



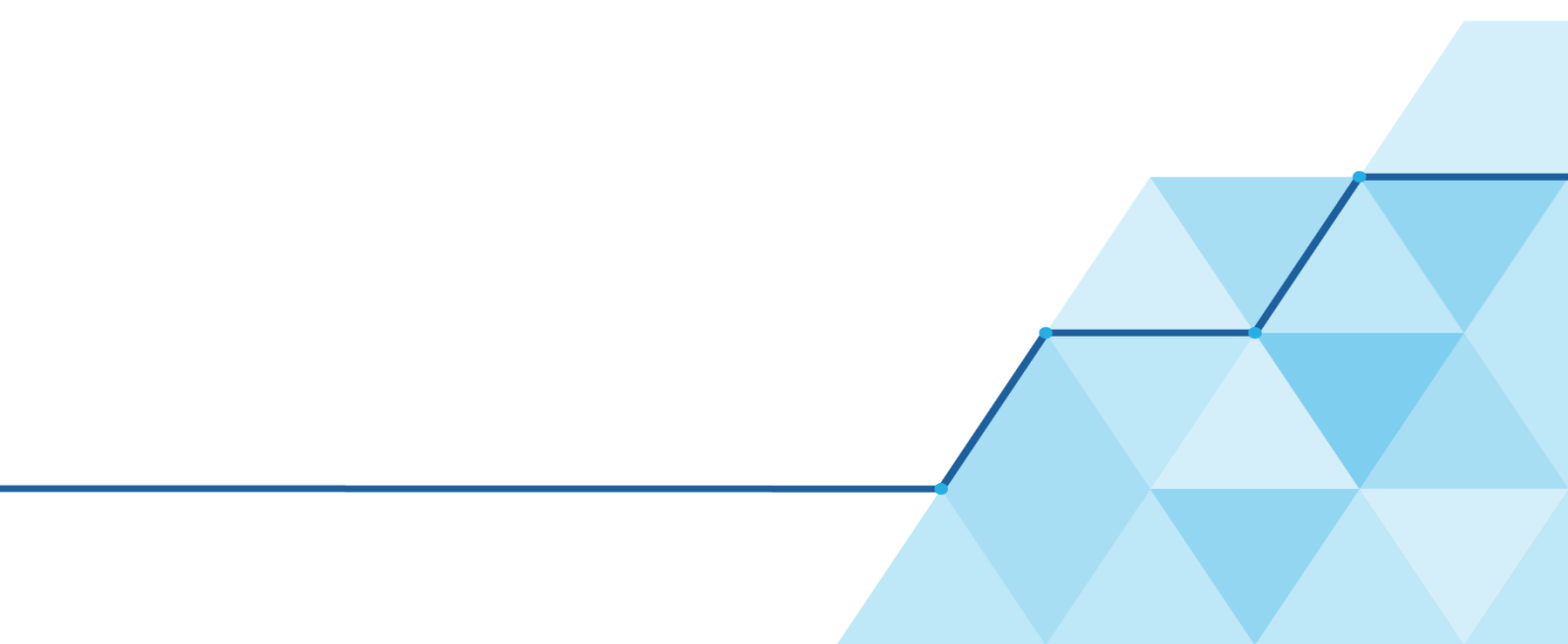
Ministry
of Justice

Mental Health Support in Approved Premises – Early Process Evaluation and Research Findings

Jemma Jones and Chloe Enevoldsen

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1. Summary

Approved Premises (APs), also known as Community Accommodation Service 1 (CAS1), are residential units for individuals who are high risk of serious harm to others once they have been released on licence from custody. In 2024, there were 100 APs across England and Wales.

Between May 2022 and November 2024, the following elements were introduced to improve mental health support for AP residents:

- Piloting co-located Mental Health (MH) Practitioners within six APs (first MH Practitioner was in post in April 2024),
- National mental health training offered to all AP workforce (commenced in July 2024), and
- National funding available to improve the physical environment of APs (commenced in 2022).

Funding was also made available in 2024 to support the rollout of Rehabilitative Activities (RA).

This report presents findings from a small-scale process evaluation of the pilot, and complementary research at the early stages of projects. The pilot evaluation aimed to understand early implementation and delivery to inform decisions on future provision and rollout. The research aimed to generate learning on how all elements worked together to improve mental health support for residents and enhance AP environments.

1.1. Methods

The pilot evaluation and research, conducted by Social Researchers within the Ministry of Justice's (MoJ's) Analysis Directorate, took place between May and November 2024. A mixed-method approach was employed, including qualitative interviews, a national AP staff

survey, a desk review of project documents, and an analysis of project monitoring information.

The evaluation and research were designed and delivered quickly to inform future spending decisions. Measuring impact was not within its scope. It focused on assessing the early implementation, particularly for the co-located support pilot, as interviews were conducted only two months after MH Practitioners began their roles.

