered this to be a health and safety hazard. All had a communal television; rules varied about whether residents were allowed to have a TV set in their own room.
- 10.1.5 Some had large gardens whilst others had very little but opinions differed as to whether residents were encouraged, or allowed, to work in them. There was confusion amongst managers about whether gardening by residents was prohibited by the Facilities Management contract or under health and safety rules. However, in two probation board managed hostels, gardening was run as

an organised activity by one of the residential officers, complemented by DIY in one. In another, individual residents were allowed to work in the tiny garden on their own. In the voluntary managed hostel, which was under new management when we inspected, gardening was under consideration. We saw no reason why it should not be treated as any unpaid work project following a risk assessment. All hostels had access to health and safety advisors and had staff who were first aid trained.

- 10.1.6 One of the hostels had never allowed smoking on the premises and had built a small shelter next to the hostel. Residents were not allowed to use it during the curfew time, although this did not seem to present problems. Life had changed substantially for the other seven following the ban on smoking in communal areas in July 2007. Some allowed smoking in individual rooms whilst others had banned smoking completely from the hostel. All staff in the seven hostels, which had allowed smoking, complained about the negative impact the ban had had on the life of the hostel in that the communal areas had used to be busy and were now largely empty. In addition, residents were constantly going in and out of the hostel, either alone or in small groups, to smoke which was a time consuming distraction for staff who had to check them out and let them back in. Where residents were allowed to smoke in their room and to have their own TV, they were unlikely to mix in the communal areas or to be visible to staff. We observed that this was largely true, though less so where residents were required to attend activities as they were more likely to be around for the various events, to stay in for lunch and to take the meals provided. Some hostels did still organise leisure activities and were prepared to do so for small numbers. We thought that others could have persisted more as even if only a small number initially took up the offer of a quiz, for example, more might follow.

10.2 Daily life

- 10.2.1 Staff and resident safety was the first priority within all of the hostels. The restrictive measures, which meant that staff could keep an eye on residents, also ensured their own safety. Staff got to know residents and kept a look out for subtle signs of bullying which, as we observed, were dealt with swiftly when seen.
- 10.2.2 Residents said that they felt safe in their own rooms, shared rooms and communal areas. This applied equally in the mixed hostel and does not detract from our comments in Section 8 but is a testament to the management of that hostel. In the five hostels where we observed staff taking an active approach to resident supervision, the atmosphere was more relaxed. Supervision tended to be more remote, by CCTV in the other three but in terms of safety was no less effective.
- 10.2.3 We found that the hostels that demanded more of their residents got a better level of cooperation. All required them to keep their own rooms clean and to do their own laundry except for bedding. Where there was a residents' kitchen there was an expectation that they would clean it themselves. In the voluntary managed hostel residents also did the washing up after breakfast and the evening meal. Managers in the other hostels had opposing views about what the

Facilities Management contract allowed them to do: some took the view that residents were not allowed in the hostel kitchen at all or that they were not allowed to do any cleaning outside of their own room. This approach did not foster a level of responsibility. Others, under the same contract, required residents to wash up after each meal and also to clean communal areas at weekends when there were no cleaning staff. In the voluntary managed hostel, residents cooked breakfast each day under supervision by residential staff in the main kitchen and in one of the others prepared the main meal at weekends, again under residential staff supervision. These were not staff employed over and above the normal complement, just using them differently and out of the office. The benefits to residents were obvious: taking responsibility, learning self-discipline, skills development and constructive use of time.

- 10.2.4 In one hostel, residents were required to be up and dressed by 9am and then to stay out of their rooms from 9am to 1pm. This had been a relaxation of the previous manager's requirement that they had to stay out of their rooms until 4pm. It ensured that they had the opportunity of eating breakfast and being up in time to get to appointments. However, there was little constructive activity in this hostel and the day must have stretched away in front of the residents without employment or other activity. Residents were not denied access to their rooms anywhere else.
- 10.2.5 In another, residents who were not in employment were required to attend a morning meeting at 9.30 am to review plans for the day. This served the same purpose as in the first example; we thought that the principle was positive but that the content of the meetings needed more thought. Everywhere else residents were 'encouraged' to get up if they had not emerged by a certain point in the morning. Staff seemed to know what appointments they had on the day and saw to it that they left the hostel in time to keep them. Two hostels required residents to fill in a detailed diary at the start of each week, then to keep it up to date. This served the dual purpose of encouraging them to plan as a focus for key work sessions and enabling them to account for their movements, should they be required to do so.
- 10.2.6 We thought that residents' meetings were potentially an important focus for hostel life but the content needed to be developed further. One did not have residents' meetings at all so there was no vehicle for consultation or development of a common understanding about hostel life. Minutes were taken of meetings where they took place, although this process usually only served to demonstrate that actions tended not to be followed up as promised as issues recurred time after time.

GOOD PRACTICE EXAMPLE

In the West Yorkshire hostel there were two notices on the hall wall that featured "What you told us" and "What we did about it". This was to encourage residents to engage with staff at meetings, to show them that they listened.

10.2.7 A six monthly or annual survey of residents' views was taken in most hostels. It was usually conducted by an area's information or research staff. Where there was more than one hostel in an area the views were often aggregated. We were disappointed that whilst most had published their surveys, not one had taken any action to rectify issues that were seen as negative. Hostel managers did not seem to 'own' the survey or to have considered addressing the issues. We also questioned how useful aggregating survey results could be, except as an academic exercise.

10.3 Treatment of residents

10.3.1 One of the reasons we thought it important that staff mix with residents in an informal way was that it gave staff the opportunity to model the behaviour they expected of offenders. They also had the opportunity to reinforce learning. Many hostel residents had served prison sentences due to their inability to live alongside others, respecting their rights and needs, and needed to be shown alternative ways of behaving as well as being punished then monitored. If staff knew residents well, they could challenge inappropriate behaviour and language in a positive way. Whilst we have made the point that staff could, in some instances, have spent more time with residents, in most of the contact we observed they treated individuals with respect and in a fair and courteous manner.

GOOD PRACTICE EXAMPLE

In Bedfordshire, Staffordshire and Northumbria one member of residential staff at a time was freed from office duties to go and be with residents. When they were not conducting a key worker session or leading an activity, they sat with anyone who was in the communal areas. They understood the value of this informal contact and took every appropriate opportunity to be with residents, e.g. during meal times.

10.3.2 In all but one of the hostels we visited there was a hatch through which residents were meant to communicate with staff. This established a clear demarcation line but did not support the development of positive relationships. One of the hostels got round this by taking a resident into an interview room for a discussion rather than dealing with any but the shortest of exchanges at the hatch. In the others, the most intimate and sometimes painful discussions, for example about health or contact with children, were conducted in this semi-public way. In two hostels, we also observed staff continuing their conversations with colleagues without the courtesy of acknowledging that they had seen the resident who had come to collect their medication at the required time.

10.3.3 There was a national set of hostel rules that had been adopted by all and slightly modified where necessary, as in one where residents were denied access to the nearby park. The induction procedure was the main vehicle for publicising what the rules were. Although the rules were not displayed prominently, we found that they were applied consistently within each hostel. Sanctions were also applied

fairly and any extra restrictions imposed were proportionate to the assessed Risk of Harm.

- 10.3.4 The induction interview was the main vehicle for explaining how to make a complaint. Residents in half of the hostels visited were clear about the procedure, but it was not well publicised in the others. In these hostels, residents were consequently not aware of what they should do to make a complaint.

10.4 Opportunities to promote diversity

- 10.4.1 Hostels did not have their own policies regarding promoting diversity and equalities. However, all the probation areas had developed appropriate procedures, some of which referred, in discreet sections, to the hostel. We thought that this was an opportunity missed as shown by the lack of systematic consideration of how diversity and equality could be promoted. Staff responded well to individual residents needs but, except in two instances, did not work proactively to consider what they could do to support any of the minority groups that might live in the hostel. These two had significant numbers of black or minority ethnic residents: indeed, in London, residents from these groups made up the majority of the population at 52% of the snapshot sample. In West Yorkshire it was 25%.