1.2. Summary of Findings

1.2.1 Pilot of Co-located Mental Health Support

Commissioning and Design

His Majesty's Prison and Probation Service (HMPPS) project funding was used by NHS England (NHSE) to commission local teams within existing services to deliver the pilot. The model was piloted in two areas: Avon and Somerset and West Yorkshire, covering six APs.

Staff and MH Practitioners noted the time required for co-located mental health support varied across AP sites and was influenced by AP size, resident needs, and time of day. Staff interviews revealed a lack of clarity about different services (e.g. the difference between services provided within APs via Reconnect and the Offender Personality Disorder Pathway), highlighting a need for clearer communication on support pathways. To manage this, local stakeholders joined the Project's Strategic Board, and development days were held to review issues and clarify roles and responsibilities.

Pilot Model

Qualitative interviews identified six key elements of the pilot model:

- referrals by Probation Support Officers (PSOs), Residential Workers (RWs), or residents;
- holistic assessments of residents' mental and wider health needs by MH Practitioners;
- triaging and signposting through community referrals, either directly or local services;
- brief interventions provided by MH Practitioners as needed;

- recommendations and reports for key workers; and
- knowledge and skills exchange between AP staff and MH Practitioners through informal conversations, structured recommendations, and training.

Referrals, Attendance, and Ongoing Support

By 11th November 2024, 130 referrals to MH Practitioners were made across pilot areas. Attendance at appointments was 73%, with 22% of residents not attending, and 5% of scheduled appointments had not taken place at the time of analysis. Approximately 19% of residents required secondary mental health care and staff interviews indicated the pilot supported residents in accessing GP services.

Perceptions of Early Implementation

AP staff interviews highlighted some early challenges including communication of the service and its non-clinical nature, coordination difficulties due to staff shift patterns, and gaps in monitoring data. Positive aspects included MH Practitioners becoming embedded within APs, successful collaboration on referral forms, and the commitment to ongoing development through 'development days'.

Mechanisms of Change

The pilot was perceived to improve collaboration and partnership working, facilitated knowledge and skills exchange, and provided early indications of increased staff confidence. MH Practitioners' presence was believed to improve residents' confidence and access to mental health services.

Perceived Outcomes

The evaluation did not measure impact, however, AP staff perceived improved access to mental health services, increased resident confidence, and a sense of being heard. Some staff believed the pilot helped prevent unnecessary recalls to prison.

Challenges

Interviews highlighted broader challenges across the pilot, which included commissioning issues, gaps in community mental health provision, AP staff shift patterns and turnover, resident engagement, and the placement of residents in APs outside their home area. These challenges led to ongoing support and adjustments to the pilot model.

1.2.2 AP Workforce Development

Training Offer and Attendance

Between July and September 2024, eighteen half-day sessions Adult Mental Health Awareness Courses¹ were delivered. By 30th September 2024, 141 of the 1,393 AP staff² had received training. Records indicated that of the 216 training places accepted, 77 AP staff withdrew or did not attend, representing a 34% non-attendance rate. Non-attendance was often due to shift patterns and covering for colleagues, though many did not provide a reason. While high attrition rates are common across training programmes for AP staff, this issue was raised with senior leaders for regional-level solutions.

Self-Reported Competency

The national survey sent to all AP staff provided an indication of staff self-reported knowledge, confidence, and awareness of mental health. 37% of AP staff responded to the survey, across 84 APs. The findings indicated: between 49% and 79% of respondents rated their mental health **knowledge** as 'very good' or 'good'; **confidence** levels were lower, with 42% to 62% of respondents feeling 'extremely' or 'very' confident in supporting residents with mental health issues; and **awareness** of mental health services varied, with 37% to 56% of respondents reporting 'very good' or 'good' awareness.

Factors Associated with Self- Reported Competency

A multiple regression analysis identified several factors associated with staff self-reported survey scores. The most significant factor was the number of bed spaces, with larger APs associated with lower competency scores. Staff in Psychologically Informed Planned Environments (PIPEs) reported higher competency scores, and managers scored higher than residential workers. There may have been other influencing factors, however, as data quality issues limited the analysis.

¹ A half-day course Mental health training course delivered by Mental Health First Aid (MHFA) England.

Rehabilitative Activities (RAs)

RAs³ were introduced in July 2024 with an online resource library. This was included in the research due to its connection with AP workforce development in mental health support.

The project team⁴ delivered RA development days, attended by 503 AP staff over nineteen regional events. Interviews with AP staff in pilot areas highlighted that these days supported group discussion and shared learning. The all staff survey indicated low confidence in the roll out of RAs, and some interviews indicated uncertainty around what constitutes as an RA, alongside workload pressures limiting time to support residents' RAs. It should be noted that responses were collected while the roll-out was still underway, so findings were unlikely to represent the full picture.

1.2.3 Perceptions of the AP Physical Environment and Social Climate

AP Physical Environment

National funding was available to all AP Managers to improve the physical environment of APs. Around half of APs accessed funding used to fund new storage and furniture, re-decorating, installing blinds and curtains to let in more light, supplies for activities, and additional wellbeing spaces.

The national staff survey sent to all AP staff suggested around 40% of respondents perceived an improvement in the physical environment over the prior year. However, 32% felt the environment remained the same, and 15% believed it had worsened.

Social Climate

EssenCES⁵ was used to measure staff perceptions of the AP social climate. It found that PIPE was the most significant factor in positively influencing staff perceptions of resident

³ RA within APs involves AP staff delivering structured actions to address offending behaviour, aiming to reduce reoffending and support reintegration. This includes therapies, skills development, and fostering prosocial attitudes to help residents live healthier lives and lower reoffending risk.

⁴ The project team included HMPSS Approved Premise's Strategy and Operational Support Team and one staff member within the HMPSS Health and Care Partnerships team.

⁵ The Essen Climate Evaluation Schema (EssenCES) assesses the social and therapeutic environment of institutions. It is used in correctional and psychiatric settings, including Approved Premises. EssenCES consists of 15 items on a 5-point Likert scale, divided into three subscales: social cohesion, experienced safety, and therapeutic hold.

cohesion and experienced safety. Scores for AP staff perception of resident cohesion were lower in larger APs and, unexpectedly, APs with the Enabling Environment (EE) Award. For the latter, there may have been other factors driving scores, for example, higher levels of need amongst residents. AP size and EE Award status did not correlate with experienced safety.

1.3. Considerations

Based on findings, some considerations for further delivery and research have been identified.

1.3.1 Delivery

- **Pilot Continuation and Expansion:** Positive early evidence led to pilot continuation in the North West and expansion to two more locations from March 2025. Consideration should be given to challenges around commissioning and implementation if rolled out further.
- **Workforce Capacity and Staff Training:** High staff turnover, low training attendance, and workload pressures should be considered as part of future project planning and delivery. To address high self-reported mental health knowledge but low confidence in AP staff, more practical, hands-on training could be considered.
- **Staff Collaboration and Partnerships:** Future projects should look to build on improved collaboration by further enabling joint working and knowledge sharing between AP staff and MH Practitioners.
- **Environmental Factors:** Future projects should consider the influence of AP size and PIPE status when implementing mental health support in APs.

1.3.2 Research and Evaluation

- Develop a follow-up evaluation programme to address evaluation limitations, guided by a clear evaluation plan. This should define aims, methods, measures, include qualitative input from **both residents and staff**, and maintain routine supplier monitoring to robustly assess the MH Practitioner model before wider rollout.

2. Background

2.1. Context

Approved Premises (APs), also known as Community Accommodation Service 1 (CAS1), are residential units for individuals who are high risk of serious harm to others once they have been released on licence from custody. They provide an enhanced level of public protection to society and are typically used to accommodate individuals following serious violence or sexual offences.

The role of APs sits within the broader probation landscape. Sirdifield & Brooker (2020) highlighted the importance of maximising mental health outcomes for people on probation. Their recommendations align with key Ministry of Justice (MoJ) objectives, including reducing reoffending, supporting compliance with probation, improving the health of people on probation, and supporting the wider agenda to reduce health inequalities.

Sirdifield & Brooker (2020) outline various steps that may maximise positive outcomes for people under probation supervision, including: improving literacy and health literacy; improving commissioning processes and provision for complex needs; improving access to data and training; increasing integration between health, social care, and probation services; improving GP access; addressing the social determinants of health; and investing in research and evaluation.

2.2. Existing Services

In 2024, there were several key national initiatives aimed at supporting individuals as they were released from custody into the community, with links to supporting the mental health of those released into APs⁶. These included:

- **The Offender Personality Disorder (OPD) Pathway**, a long-term change programme running since 2012 in partnership between His Majesty's Prison and Probation Service (HMPPS) and NHS England. It commissions treatment and support services nationally

⁶ At the time of publication (2025), these initiatives are currently active, and descriptions remain accurate.

for people likely to meet the clinical threshold for a diagnosis of ‘personality disorder’. It focuses on those whose complex mental health problems are linked to their serious offending, both in custody and on release. Within APs, the service is jointly delivered to AP staff and residents by NHS Clinicians and Specialist Probation Officers.