- 10.4.2 We were not able to judge therefore whether the racial and ethnic profile of hostels reflected the local offender profile. Although hostels carried out basic monitoring, no-one had used it to undertake an analysis of local need against referrals and admissions. Certainly, from the areas inspected, one would anticipate that the two hostels cited above to have a significant minority ethnic population.

GOOD PRACTICE EXAMPLES

The fieldwork for the inspection started towards the end of Ramadan. In London meals were saved for those who were fasting and there was a timetable for sunset on display. At a residents' meeting that week there had been a discussion about the possibility of celebrating Eid in the hostel. There was a buzz of anticipation around as a consequence and Muslim residents had been pleasantly surprised at how positive and interested others were about the festival.

In West Yorkshire staff were concerned that low levels of literacy could restrict their ability to communicate with residents. They had established a proof reading group of residents who were willing to check that new documents were written in as understandable way as possible. Members for the group told us how valuable this was and that being asked to do it had given them a boost in confidence.

- 10.4.3 All but one hostel had a bedroom that was wheelchair accessible. The limitations in the eighth building made this impossible. One of the rooms so designated was not suitable however as it was too small, a fact which was acknowledged. A resident in this hostel, who had restricted mobility, had chosen to use a first floor

room in preference to the ground floor designated disabled access room as it met her other needs better. This meant that she restricted the number of times she went downstairs in a day.

10.4.4 We walked around hostels to look at their signs and notice boards. The door signs in most of the hostels decorated under the Facilities Management contract had the words underneath them picked out in Braille. Some hostels had a few standard but old probation service multi-cultural posters on display. One had notices translated into different languages. The hostels for women had notices about facilities for women. We saw very little about faith groups or places of worship and nothing to support gay, lesbian or transgender residents. There was no evidence that residents could be directed to any minority community resource without having to ask.

10.5 Food and meal times

10.5.1 The quality of the main meal of the day was surprisingly good, given what we had been told about the operation of the Facilities Management contract⁶. With one exception, the cooks did an excellent job with the ingredients at their disposal and we enjoyed the meals we had, as did those residents who ate them.

10.5.2 There were many problems with this aspect of hostel life, however, which represented missed opportunities and were beyond the scope of hostel staff to remedy. It was interesting to note that one hostel was able to use cash to buy food locally to prepare with residents at the weekend. Others were frustrated that they had lost the chance to support local business and court an element of local good will.

10.5.3 The voluntary hostel was able to cook and offer what it liked within its own budget. Everywhere else operated a four week rolling menu that changed slightly with the seasons. For the main meal, there was always a vegetarian option. Hostels were also geared up to prepare Halal food when required and said they could accommodate other diets. However, in one the manager had had to insist that the contractor provided Kosher food as they had been unwilling to do so, offering money for the resident to eat out instead.

10.5.4 Our concern about the basic menu was that for anyone living in the hostel for a number of months, it represented a heavy diet with an overemphasis on potatoes in the winter months. Fruit was freely available in the voluntary hostel but not in the others where it was only offered as an alternative to an often stodgy pudding. We saw that, for some residents, the hostel provided the only meal of the day and that they were unlikely to choose the healthy option, even if available. We noted that the Healthy Living Project in Lincolnshire brought a supply of fresh fruit into the hostel to supplement the normal diet which it regarded as inadequate.

10.5.5 Breakfasts in the voluntary managed hostel were simple but freshly cooked by residents for one another, supplemented by cereal, etc. Elsewhere they were poor. We found the dreary 'breakfast bar' in all but one of the other seven hostels: a large cupboard that was opened up by residential staff in the morning

from which residents could help themselves to toast and cereal but no fruit or juice and nothing hot.

- 10.5.6 Two hostels also offered to make sandwiches or simple snacks for a very small charge outside of the contract. They represented very good value for people on a tight budget and who were, in some cases, a long way from shops and could be confined to the hostel by extra curfew.
- 10.5.7 There was a residents' kitchen available at varying times, sometimes throughout the day and night. Equipment varied but tended to include a fridge and microwave rather than a cooker.
- 10.5.8 Most residents did not eat the main meal despite having to pay for it in their service charge. It was called the evening meal but in two was served for a half hour period at 4.30pm and in most well before 6pm. This was far too early. Only those in employment, or with another approved reason for being absent, could have a meal saved and reheated. Catering staff in the board managed hostels were instructed to throw away any leftover food. Residents who were out all day were reluctant to return to the hostel so early. Several hostels were prepared to offer a supper of toast or cake at around 9pm. In the others we saw residents secreting food away with them from their 'evening' meal as they would have no opportunity of accessing food again between 5 or 6 pm and 6am; this was not hygienic and was far too long without a meal.
- 10.5.9 In some hostels meal times were seen as an opportunity for staff to mix with residents. Whether they took a meal with them or not, they ensured that a member of staff sat and chatted with residents during the meal time. In addition, in a few hostels, the cook was prepared to stand and engage with residents as they served up meals and to stay around until they had been finished. We saw this positive practice in West Yorkshire and Bedfordshire. In other hostels, staff supervised mealtimes, particularly breakfast, via the CCTV.

Summary:

All the hostels visited were able to provide at least a minimum standard of basic decent accommodation. Although the highest priority was given to the protection of the public, staff and residents, within the necessary restrictive conditions, residents were treated with respect by staff. The level of engagement with residents varied a great deal from hostel to hostel; those hostels that demanded most from their residents got the greatest level of cooperation from them. These were hostels where staff spent more time, both formally and informally, with residents.

Key Findings:

- All of the hostels visited were fit for purpose and provided a decent standard of clean accommodation.
- The national smoking ban meant that residents were less likely to use the residents' lounge and participate in informal activities with staff.
- All residents consulted said that they felt safe in the hostel.
- Insufficient use was made of residents' meetings as a method of consultation and of gaining ownership of hostel life.
- Overall, staff treated residents with respect and were fair and courteous.
- Only two hostels supported the active promotion of diversity through locating and advertising resources for different faiths and minority groups.
- The quality of the main meal was good but it was often served far too early, resulting in considerable waste.

RECOMMENDATION:

- Each hostel should develop and implement a strategy for promoting equalities and diversity; the strategy should be monitored and regularly reviewed.

11. OFFENDER MANAGEMENT

11.1 Referral

- 11.1.1 In addition to discussing cases with individual offender managers and hostel staff, in the eight areas visited, we met with middle managers with responsibility for offender management teams and either MAPPA or public protection teams. All were absolutely clear that the purpose of approved probation hostels was to provide a period of enhanced supervision for offenders assessed as posing a high Risk of Harm to the public.
- 11.1.2 The Risk of Harm profile in the eight hostels demonstrated that this was the case. We were satisfied that most cases, which were currently assessed as medium Risk of Harm, had been appropriate referrals.
- 11.1.3 Whilst most regions were considering how far they could, or would, go towards regionalising the management of their hostel estate, all offender managers that we talked to would welcome a central referral arrangement. They were less concerned by the loss of control than the need to find a place to meet the deadline of a release date. There were too many offenders for the hostel places available, resulting in their offender managers having to make multiple applications, often on different forms, which could literally take up days of their time.
- 11.1.4 MAPPA regarded their local hostel(s) as part of their toolkit. The relationship between the two was positive in the main, but we did see some cases where a MAPPP had taken a very narrow view of the purpose of the hostel and seen a condition of residence, whether as part of a community order or licence, as an end in itself. We thought that the panel and offender manager needed to be able to define the purpose in terms of outcomes; otherwise the offender would be just as dangerous when the licence period ended and living in the community but no longer on supervision. This approach again underlined the need for purposeful activity.
- 11.1.5 Prohibiting 14 of the 100 available hostels from accommodating those convicted of sexual offences against children under the age of 16 had had a profound effect on the ability of offender managers in some areas to find appropriate hostel accommodation for these offenders. Prior to June 2006, when the Probation Circular listing the relevant hostels was issued, hostels, MAPPA and offender managers had assessed the appropriateness of referrals on a case-by-case basis. Assessment of the ability of a hostel to contain and manage Risk of Harm should always be paramount and we saw nothing in this inspection to suggest that this was not the case.