- **Psychologically Informed Planned Environments (PIPEs)** are interventions offered as part of the wider OPD Pathway. PIPEs are established in prisons and APs and are designed to support an OPD resident’s transition and progression through the criminal justice system and into the community. AP PIPEs have been determined based on their readiness and discussions with probation regional leads, and with site locations selected that ensure national distribution⁷. An impact evaluation of PIPEs in prison and APs concluded: ‘Due to implementation challenges across the AP estate, the research was unable to robustly answer the questions relating to AP PIPEs. These are, however, promising preliminary findings for the success against stated goals of an improved social environment, linked to improved social functioning’ (Kuester, 2022). In May 2024, thirteen out of 100 APs were PIPEs.
- **Enabling Environments (EE) Programme** is run by the Royal College of Psychiatrists who assess Enabling Environments through standards based on ten values. All APs are currently expected to attain the Enabling Environment Award (EEA) and, for an AP to achieve the EEA, they are required to submit a portfolio of evidence of clinical practice for assessment by the Royal College of Psychiatry, which is renewed every three years. In May 2024, there were 38 APs that hold an EEA.
- **RECONNECT**, funded via NHS England, offers liaison, advocacy, signposting, and support for any person aged eighteen or above leaving a secure or detained setting (prison or IRC) with an “identified health need”. It aims to do this by facilitating engagement with community-based health and support services. RECONNECT operates a “no wrong door” referral system where referrals can be accepted from the probation service, liaison and diversion services, and/or Home Office enforcement teams for individuals who have been released in the past 28 days. Self-referrals and

⁷ For more information, please see [The offender personality disorder \(OPD\) pathway: a joint strategy for 2023 to 2028](#)

those from friends and family can be made on behalf of an individual whilst they are in prison or immigration removal centre.

- **Enhanced RECONNECT** is a pilot scheme that builds on the RECONNECT service and provides interventions, structured support, advocacy, and signposting to those with complex needs. In 2024, RECONNECT had almost full (98%) coverage in England meaning most APs residents were eligible for the service, and Enhanced RECONNECT were live in four pilot sites.

There are also **three existing models of local co-located mental health support** provided in APs:

- In **South Wales**, the OPD Pathway has an established Transitional Support Liaison Service. Men are eligible for the pathway if they are assessed as having a high or very high risk of serious harm to others at any point during their sentence that is linked to a likely severe personality disorder. Women are eligible using the same criteria, but without the need to be high risk. It is jointly delivered by HMPPS in Wales and the Welsh Health Boards. Intensive Intervention and Risk Management Services (IIRMS) are also delivered as a part of this service, also delivered across England and Wales as part of the OPD Pathway.
- In **Birmingham**, NHS Services at Elliott House are provided through a well-established partnership model between Birmingham and Solihull Mental Health Trust and The Probation Service. The model involves the NHS Trust providing a staff on a weekly basis. This includes a Consultant Forensic Psychiatrist (half a day per week), Senior Forensic Psychologist (half a day per week), Community Psychiatric Nurse (3 days per week), and an Occupational Therapist (1 day per week). They form a multi-disciplinary team, who review residents each week. Lead responsibility for residents, however, remains with the Community Mental Health Teams who co-ordinate care. Elliott House is a national resource and can take cases from across England and Wales, but most residents tend to be from the wider Midlands area.
- In **Greater Manchester**, the Greater Manchester Mental Health Trust has a longstanding contract to deliver a Mental Health service into St Joseph's AP, which is

primarily a liaison service. The service is only available to residents within the Greater Manchester area, who have a severe and enduring mental health diagnosis, with most referrals made prior to release⁸. The service is commissioned by NHS England via the Greater Manchester NHS Integrated Commissioning Board.