11.1.6 Offender managers and their senior and middle managers in areas with a hostel on this restricted list, and those in neighbouring areas, continued to be distracted by the issue. There was a net shortfall of hostel places in any case and MAPPPs were often unwilling to accept referrals of potentially dangerous offenders from out of area. We were told about specific cases where potentially dangerous offenders had been released to live with inadequate supervision due to the restrictions on admissions in a local hostel and refusal of other area's MAPPA or hostels to accept them.

11.2 Preparation and induction

11.2.1 Few residents we interviewed had wanted to live in the hostel. We were struck by how many had not known that they would be released from prison to a hostel until very shortly before the event. The referral to the hostel was usually a consequence of a decision made by MAPPA. It illustrated the reality of the sentence being only partly served in prison and the rest in the community, i.e. the prison – hostel – community continuum. The position was different for those subject to community orders who had been given the option of a period of bail assessment in advance to gauge suitability.

11.2.2 In most cases, the need to give information swiftly and as constructively as possible to the prisoner about their accommodation on release was done well. It would obviously be best practice to convey this information through a prison visit, but this was not always practical so offender managers relied on prison staff to act on their behalf. It was important to the prisoner's management on release that the role and authority of MAPPA, where relevant, was understood and that the assessment of Risk of Harm was discussed openly. There would be some cases where the decision to impose a period of hostel residence was not accepted and where a prisoner immediately breached their licence rather than live in one. We met residents who did not want to be there and engaged as little as possible with hostel life; they would benefit the least from being there and were potentially wasting a place. Others, however, were open with us about the Risk of Harm that they presented and whilst they would have preferred to live elsewhere, understood what was required of them before that could be achieved. These were the people who were likely to make most progress. Some of these residents, in both groups, had records of serious violence; credit should therefore be paid to their offender managers and the hostel staff for dealing with them in this transparent way.

11.2.3 For most people to be faced with a period in a probation hostel would be a daunting prospect. In order to ensure that new residents settled well and adjusted to the regime, it was important that they knew what hostel life entailed and, in particular, what was expected of them. In one hostel, staff were not entirely clear themselves about what they could require of residents and the key worker sessions were not seen as enforceable. As an essential component of hostel residence, we were clear that they were.

GOOD PRACTICE EXAMPLE

The hostel in Cheshire had recently had video conferencing equipment installed linking them to two open prisons. We thought that this was a very positive investment; it would make it much more likely that potential residents would be well informed about what to expect.

11.2.4 Formal induction completed this process. Ideally, it took place on the day of admission to the hostel, depending on time of arrival. Each hostel had a thorough process, delivered on a duty system if the nominated key worker was not present. Most were sensitive to the fact that, immediately on release from prison, a new resident might not be able to take in all the information given. Staff ensured that they delivered and could evidence information about basic rules, e.g. the curfew at this first short meeting; an early subsequent meeting would then be arranged to go through the whole induction procedure which would include information about the key worker role.

11.3 Planning and delivering work with individual residents

11.3.1 In most cases the quality of work undertaken with residents was good and, in some, very impressive. The relationship between the key workers (residential officers) and offender managers, in particular their joint work and liaison, was central to successful outcomes. We saw little evidence of cases being 'dumped' as had often been the case in the past, with the hostel being left to get on with supervision.

11.3.2 The quality of work was best where offender managers were responsible for numbers of hostel residents. Some areas had either retained or reinstated public protection teams who worked closely with the hostel. In six of the areas, the field team probation officer and hostel key worker relationship had been integrated into the offender manager/offender supervisor model, with the offender manager driving the agenda. Each was clear about what the period of residence was meant to achieve and who was responsible for which element. Plans were drawn up with the offender who knew what had to be accomplished in order to move on. In the two remaining hostels, we saw some good quality liaison and planning but less consistency.

GOOD PRACTICE EXAMPLES

In Lincolnshire the two public protection team senior probation officers had their office base in the hostel. This was both a symbolic and practical arrangement. Team members were often at the hostel therefore for formal or informal meetings with residents and staff. We saw the same quality of liaison in the Northumbria hostel. As there was no deputy manager in the hostels in either area, the offender manager was expected to play a significant role in driving work in the hostel. The approach had been successfully implemented in both areas. They each managed some very difficult offenders with histories of very serious offending and demonstrated how well a period of hostel residence could contribute to public protection.

In Bedfordshire, there was an offender manager post located in the public protection team that was shared between its two hostels. The post holder was based in the hostel that we inspected. She had developed the same close working approach described above with key workers but was also able to contribute to the day-to-day management of the hostel and residents.

In all of these hostels, the quality of offender management was impressive.

- 11.3.3 The sentence plans seen in Bedfordshire, Lincolnshire and Northumbria identified the objectives of hostel residence and the methods to be used to achieve them. The objectives were then translated into the agenda for key work sessions and were reviewed regularly. In most cases, however, sentence plans tended not to mention the hostel at all or if they did it was usually in terms of moving out as an objective. This did not do justice to the work being undertaken in the hostel. The risk management plan was more likely than the sentence plan to be specific about work to be undertaken.
- 11.3.4 In two hostels, a deputy manager wrote a hostel supervision or action plan based on the completed OASys. We considered that this was a waste of their time and undermined the role of the key worker who should be responsible for preparing the plan. The sentence plan in OASys had to be very long and detailed, and updated frequently, to be of sufficient quality for hostel cases. Ideally there should be only one plan, but we conceded that a discreet hostel plan could be more useful for daily practical guidance and a weekly review. It must, however, be derived from the sentence plan in OASys. Where we saw this working well, the key worker had agreed the content of the plan with the offender manager using a standard hostel format.

GOOD PRACTICE EXAMPLE

In South Wales key working was supported through the development and use of a number of standard forms. These ensured a consistent approach to planning, and were shared with the resident and their offender manager. They listed issues for discussion that essentially fell into two categories: one was about potential rubbing points in daily hostel life, e.g. paying the service charge and carrying out chores. The other was a list of the criminogenic factors identified in OASys where the key worker took responsibility for the delivery of certain elements of the sentence plan. We saw other versions of this approach but thought this worked particularly well.

- 11.3.5 We have already commented that opportunities to promote aspects of diversity generally had not been taken in most hostels. This criticism did not apply to individual offender management and supervision, however. We were impressed overall by the careful attention given by hostel staff to the residents' needs, including issues that had often previously been linked to their offending, e.g. self-image or sexuality.
- 11.3.6 It was not anticipated that all contact with a resident would be recorded in the electronic case record. Generally, however, there was room for improvement in the level of recording, as seen in the comments about the hostel log, etc. in Section 9. Each hostel needed to be clear about what kind of information should be recorded, and accessible to all, and for what purpose.

11.4 Managing the Risk of Harm: outcomes

- 11.4.1 This was central to the role and purpose of probation hostels so was the focus of our inspection. All other issues contributed to this objective, directly or indirectly. We found a good news story. Within the case sample of 100 cases, there were very few who did not pose a sufficient Risk of Harm to justify accommodation in a hostel; in addition, there was only one case where we had such concerns about the quality of offender management that we requested changes be made. We also read and heard about most of the current residents during our visit. We can say that their Risk of Harm was contained and managed during their period of residence in the hostel. In some cases, the level of Risk of Harm was actively reduced as residents learned appropriate ways of behaving in certain situations or of managing addictions. The public was therefore better protected than it would have been if the hostel place had not been available.
- 11.4.2 Being a hostel resident meant that individuals were contained and kept away from potential victims for substantial periods of each day. We also saw how important the monitoring and surveillance role could be. At one level, hostel staff worked with the police and shared intelligence that could lead to a prompt recall or prosecution. More common, though, was a lower level of information gathering, just by getting to know an offender. The success of this work depended on hostel staff knowing what to look for as indicators that the level of risk was escalating, or reducing. These included small pieces of detail, e.g. about changes in clothing or acquaintances.

11.4.3 Staff could also have an impact on the level of Risk of Harm through more constructive measures. Examples seen included:

- ▶ offenders who were clear about why they were in the hostel and what the role of the various staff and MAPPA were. They felt involved in managing their own risk and saw being in the hostel as an opportunity to demonstrate that they could change
- ▶ use of daily contact to translate and reinforce learning from an offending behaviour programme into everyday life, e.g. by observing a resident and using opportunities to point out to him examples of controlling behaviour that he was not aware of
- ▶ where a family member or partner had been a victim, the use of the supervised environment in the hostel, supported by close monitoring, to provide a phased return home
- ▶ work with a resident on practical budgeting which had proved a flash point in the past
- ▶ offenders who had spent many years in prison being reintegrated into the community and tested gradually by being given the opportunity to develop skills rather than being expected to manage alone after becoming institutionalised
- ▶ a more intense approach to tackling the criminogenic factors that had contributed to risky behaviour, such as alcohol misuse, than would have been possible outside of the hostel setting.

11.4.4 Conversely, where there was little purposeful activity in the hostel beyond the key work session, boredom could lead to an increase in the level of Risk of Harm. In the three with the least organised activity, some residents complained about needing assistance to keep away from offending but finding little to divert them in the hostel.

11.5 Moving on: outcomes

11.5.1 There were essentially three ways of leaving a hostel, only one of which constituted a positive outcome for the individual resident. In one, a bed could be withdrawn for breach of hostel rules. We did not find that this sanction was used for trivial reasons. Indeed, hostels had worked out ways of warning residents formally and informally without having to threaten eviction. Withdrawal of a bed would mean recall to prison for licencees or a return to court for those with a community order and requirement to reside at the hostel. Eviction was used for the more serious breaches after a warning, e.g. failure to return at curfew or bullying. Recall and loss of the bed could also be the outcome of reoffending.

11.5.2 Residents in almost all cases had to leave the hostel when their order or licence ended; this was the second way of moving on. Otherwise the timing of moving on was the responsibility of the offender manager, with or without the direction of a MAPPP. With the exception of very short licences, where little else was practically possible, moving out of the hostel at the licence end date without suitable accommodation to go to and any form of further supervision, was

unlikely to be a positive outcome. In one hostel, in particular, the local Level III MAPPP seemed to see living in the hostel as an end in itself and to refuse to countenance a return to independent living whilst the offender was under supervision. We thought that this was a defensive, but not defensible, approach as residents could, and did, disappear at the end of their licence with impunity.

- 11.5.3 A third option, and the only positive outcome, would be the achievement of an objective that had been identified at the start of the period of residence, e.g. safe return to the family home, moving into supported housing or move to a less structured hostel environment. Several hostels required a move on plan to be built into the initial sentence plan. We applauded this requirement as it rightly implied that an offender needed a hostel place for a specific reason, that they knew what the next move needed to be and what they needed to achieve to be ready for it. We accepted that, in reality, assisting the resident to find a place was often a very time-consuming job that, in most areas, fell to the offender manager. Two hostels that tended to take a high proportion of referrals from outside areas imposed a three and six month limit respectively. Longer stays were not impossible but had to be negotiated.
- 11.5.4 Approximately half of the case sample was chosen because residents had moved on. We found that there tended to be an optimum length for a period of residence after which the restrictions became too burdensome. It varied from individual to individual and could be after three to four months. If some residents were unable to move on at that stage, they could reoffend or be recalled for other reasons. They tended to be cases with complex needs who had reached the stage where probation hostel restrictions were no longer necessary but who needed a place in other specialist provision which was hard to find. We found examples in some of the women's files that we read and in men with mental health problems.
- 11.5.5 The monitoring undertaken nationally and regionally could not distinguish between individuals so there was no national picture of how long people stayed in hostels. For our part, we could see no practical use of calculating the average length of stay. Anecdotally we were told about 'bed blocking' adding a further burden on the small hostel estate. With one exception, however, we did not find this to be an issue. The exception related to one of the hostels where typically residents were required to stay until they had completed a sex offender treatment programme. Waiting lists were long and so was the duration of the programme. As a consequence, eight of the 24 residents had been there for over a year and one for over two years. We had asked hostels for information about all of their current residents on two dates eight months apart. In the first taken at the end of 2006 there had been 161 residents in total. Eight months later on 15 were still in residence.
- 11.5.6 Whilst we saw 'bed blocking' as a potential problem for that particular area, we did not support the proposal that there should be an average length of stay as one of the performance targets. We believe that hostel residence ought to be a short-term option for monitoring and resettlement around risk management. We also think that the introduction of the practice of identifying the optimum period of residence at the outset, supported by a sentence and move on plan, would be

an improvement where such an approach was not already being used. Residence ought to be dependent on the assessed level of Risk of Harm and the progress being made in the work to address it. We would foresee an obvious if unintended consequence of imposing average length of stay as a target, i.e. that residents would be moved on to meet it regardless of ongoing need.

11.5.7 We were told everywhere that finding suitable accommodation was difficult. However, in this sample we found that the majority of cases had moved on positively. This was often due to some residents having sustained family contact and being permitted to move back whilst still under supervision. Clearly, in cases with a history of domestic abuse, any return home had to be done carefully but was more likely to be safe whilst the perpetrator was still under supervision than not.

11.6 Public expectations

11.6.1 We were aware that the public knew little about the work of probation hostels. They would hear about it from time to time from the media, usually when something had gone wrong and a resident, or former resident, committed a serious further offence. We have said elsewhere that the public has the right to expect that probation staff and those employed by voluntary management committees do their job properly. It is not possible to remove all elements of risk; some people are and will remain a danger to the public. The task of those working in hostels and their offender managers was to contain and manage that risk within the law and to the best of their ability. In the eight hostels that we inspected, that was precisely what staff were doing.

Summary:

The likelihood of achieving sustainable outcomes including rehabilitation and attaining suitable accommodation was enhanced by a period of residence in a hostel. All the hostels were able to demonstrate that they contributed positively to public protection through their work with offenders who posed a high Risk of Harm and we saw some very impressive work undertaken with residents with a history of serious offending and complex needs. The liaison between hostel key workers and offender managers was very productive.

Key Findings:

- The probation service was clear that the role and purpose of hostels was to provide a period of enhanced supervision to offenders assessed as posing a high Risk of Harm to the public.
- The Risk of Harm presented by residents was contained and managed during their stay in the hostels we visited and in a number of cases actively reduced. The public was therefore better protected.
- In most cases, the quality of work undertaken with residents was good and in some very impressive.
- The relationship between the offender manager and key worker was pivotal in achieving a successful outcome.
- There were insufficient hostel places to meet the demand.
- Few offenders actually wanted to live in a hostel and were often only informed that they had to do so shortly before release from prison.
- Offenders' period of residence in a hostel was not always supported by a plan outlining the objectives of their stay; hostel plans, where written in addition to OASys, did not always link to the sentence plan.
- Careful attention was paid to the diverse needs of individual residents that had contributed to their offending.
- There was insufficient suitable move on accommodation to meet the needs of hostel residents and continue the process of protecting the public.

RECOMMENDATION:

- Offender managers should draw up a sentence plan for offenders residing in hostels which is supplemented within OASys or in an additional plan with details of the contribution that the hostel is intended to make. It should identify the proposed outcomes of the hostel stay, and include:
 - a move on plan
 - how Risk of Harm to others will be managed and
 - what the offender needs to achieve.