2.3. Project Background

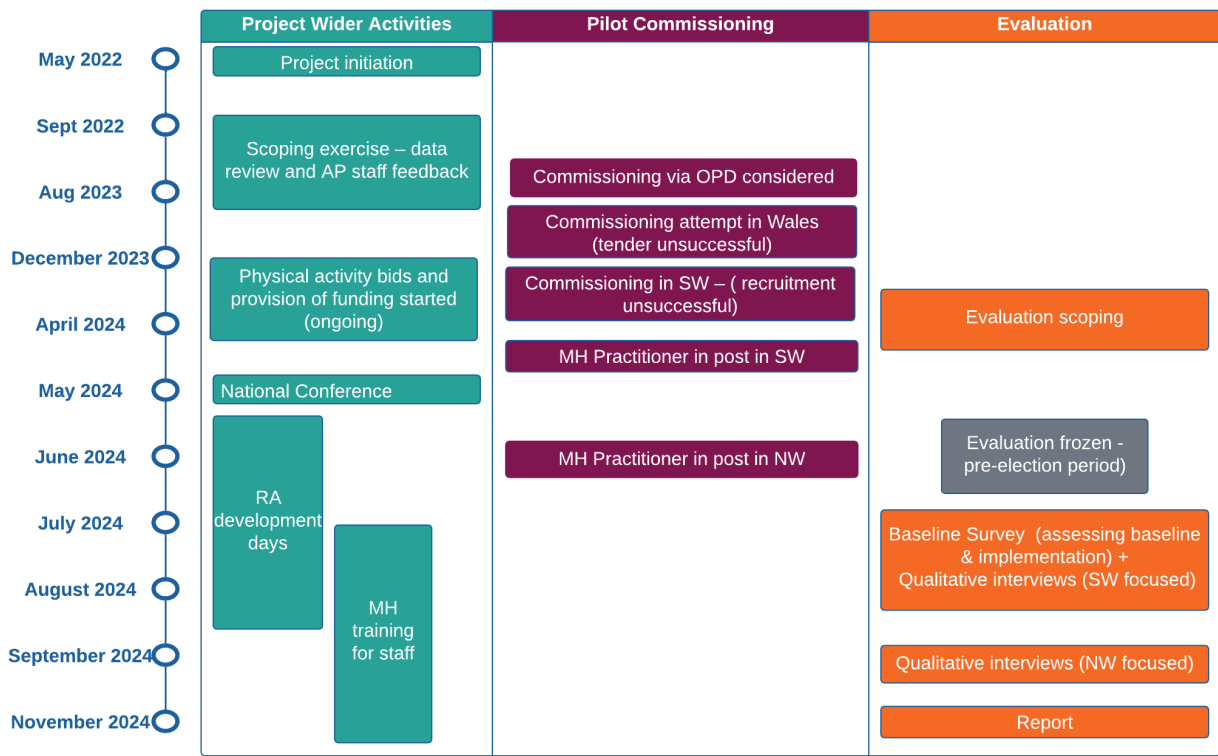
The Approved Premises Mental Health (APMH) project aimed to provide improved mental health support for AP residents. It focused on piloting co-located mental health practitioners, alongside two complementary strands: AP workforce training and funding to improve the physical environment of APs. The project involved several phases of scoping, implementation and research and evaluation activities.

2.3.1. Development and Implementation Timeline

The project was delivered between May 2022 and November 2024, involving scoping, commissioning, and implementation phases. These activities were undertaken alongside research and evaluation. Figure 1 shows the timeline for these phases.

⁸ Following this evaluation, the eligibility criteria was revised to encompass a broader range of mental health and wellbeing needs.

Figure 1: Project Timeline



2.3.1. Scoping Activities

Between September 2022 and August 2023, the project team⁹ completed an initial scoping exercise to inform the development of the project. This involved a review of existing evidence, informed by Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system (2009) and engagement with AP staff and residents. This included specific recommendations related to the need for the better identification of mental health needs of residents in APs as well as the need for mental health awareness training for AP staff.

Review of Existing Evidence Base

This involved a review of the existing models outlined in 2.2., alongside analysis of data provided by the National Applications Reporting Team, which manages and reports on

⁹ The project team consisted of staff within the HMPPS Approved Premise’s Strategy and Operational Support Team, including a Senior Project Lead, Senior Project Manager, Senior Operational Support Manager, Senior Admin Officer, and a Stakeholder and Engagement Manager. The project team also included one staff member within the HMPSS Health and Care Partnerships team.

applications submitted through the National Delius system¹⁰. The analysis was based on a snapshot of data taken on 13th December 2022 of 1,349 AP residents and found:

- Of the total number of AP residents, 342 (25%) had a mental health registration¹¹ and 316 (23%) had a suicide self-harm registration.
- Of the 342 residents with a Mental Health register, 165 (48%) also have a Suicide/Self harm register.
- Nearly half of the AP caseload, amounting to 690 individuals (49%), were registered as having some form of disability. Of this group, 222 (33%) were recorded as having a “learning difficulty”, “learning disability”, “dyslexia”, and “autism”.
- Of the total 1,090 screened for the OPD Pathway, 279 (26%) did not meet the criteria to be screened. Among this group, 35 had a suicide/self-harm register and 36 had a mental health register. Most of these individuals were not the same service users.

AP Staff and Resident Engagement

The project team also consulted with AP staff across 30 APs in all geographical areas, through group and one-to-one consultations. Resident feedback was also gathered through the Engaging People on Probation (EPOP) forums, established in each probation region, and included current resident representatives. Mental health support services were proposed as a discussion topic, and EPOP Managers provided feedback from these forums to the project team.

Feedback from AP staff indicated that managing even a single resident with significantly challenging behaviour linked to mental health could be difficult where there is a lack of support services. Staff highlighted the need for services that support both the resident and staff to understand and manage presenting behaviours. AP staff also reported that the

¹⁰ While National Delius data accuracy has been assured as far as practical, as with any large administrative data source, the likelihood of some errors cannot be eliminated.

¹¹ There are no detailed criteria to govern what deems a service user to need a mental health register. The guidance available indicated this can be used to identify offenders who present any form/degree of mental health issue. This could be used to reflect temporary/permanent/recurring issue. It is intended to assist and to highlight potential health and safety/ risk of harm issues that need to be considered by any member of staff working with the offender.

most concerning cases, and those most likely to be recalled, often involve individuals presenting with complex emotional and behavioural difficulties. Staff perceived, however, that few of these individuals had a formal clinical diagnosis of mental illness.

Implications for design

Using the findings, the project team agreed that the pilot design would not apply strict criteria for eligibility as this would risk residents ‘falling through the cracks’ of provision who could benefit from support. Instead, the pilot would have a key set of principles, with flexibility built in to accommodate a wider range of resident needs¹².

2.3.2. Project Delivery

The overarching aim of the project was to test whether co-locating mental health practitioners within APs could improve outcomes for residents through a pilot. This involved:

1. **Pilot of Co-located Mental Health (MH) Practitioners:** Piloted in six APs by NHS MH Practitioners, commissioned via Liaison & Diversion and RECONNECT teams. The project sought to build on existing models of co-located provision and extend this approach to additional sites. Practitioners provided assessments, brief interventions, and facilitated referrals to wider services. The first MH Practitioner was in post in April 2024.

This was delivered alongside two complementary investments:

2. **National Delivery of AP Workforce Mental Health Training:** Mental Health First Aid (MHFA) England delivered a half-day Adult Mental Health Awareness Course nationally. The training targeted AP staff, including Managers, Probation Service Officers (PSOs), and Residential Workers, aiming to increase confidence and

¹² Research conducted by The [UK Acquired Brain Injury Forum](#) (April 2024) reviewed the unique needs of young adults with acquired brain injury, and the lack of diagnosis and support for this particular cohort.

capability in supporting residents with mental health needs. Training commenced in July 2024.

3. National Funding for Improvements in the Physical Environment of APs:

Funding was made available to AP Managers to enhance the physical environment in ways that support resident wellbeing. Funded projects included redecoration, new furnishings, and the creation of dedicated wellbeing spaces. Funding commenced in 2022.

Rehabilitative Activities (RA) were introduced in July 2024, alongside an online RA Resource Library. Within APs, RAs involved AP staff delivering activities such as cognitive-behavioural therapy, skills development, and other support, to reduce reoffending and support reintegration. The implementation during the project period was connected with AP workforce development, particularly around mental health support, and access to additional MH resources. The research briefly explored this area as part of the “National Delivery of AP Workforce Mental Health Training”.

3. Methodology

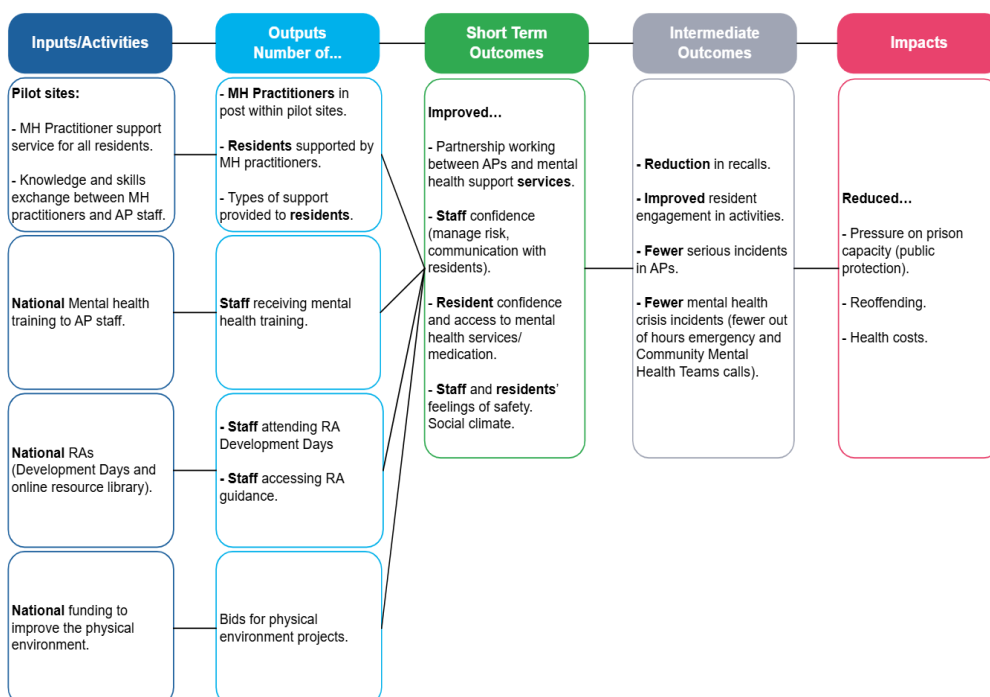
A small-scale process evaluation was conducted to understand the implementation, generate learning for future service delivery, and support policy development. Additionally, complementary research explored how workforce training and physical environment improvements, delivered alongside the pilot, interacted, and enhanced experiences and improved mental health support for residents.