12. HEALTH

12.1 The health of hostel residents

- 12.1.1 Ill health and medication were dominant features of the life and management of hostels. The proportion of all residents suffering from common but serious ailments was not measured, but many of them were taking prescribed medication. These conditions routinely included heart problems, diabetes, and mental illness including depression and schizophrenia. In our sample of 100 cases, over a quarter were described as having a disability that potentially had a medium or severe impact on their capacity to benefit from supervision. In the majority of these cases, 'disability' related to mental health or emotional well being (as opposed to learning difficulties). Medication associated with substance misuse, either as a substitute or for symptom relief, was also used.
- 12.1.2 We also had access to data from OASys²¹ in relation to some aspects of health, though not physical health as this is not captured statistically. These showed, in 2006/2007, the high number of offenders under supervision with problems relating to substance misuse, alcohol misuse and emotional wellbeing. The last category included mental health issues at all levels.
- 12.1.3 Why should hostel residents appear to enjoy less good health than the population in general? We asked for the resident profile in two snapshots, the first from around December 2006 and the second from around September 2007, a total of 312 people. We ensured that those who featured in both were only counted once. There were some elderly residents, but not many, who we will consider further below. The vast majority had been in prison, however, and the profile of hostel residents with mental health problems appeared to be consistent with what was found in the recent HMI Prison mental health thematic review²². Here, 50% of the prisoners assessed using the general health questionnaire were found to have primary or secondary mental health needs and 17% of the case sample had disclosed a previous psychiatric treatment history.
- 12.1.4 There were no similar studies of the health of offenders in the community to draw on. However, we did find one small study. Lincolnshire had undertaken a survey in 2004 to support their successful bid for Lottery funding to establish a Healthy Living Project. One hundred and sixty-four offenders under supervision had completed a questionnaire. Extracts supported the proposition that hostel residents were likely to enjoy relatively poor health: 31% described their health as fair or poor and said that their physical health had interfered with their work in 33% of cases and their mental health in 23%. 71% smoked daily and 57% did not eat fresh fruit or vegetables daily.
- 12.1.5 We understood from visiting the hostels that a significant proportion of residents had previously or currently had a problem with illegal substance misuse or

alcohol, again consistent with the prison thematic review on mental health. Listening to residents, we also became aware that some had been homeless, often after leaving care and had spent time living on the streets or in unsatisfactory accommodation. By the time offenders reached a hostel, most had had a troubled past and were often suffering the long-term effects of earlier abuse, self-inflicted or otherwise.

12.2 Managing medication and confidentiality in a hostel setting

- 12.2.1 It was impossible to keep personal health information confidential in a hostel as national policy²³ required that residents should not keep their prescribed or over the counter medication in their own possession. As part of the induction process, residents had to agree to hand over immediately any medication they had with them; all further supplies were meant to be delivered straight to hostel staff or collected by them on the resident's behalf. The reasons for this were, essentially, to prevent further crime (selling prescribed medication) or self-harm, deliberate or otherwise. The only exceptions were in the case of residents prescribed medication they needed to have in possession for acute use, such as for asthma or food allergies, which could be retained by the resident.
- 12.2.2 The result was that, in many hostels, the day's routine was punctuated by residents asking for their medicine. It was meant to be offered to them so that they could take the required dose in the presence of staff, out of sight or earshot of anyone else. This proved impossible to achieve in most hostels even though some had good procedures in place.
- 12.2.3 For residents who had been released from prison to the hostel, this practice was a backwards step in terms of their levels of personal responsibility. In prison, a risk assessment should be made based on the presumption that a prisoner would retain responsibility for their own medication unless there were contra indications to this²⁴.
- 12.2.4 The approach to maintaining confidentiality and protocols around information sharing about residents' health needed to improve. No hostel had a satisfactory or up-to-date written protocol with healthcare professionals providing care to residents, either in-house or on a regular basis in the community. With the exception of South Wales, residents were not made aware that they did not need to allow hostel staff routine access to their medical notes. Unless relevant to the safe management of a resident, their notes should not be copied onto the individual's hostel file and be accessible to all staff. Even then, only the sections relevant to managing risk should be copied.
- 12.2.5 Concerns had been expressed about the system in hostels by the Department of Health, the Prison and Probation Ombudsman and HM Prison Service Safer Custody Group. As a consequence, a working group made up of representatives from these agencies and hostel managers convened by the approved hostels team within the Public Protection Unit had recommended a scheme called *Medication in Possession* that would be piloted in six hostels from the beginning of 2008. It was not assumed that a system that worked successfully in prisons

would necessarily do so in a hostel; the setting and staffing levels were quite different. Advice had been sought from the Health Service and each of the pilot hostels had the support of its local Primary Care Trust and GP, which was seen as crucial. It was recognised that whilst staff would be relieved of many routine tasks, they would need to work more positively with residents to promote a responsible approach to medication. They would also need to be vigilant that it did not become a focus of bullying or crime.

12.3 Staff approach to dealing with health issues

- 12.3.1 The staff with responsibility for day-to-day management of these issues were not health professionals but probation or voluntary management committee staff. Prisons, being much larger, had the benefit of dedicated health staff in situ and, in most, community mental health teams providing an in-reach service. Access to training varied from hostel to hostel. In this context, some staff had had no relevant training, although most were up to date with first aid. Others had had a limited amount of training around mental health but tended to say that they needed more.
- 12.3.2 What staff were trained to do was to respond appropriately under pressure to difficult circumstances. Thus, we witnessed staff acting calmly and making appropriate judgements about when to request out of hours or emergency services assistance.
- 12.3.3 In none of the hostels we visited was the handling of resident medication done wholly satisfactorily. This was often due to physical limitations of the building, but was also associated with the large numbers of residents wanting their medication and the logistics of a member of staff getting out of the office to do this in a confidential manner. On the whole, Northumbria and West Yorkshire did get this particular aspect of the process right.
- 12.3.4 From the office side, this process was also occasionally chaotic, as handovers and other work were constantly interrupted, even when there was an attempt to limit the times when medication would be issued. We thought that the whole practice did not lend itself to treating residents with respect nor could it contribute sensitively to supporting their health needs. In addition, medication ought to be available for collection according to appropriate clinical need rather than the hostel regime.

GOOD PRACTICE EXAMPLE

Northumbria had taken a radical approach to staffing and had a 'duty probation service officer', one of whose responsibilities for the day was handling medication. This staff member was able to sit in an interview room during the period designated for issuing medicines.

- 12.3.5 Medication was stored in large locking metal cabinets and recording was satisfactory in all but one hostel. There were problems everywhere though with the way medication was issued including: the use of 'compliance packs' made up

by pharmacists but where the different tablets were not identifiable, medication being taken out of the boxes it came in and put in smaller unlabelled boxes that would fit in the cabinet and residents being given a day's medication to take away instead of being watched whilst they took it. In two hostels, no attempt was made to follow up residents who did not turn up to take their medication, regardless of their medical condition. In one, we noted that only three residents had taken all their prescribed medication within the previous ten days, whilst three others had not collected or taken any of theirs. In some other hostels, only those with psychotic or potentially life threatening disorders were chased up; however, as staff were not trained in this area they may not always have been aware which conditions were so serious.

12.4 Access to healthcare professionals

- 12.4.1 The access to healthcare and advice, which was negotiated by local managers in the main, was crucial. There were different schools of thought between probation areas about the desirability of healthcare provision in the hostel as opposed to 'normal' access in the community. Decisions tended to be pragmatic and most GP services were satisfactory or at least reflected the level of care experienced by local residents. There was no evidence of hostel residents being discriminated against, although being a temporary resident in an area did occasionally throw up problems. All hostels put a proper emphasis on their residents having access to a GP. Information about dentists and opticians was less systematically provided and was absent in some.
- 12.4.2 West Yorkshire paid for one GP practice to provide a weekly clinic in all four of its Leeds hostels. The area had previously found that many residents either failed to register with a GP or, more likely, were registered but had been refused appointments for perceived inappropriate behaviour. We were surprised to find that in several areas, regardless of whether the GP ran a dedicated surgery within the hostel, they required payment of several thousand pounds per year. We did not receive a satisfactory explanation for this as the hostels appeared to be paying for GP services which should have been available to their residents as any other NHS patient without cost.