The research and evaluation were conducted independently from the project team by Social Researchers that sit within the Ministry of Justice’s (MoJ’s) Analysis Directorate, referred to as the Analytical Team throughout the report. This chapter outlines the methodology adopted.

3.1. Project Logic Model

A high-level logic model for the project is presented in Figure 2 (see Appendix A for the more detailed theory of change of the pilot sites element of the project). This was used to inform the research presented in this report.

Figure 2: High-Level Project Logic Model



3.2. Evaluation Questions

This research and evaluation were structured at a high-level around five primary research questions, each aligned with one of the three elements of the project (pilot of co-located mental health support, AP workforce training, and investment in the physical environment).

Chapter 4 addresses questions specific to the pilot element which were:

1. To what extent did the pilot align with established good practice principles? Including commissioning processes, support for individuals with complex needs, access to data and training, service integration, and access to GP services (Brooker et al., 2020).
2. Did partnership arrangements function effectively?
3. What learning and best practice emerged from the skills and knowledge exchange model?
4. What early implementation challenges were identified, and how might delivery be improved?

Chapter 5 focuses on AP workforce development (along with RA), and **Chapter 6** explores improvements to the physical environment. **Both chapters** address the following overarching question:

5. How did the different elements of the approach begin to work together to improve experiences of AP environments and mental health support for residents with mental health conditions?

Please note, that the chapters do not explicitly refer to questions. This was due to the exploratory nature of the approach and the complexity across projects and the AP landscape more generally. The themes presented in the chapters are informed by the questions, to ensure that the findings were contributing to the overarching aims.

3.3. Research and Evaluation Design

The research and evaluation used a mixed-method approach. This included qualitative interviews with pilot staff and stakeholders, a national AP staff survey, a review of project documentation, and analysis of project monitoring information. This allowed for triangulation of findings.

Qualitative interviews

As part of the evaluation of the pilot, MoJ Social Researchers conducted 29 semi-structured interviews with individuals from the project team, AP staff, and wider stakeholders from HMPPS and NHS, as outlined in Table 1. Interviews took place during July, September, and early October 2024.

All members of the project team and AP managers were invited to participate. In addition, MH Practitioners, Residential Workers, and Probation Service Officers were initially invited to take part in focus groups to encourage multi-agency discussion. Challenges such as conflicting shift patterns and low uptake, however, limited participation. One-to-one interviews therefore were conducted with staff who had expressed interest in the focus groups.

Additionally, all NHS MH Practitioners were invited to participate in individual interviews alongside key members of the project's strategic board to capture strategic-level insights.

Table 1: Stakeholder Interviews Sample

Stakeholder Group	Number of interviews
Project team	5
AP Managers	5
AP Probation Service Officers/Residential Workers	9
Wider HMPPS stakeholders	3
NHS MH Practitioners and NHS Managers/Commission Leads	7
Total interviews	29

Interviews were designed to explore the implementation of the pilot, partnership working, and knowledge exchange. Participants were asked to describe each element of the pilot

and how these elements interacted. A summary of these interactions is presented in Figure 3 (Chapter 4).

Interviews were conducted both virtually and face-to-face. All interviews were transcribed and analysed using NVivo, a qualitative data analysis software. Thematic coding was applied to identify key patterns and insights across stakeholder groups.

National AP Staff Survey

A national survey was sent to all AP staff across AP sites, reflecting a census approach. This aimed to develop a broader understanding of staff perceptions and provide potential ongoing measure for possible future analysis.

The project logic model informed the survey, and covered questions related to the national delivery of AP workforce mental health training (including RA) and funding for improvements in the physical environment of APs. The survey included staff self-reported mental health knowledge, confidence and awareness and questions related to the physical environment and social climate, including the Essen Climate Evaluation Schema (EssenCES) (Milson et al, 2013) (see appendix B for more information). Analytical colleagues working within the Health and Justice field reviewed the survey, and reliability was assessed using Cronbach Alpha¹³.

The survey was distributed in July 2024, and 513 responses were received (37% response rate), covering 84 APs in total (see appendix C for information on the survey respondent background). Descriptive statistics were conducted alongside multiple linear regression to explore factors influencing AP staff self-reported competency scores and perceptions of the social climate.

Desk Review

The research and evaluation were informed by a review of project documentation, relevant academic and grey literature, and thematic inspection reports. This encompassed academic insights and systemic reviews relating to APs which were used to provide

¹³ A statistical measure used to assess the internal consistency or reliability of a set of survey or test items that are intended to measure the same underlying concept.

context to the research findings and align the research design with existing evidence and practice.

Analysis of Management Information

An analysis of project monitoring data was conducted, which included resident referrals, staff training records, and monitoring information related to bids for physical environment improvements. This data was used to monitor activity and contextualise findings within the broader framework.