GOOD PRACTICE EXAMPLES

Lincolnshire was fortunate in having a local GP with a surgery nearby having approached them to offer to register all residents who were not already registered in the city.

Once the hostel knew a resident was due to come to them from prison, the prison healthcare department was contacted and asked to fax any information regarding any current prescriptions directly to the GP to ensure continuity of prescribing. However, the GP told us that despite this information being requested, it was often difficult to get necessary information. The GP also acted as the gateway to other health and social care services and told us that residents were entitled to the same range of services as anyone else on his list.

A similar arrangement existed in Cheshire. Residents were registered with the GP whose surgery was close to the hostel. He also ran a surgery at the hostel on Monday afternoons. On the preceding Sunday, residents were asked if they wanted an appointment and a list was faxed to the surgery in advance. This GP also contacted prisons about new residents but, again, often experienced problems in obtaining medical records from prisons prior to discharge.

- 12.4.3 With one exception, there were no plans and little apparent knowledge about what to do in the event of an outbreak of a contagious disease. This needed to be added to the hostel contingency plan following advice from the communicable disease consultant (public health).

GOOD PRACTICE EXAMPLE

There was a lottery funded Healthy Living Project running in Lincolnshire to assess and address the health needs of offenders subject to probation supervision across the area. It included an initial assessment and the option of a more detailed screening. Residents could access free gym membership through this scheme and specific health awareness events were run regularly at the hostel. A project nurse regularly visited and additional fruit was provided for residents through the scheme; this was a welcome addition to an otherwise potentially stodgy diet. The funding was for a limited period and was due to end in July 2008.

12.5 Mental health

- 12.5.1 Access to mental health services was variable. Given the prevalence of mental ill health, this could be problematic. Community mental health teams were linked to GP practices. Where there was a delay in registering with a GP, for whatever reason, the mental health team in some areas would refuse to accept a referral until this had been done.

12.5.2 There were, however, examples of positive relationships with mental health services: the hostel we inspected in London was well served by a local community psychiatric nurse who was linked in to it. Staff could refer residents to him and he visited once or twice per week. In West Yorkshire, a community psychiatric nurse visited weekly to carry out assessment and make referrals for treatment if necessary. There was a less frequent but similar service available in Bedfordshire which could be supplemented by telephone advice if necessary. In several hostels, basic training in mental health issues had been provided by health staff.

GOOD PRACTICE EXAMPLE

In South Wales, there was a community psychiatric nurse post jointly funded by the NHS and the probation area. She could take referrals direct from residents or staff. She carried a small caseload of patients requiring additional support and also made referrals to a local community team. She also provided informal training as she sometimes did work on the management and support of specific residents with mental health issues.

12.6 Substance misuse

- 12.6.1 The misuse of illegal drugs was not an overwhelming problem for hostels, given the age and offending profile of residents. Arrangements for addressing substance misuse varied from hostel to hostel and were satisfactory on the whole. Some residents were encouraged to attend a community-based drugs team, whereas others had drugs workers visiting the hostel on a weekly basis. The lack of an information sharing protocol with health-based agencies also had an impact on this issue; in one hostel, neither the drug team nor hostel staff were aware that they needed to share information about positive drugs tests with one another which made the management of individual offenders' drug misuse impossible. This issue had been addressed in South Wales where the 'drugs contract' that residents were asked to sign as part of their induction process included an agreement for 'exchange of any relevant information between the hostel, the drug agency and the GP surgery'.
- 12.6.2 It was common practice for residents on methadone prescriptions to attend the local pharmacy to receive their medication, only bringing weekend or bank holiday doses back to the hostel. These doses were in daily bottles. This was seen to be a pragmatic solution and a way of beginning to reintegrate residents into community-based services.
- 12.6.3 Hostels inspected had adopted the national policy of harm reduction²⁵ expressed in relation to substance misuse rather than evicting residents for illicit use alone. The rules prohibited residents from having illegal drugs or associated paraphernalia on the premises, which could lead to eviction and recall to prison. Residents with a known problem or suspected relapse were meant to be subject to planned and random drugs tests. Whilst planned testing was undertaken, random testing was rare. Rules tended to be rather vague about the consequences of positive drugs tests as the policy was to make decisions on a

case-by-case basis; hostels did not want to be put in the position of evicting someone who was generally compliant but who still had a drug misuse habit if they were attempting to deal with it. Whilst this was an acceptable approach in terms of harm reduction and protection of the public, it could be hard for residents to understand and potentially be seen as discriminatory. Staff, however, did not condone illegal use nor did they want to be seen to. They did issue warnings and referred residents to their offender manager. Staff also encouraged them or, in some cases, required them to engage in treatment following positive tests.

- 12.6.4 The practical arrangements for drugs testing by hostel staff were variable. In one hostel, we advised that urine testing in inadequate conditions should cease. In another, we observed the discreet application of an oral test. However, residents in this hostel also told us of a practice of conducting an oral swab test at the office hatch. Some of these arrangements, therefore, did not give proper consideration for the privacy and dignity of the resident and could not always be effective.
- 12.6.5 Resources in the community for addressing alcohol misuse were generally poor and no attempt had been made in any of the hostels visited to establish any sort of provision to compensate for this gap. It was still a national problem: resources being invested in illegal drugs rather than in alcohol misuse which was much more prevalent and more likely to be associated with crime of a violent and/or sexual nature. (It is of note that the Westgate Project in Wakefield which was outside of the scope of the inspection had developed a programme for dealing with binge drinking based on an alcohol education model.) The only resources routinely available to staff in the hostels visited were of a restrictive nature, i.e. breath testing on return to the hostel to check whether the requirement for abstinence in some licences was being adhered to.

12.7 Elderly and infirm residents

- 12.7.1 Out of the 312 offenders resident in the eight hostels during the two periods when we asked for a snapshot, 20 were aged 65+ of whom nine were 70 and over with 78 being the oldest. We were told that in two there had been residents aged over 80.
- 12.7.2 Whilst these residents made up a small minority, their needs could not be catered for if they became infirm with age. They were there because they had been assessed as still posing a high Risk of Harm to the public, often to children, despite their age and length of time served in prison. Agencies with responsibility for providing care and accommodation to people aged over 65 and sometimes MAPPPs seemed to take a very narrow view of how their Risk of Harm could be managed. Social care and nursing homes had experience of managing people who posed a Risk of Harm to the public due to mental health problems and, increasingly, dementia. However, we were told that where the harm was linked to previous and possibly continuing offending, often neither the local authority Social Service Department nor the homes themselves would consider a referral.

- 12.7.3 All persons aged 65 and over with social care or nursing care needs should undergo an assessment according to the *National Health Service and Community Care Act 1990*²⁶ and the *Health Act 1999*²⁷ respectively. If the primary need was for nursing and/or social care, it should take priority in the choice of accommodation and support, informed by an assessment of Risk of Harm and its management. Local authorities had a duty to cooperate with other agencies under MAPPA to protect the public. We were told that what tended to happen, however, was that the offending history and current assessment of Risk of Harm obscured other needs. The probation service had responsibility for the supervision of these cases in relation to their offending behaviour and often could not persuade the local authority to address accommodation and care needs. It is not defensible for an offender assessed as posing a high Risk of Harm and under statutory supervision to be homeless; therefore probation hostels were sometimes presented with no alternative but to accept them.
- 12.7.4 In our inquiry in Avon and Somerset conducted in 2006³, we had been informed that one of the four hostels in the area at that time specialised in taking residents who had usually served long terms of imprisonment and who had been released either with physical disabilities or who were elderly and needed some level of nursing. Staff there were not qualified or trained to provide the consequent necessary care, e.g. manual handling and coping with incontinence. The Prison and Probation Ombudsman had also commented on the inappropriateness of a probation hostel placement for people who need nursing or other personal care²⁸.
- 12.7.5 We found a further example of this in one of the cases we came across in Cheshire. It concerned a frail man of 65 with a condition that was likely to deteriorate and require full nursing care. He was referred by his offender manager to his home local authority which refused to accept the referral as he was living elsewhere. His social worker made numerous referrals to residential care homes, all but one of which was unsuccessful. In the meantime, he had to be released to the probation hostel which agreed to take him at short notice as he would otherwise have been homeless. This resident's medical condition and frailty meant he was unable to participate in hostel life or any meaningful supervision and was potentially vulnerable to other residents. No-one minimised the level of risk posed by this offender but it would have been manageable elsewhere, in accommodation better suited to his particular individual needs, without taking up a scarce hostel place.

Summary:

Staff in hostels were dealing with high numbers of residents with physical and mental health problems. On the whole they did this well, although conditions in the hostels made it difficult to maintain confidentiality about medical issues. They were often supported on site by mainstream health professionals, including services for substance misuse. The trend towards accommodating elderly and infirm residents who had been unable to get proper access to social or nursing care was worrying and suggested a lack of cooperation with local authorities.

Key Findings:

- Staff would need to develop a more proactive approach to resident supervision in some hostels to implement the changes proposed under the *Medication in Possession* pilot.
- There were few services for alcohol misuse in any of the hostels inspected despite the high level of prevalence.
- It was unclear why certain hostels were required to pay for GP services.
- None of the areas visited had a satisfactory written protocol about sharing information between the hostel and healthcare professionals.
- In addition, prisons often did not respond to requests for hostels or GPs for information to ensure continuity of care.
- None of the hostels visited had drawn up procedures about what their response would be to the potential outbreak of a contagious disease. No reference was made to this eventuality in any of the contingency plans examined.
- Not all of the hostels were following national guidance for testing for the use of illegal drugs. All did, however, adopt a harm reduction approach.

RECOMMENDATIONS:

- NOMS should discuss with the Offender Health Unit the necessity and propriety of paying for GP services where no extra services are provided.
- Probation areas should seek advice from the local communicable disease consultant (public health) about what to do in the event of an outbreak of a contagious disease. This should be included in the hostel contingency plan.
- Where it is not current practice, local authorities should play a part through MAPPA in the assessment and planning for those aged 65 and over with social care and nursing needs who require residential accommodation but also have a criminal history and pose a Risk of Harm to others. They should add a variation to their contracting and commissioning arrangements in order to ensure access to achieve this.

13. SUICIDE AND SELF-HARM

13.1 Vulnerability

13.1.1 Most hostel residents had been released on licence from prison. HMI Prisons, in its recent thematic review on prisoners with mental health problems²² reported that 16% of prisoners in its sample had had a previous history of self-harm and 5% experienced current thoughts of self-harm. It noted that women prisoners were much more likely than men to experience these problems, though were also more likely to express their needs to staff. Data from OASys²¹ (see table below) also showed that women offenders in general were almost twice as vulnerable as men to the risk of self-harm or suicide.

Proportion of cases assessed as having needs in these areas	Risk of suicide	Risk of self-harm
All cases – men and women	16%	15%
All offenders at start of a custodial sentence	19%	19%
All offenders at start of a community sentence	15%	14%
Men at the start of a community sentence	14%	15%
Women at the start of a community sentence	24%	25%

13.1.2 In response to these levels of potential vulnerability, we were impressed by the depth of staff knowledge about individual residents in most hostels and also with the level of care demonstrated. However, procedures around self-harm and suicide prevention needed urgent improvement in all of the hostels visited.

13.1.3 The approach to identification of the risk of self-harming behaviour was too varied and did not have the robustness we associated with the identification of Risk of Harm to the public. The section in OASys relating to self-harm and suicide was located within the Risk of Harm section; our experience of reading files, both from the samples and taken from the hostel, was that these assessments tended to be inadequate.

13.1.4 Proactive contact by offender managers or hostel staff with the prison releasing a new resident was rare, even when previous episodes of self-harm were noted on the record. Prisons were required under their ACCT system to involve probation staff in the final ACCT review if they were closing the plan and, in all relevant cases, to pass on information on discharge to probation or hostel supervision. However, there was evidence that this process was not always carried out. Both prison and probation guidance²⁹ referred to local protocols between the two

services; however, given the current dispersal of prisoners and volume of work it would take to cover all prison and probation areas, it was impractical to expect that these protocols would exist below the national level.

13.2 Deaths of hostel residents

13.2.1 The Prisons and Probation Ombudsman has the responsibility for investigating deaths of residents in Approved Premises. We had access to reports relating to deaths in the eight hostels visited and took advice from his office about issues of concern before we began the inspection fieldwork.

13.2.2 Details on the total number of deaths of residents of Approved Premises, and the causes of death, are set out below²⁸.

Year	Suicide	Overdose	Natural Causes	Accident/Homicide	Currently unknown	Total
1998	3	11	3	3	0	20
1999	4	4	1	0	0	9
2000	8	13	2	1	0	24
2001	3	12	5	2	0	22
2002	3	8	8	2	0	21
2003	4	3	3	1	0	11
2004	2	8	8	2	0	20
2005	6	6	4	0	1	17
2006	1	5	6	0	1	13
Total	34	70	40	11	2	157

13.2.3 These represent a very small number of the residents taking up one of the 2,200 hostel beds each year. However, each one represents a tragedy.

13.3 Implementing procedures

13.3.1 All but one hostel had a procedure for identifying the risk of self-harm and dealing with it. Unfortunately, these procedures were not always followed. The greatest weakness was in recording. Information tended to be located in several places which meant staff did not always access the information available to them. Given the reliance on relief staff in some hostels, this practice was potentially dangerous. In one hostel, we were aware of one case where there was absolute confusion amongst staff on different shifts about whether a resident was still subject to extra checks or not. Some of the documentation had not been kept up to date so they relied on word of mouth that the resident was now deemed to be not at risk. This despite the large white board in the office indicating that he was still at risk of self-harm.

- 13.3.2 There was a standard national Approved Premises training package addressing suicide and self-harm. Not all staff had undertaken it, not even those in post for a long time, and those that had felt the need for further training. In West Yorkshire and Bedfordshire, arrangements had been made with their respective visiting mental health professionals to put on further training and staff felt that it had boosted their confidence in dealing with the issues. Only in Northumbria did staff appear to have had sufficient training. They received regular training in suicide minimalisation from local psychiatric nurses, and two staff had completed (the prisons) ACCT training.
- 13.3.3 Staff in all of the hostels visited were clear about the risks of possible overdose due to reduced tolerance when new residents had been released from prison free from drugs and relapsed into the use of illicit drugs. This issue should be routinely addressed as part of the induction process. It was of concern that, despite clear national guidance, it was absent from the induction procedure in two hostels and only raised with those believed to be at risk.
- 13.3.4 Some hostels nationally were piloting a modified version of the prison system ACCT – ACT and a review was planned for shortly after the fieldwork for this inspection. We visited one of these hostels in Cheshire. Several other hostels had been to look at its operation in various prisons; some had felt it would not suit the hostel setting and one was waiting for the outcome of the pilot. Whilst we commended the hostel for introducing such a structured system, we had concerns about how it was operating. A plan could be opened and closed within two hours (this happened when we were there) which raised questions about its value. It was common for residents to be subject to an ACT plan one day and removed the next. We were not aware of whether this was how it operated in the other pilot sites. The training programme in ACT for new staff had lapsed and was no longer used.
- 13.3.5 Procedures in most hostels were not always backed up with guidance for staff on what factors might be indicative of possible self-harm in relation to individual residents. In West Yorkshire, we found that their documentation included information about current problems and triggers plus names and contact details of relevant family members or partners; we thought that this was good practice.
- 13.3.6 Care planning to address the risk was weak and was not always clear about staff roles. This language was not commonly used in the probation service and required a shift in thinking. Where there were plans, they tended not to be updated but were apparently left without a review. There were exceptions to this practice, e.g. in Bedfordshire.

GOOD PRACTICE EXAMPLE

In Bedfordshire, if a resident was considered to have an increased risk of self-harm, a support plan was used and others outside the hostel included if appropriate. A specific form was opened for any resident requiring a level of observation higher than the norm and the reason for its use and frequency of observation stated on the form. We saw examples of this form having been used for observation of a resident following seizure and observation of a resident who was at risk of self-harm.

At the time of our visit, we saw a resident who staff believed may have misused her medication. Advice was sought from NHS Direct, the duty manager was contacted and paramedics attended. The resident was taken to the local Accident & Emergency Department but discharged herself later. As soon as staff were aware that the resident was requiring additional support and observation, the best way of managing the situation was discussed between staff on duty and also with the resident, who was involved throughout. This was a difficult situation handled appropriately and calmly by all concerned.

- 13.3.7 The quality of the monitoring of individual residents reflected each hostel's approach to managing their residents generally. Where staff were not proactive and tended to stay in their office, monitoring the resident around the hostel tended to be via the CCTV footage. Elsewhere, as in the example above, residents were sought out and spoken to, to try and ascertain how they were. This practice also had the effect of the resident knowing that someone was not only actively keeping an eye on them but also cared about their welfare.
- 13.3.8 All hostels carried out room checks at the start and end of curfew. Where there was concern about the risk of self-harm, residents were seen and spoken to at an agreed frequency during the day and night. This could be as often as half hourly and could be very intrusive but, having assessed that there was a risk, action had to be taken. There were issues about the gender of staff that could mean a need for two to carry out checks as residents and staff were potentially vulnerable to allegations of improper conduct if they were not observable by CCTV.
- 13.3.9 Most hostels had shared rooms and one had only shared rooms. These were usually for two people but, in one, were for up to three. It was recognised that room sharing could prove a risk to the vulnerable or, conversely, introduce a level of contact that could reduce the risk. The important issue was to have a procedure and make decisions based on a thorough assessment. We found examples of procedures, e.g. in London, that lent themselves to this. Sometimes hard choices had to be made to refuse admission due to the potential risks of room sharing or to require a resident to move out of a cherished single room back into a shared one to reduce the level of assessed risk of self-harm. What was not defensible was where staff said that they had discussed a referral and the risk related to room sharing but had not recorded it, which we found happened too frequently, despite all the procedures about assessment.

13.3.10 Arrangements for confidential access to telephone helplines could be made with staff allowing access in an interview room.

Summary:

Hostel staff were acutely aware that the resident group was vulnerable to attempts at suicide and self-harm. This applied to women in particular but also to men. Staff dealt sensitively but realistically with those they assessed to be at risk and carried out frequent and potentially intrusive monitoring to try to minimise the risk of self-harm. Nevertheless, significant improvements were required in the assessment and recording of vulnerability, including in respect of room sharing.

Key Findings:

- We were impressed by the depth of staff knowledge about their residents in most hostels and by the level of care demonstrated.
- However, procedures around self-harm and suicide prevention needed urgent improvement in all of the hostels visited. They were applied inconsistently and recording was poor.
- Assessments of the risk of self-harm, by both hostel staff and offender managers, tended to be inadequate. Offender managers and hostel staff did not routinely seek information about potential residents from prisons.
- Most staff had had a limited amount of health related training but needed more. They also needed specific guidance on what to look for as potential triggers in individual cases.
- Some were well supported by the mental health care professionals who provided a regular service to the hostel.
- Care planning was weak and, with the exception of one area, there was no evidence that the plans were reviewed in most of the cases we examined.
- Staff carried out room checks at the start and end of curfew to check on the presence and welfare of residents. Where necessary, this process was carried out more frequently and, in general, was undertaken satisfactorily. We saw evidence of staff dealing calmly and appropriately with residents experiencing crises that could, in a few instances, have been fatal.

RECOMMENDATION

- Hostels should have clear written guidance on the procedures for the assessment of risk of self-harm and suicide. These should include:
 - where there is a history of self-harm, information should be sought actively from any recent prison sentence and/or medical practitioner to inform the current assessment
 - the development of a care plan that is accessible to all staff, is followed, recorded and reviewed
 - the exchange of information about the status of the level of risk and plan at handover meetings.

14. CONCLUSION

- 14.1.1 This inspection builds on the findings of our inquiry into the allegations made by the *Panorama* programme about the management of hostels and their role in protecting the public. We commented then on the need for greater strategic investment in the hostel estate which, we felt, had been lost in the transition between from the former NPS to NOMS. This work has now been taken forward through the Approved Premises Service Review which has still to submit its final report. It appears unlikely, however, from the draft report circulated in November 2007 that the review will determine whether the hostel estate should be developed in the future as a single national system, or within an approach led by the regional commissioning arrangements. Our view remains that hostels need to be managed as a national system, albeit with regional collaboration.
- 14.1.2 During the course of this inspection, we saw some impressive work undertaken with hostel residents by staff who took all reasonable action to ensure that Risk of Harm posed by the offender to others was kept to a minimum. The inspection reinforced our belief, previously stated and now repeated, that hostels provide an enhanced level of supervision, over and above anything else outside of prison and can give an excellent opportunity to contain both the Risk of Harm posed by the individual offender to the public and to contribute to their rehabilitation.
- 14.1.3 Overall, we found staff to be hard-working and conscientious. All the hostels visited had a satisfactory level of restrictive measures in place, although the amount of planned, purposeful activity varied considerably between them. In our view, those that got the most out of their residents and were therefore the most successful in working with them, also expected the highest level of contact, whether formal or informal, between staff and residents.
- 14.1.4 The inspection contains a number of recommendations, based on our findings, which will now be presented to Ministers and, subsequently, to NOMS for implementation. Our findings and recommendations will also inform our future inspections and we expect them to be taken forward by probation areas, prisons and others in their work with offenders residing in Approved Premises.

15. REFERENCES

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14. Probation Circular 37/2005: *The role and purpose of Approved Premises*
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16. Crime and Disorder Act (1998)
17. Probation Circular 25/2007: *Case transfers – community orders, suspended sentence orders and licences*
18. *What Works with Women Offenders.* Sheehan, McIvor and Trotter (2007)
19. *A Review of Women with Particular Vulnerabilities in the Criminal Justice System.* Corston. Home Office (March 2007)
20. *Women in Prison Literature Review.* HMI Prisons (2005)
21. OASys Data, Evaluation and Analysis Team. (NOMS). Information included here relates to over 58,000 completed OASys assessments during 2006/2007. These data have the following limitations:
 - 1) Only assessments that met the following standards of data completion were included in the analysis:

Core assessment: Each of the scored sections (1 to 12) within the core OASys assessment must have had at least four-fifths of their scored items completed – ensuring that each criminogenic need was assessed properly.

Risk of serious harm: In the risk of serious harm sections, the screening must have been completed, the decision whether to complete a full risk analysis should have been consistent with the information provided, and the four ratings of risk of serious harm in the community must have been recorded in those cases in which a full analysis was required.

2) OASys data should not be read as representative of the entire offending population and care should be taken in generalising the results. For example, if OASys is targeted at higher-risk offenders or offenders with certain offence types or sentence lengths, then the resulting risk/needs profiles will reflect only the risks and needs of these offenders. Analysis of 2006 data revealed that the risk/needs levels of all those offenders commencing supervision were slightly lower than the risk/needs levels of those for whom an assessment was completed.

3) The reliability of the data is also dependent upon assessors using OASys consistently. Common definitions and interpretations need to be applied to ensure that risk/needs profiles from one probation area can be compared with those from another probation area. An inter-rater reliability study is currently being carried out with probation assessors.

22. *The mental health of prisoners.* A thematic review of the care and support of prisoners with mental health needs. HMI Prisons (October 2007)
23. Probation Circular 33/2004: *Guidance on the handling of medication of residents of approved premises*
24. Prison Service Instruction (PSI) 28/2003: *Pharmacy services for prisoners*
25. Probation Circular 05/2006: *Approved Premises: drug testing of residents*
26. National Health Service and Community Care Act (1990)
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28. Prisons and Probation Ombudsman Annual Reports
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