3.4. Ethics and Quality Assurance

All research was conducted in accordance with the Government Social Researcher (GSR) ethics guidelines. The research was assessed by the MoJ's internal ethics advisory board who reviewed plans. As a result, all interview participants were provided with an information sheet outlining the purpose of the research, and written consent was obtained prior to participation. Interviews took place in a private space between interviewee and interviewer to ensure confidentiality.

All data was handled with adherence to General Data Protection Regulation (GDPR) and Data Protection Act 2018. A Data Protection Impact Assessment (DPIA) was undertaken during the scoping phase of the research and evaluation and reviewed by the MoJ Data Protection team, with no issues identified.

Quality assurance was embedded from the start, with adherence to the MoJ's Analysis Directorate's Analytical Quality Assurance (AQA) processes to ensure quality in research design, analysis, and reporting.

3.5. Limitations

The findings presented in this report do not provide evidence on the impact of APs, their performance, or specific interventions. The research and evaluation focused on **early implementation** and activity over the period, from a sample of stakeholders. As such, the findings were intended to provide process-related insights to inform future delivery and policy development.

Other limitations included:

Evaluation Timeframe

- **Early Implementation:** The pilot evaluation was conducted during the early stages of implementation. As such, findings reflect initial activity and emerging views rather than longer-term perspectives. Further evaluation would be required to assess delivery, impact, and sustainability more fully.

Participant Engagement

- **Resident engagement:** AP residents were not engaged as part of the research and evaluation. It was designed to understand the implementation of the pilot from the perspective of the staff working in pilot APs. Additional ethical considerations would have applied in relation to interviewing residents, particularly given their potentially vulnerable status. Engaging directly with individuals in such settings requires careful planning, ethical approval, and safeguarding measures to ensure their wellbeing, informed consent, and researcher/participant safety. Due to the tight project timelines, a decision was made not to proceed with resident interviews.
- **Staff participation in interviews:** Engagement with staff was lower than anticipated, particularly in response to focus group invitations. As a result, the qualitative sample was more limited than originally planned. This may have led to missed perspectives or reduced diversity across staff roles and settings.

Data and Analysis

- **Quantitative analysis:** The multiple regression models used in the analysis of the staff survey may have been influenced by factors not included in the models¹⁴. These could have affected the competency and social climate scores. While survey questions examining staff confidence were reviewed by analytical colleagues and demonstrated acceptable internal consistency (via Cronbach's alpha), further cognitive testing, such as pre-testing with a small sample or conducting interviews to check understanding, would be

¹⁴ For example, the independent variable may have correlated with one or more confounding variables, which could be driving the effects on the dependent variable.

required to fully validate. Cognitive testing of the survey was stopped due to research and evaluation pause during the 2024 pre-election period, and the survey was distributed without delay to ensure timely data capture.

- **Monitoring data:** For the pilot, data monitoring processes were not established prior to implementation. As a result, referral and support data were limited in quality as the data was collected retrospectively. This reflected broader challenges with data quality, including gaps in the sequence of mental health information, and highlighted a need for improved inter-agency data capture and integration.

4. Findings

4.1. Pilot of Co-located Mental Health Support

This chapter outlines evaluation findings related to the pilot of co-located mental health support within the six AP sites. It begins by outlining the commissioning process and then provides an overview of the pilot model (4.1.1. and 4.1.2.). This is followed by analysis of monitoring data on resident referrals to review implementation (4.1.3.).

The chapter then explores qualitative insights into the pilot's implementation, including potential mechanisms of change, and outcomes (4.1.4. and 4.1.5.). Finally, it outlines key challenges experienced from the perspective of staff via qualitative interviews (4.1.6.).

4.1.1 Commissioning and Design

The pilot was funded by HMPPS project funding allocated to NHS England (NHSE) via a Memoriam of Understanding. NHSE commissioned local Liaison and Diversion (L&D) and RECONNECT teams to deliver the pilot across the selected APs. L&D services then identified people with mental health, learning disability, substance misuse, or other vulnerabilities at their first point of contact with the criminal justice system as suspects, defendants, or offenders.

Commissioning the pilot via the OPD Pathway was considered, and a draft service specification was written. Concerns raised during the scoping phase, however, suggested that the OPD criteria might exclude some residents, potentially leading to gaps in provision. As a result, the decision was made to commission through L&D and RECONNECT teams to ensure the pilot was available to all residents, regardless of clinical thresholds for a personality disorder or other MH diagnoses.

Following commissioning, the pilot was implemented across six APs: three in the South West probation region (Avon and Somerset) and three in the North West region (West Yorkshire). In the South West, three NHS MH Practitioners were in post from April 2024. Practitioners supported APs, who were employed within the existing L&D services. They

each attended an AP one day a week and then returned to work in L&D services on the other working days. In the North West, one MH Practitioner was in post from July 2024. The MH Practitioner was seconded from the local RECONNECT service, and they attended each AP site one day a week, with the other 2 days dedicated to admin work related to the pilot.

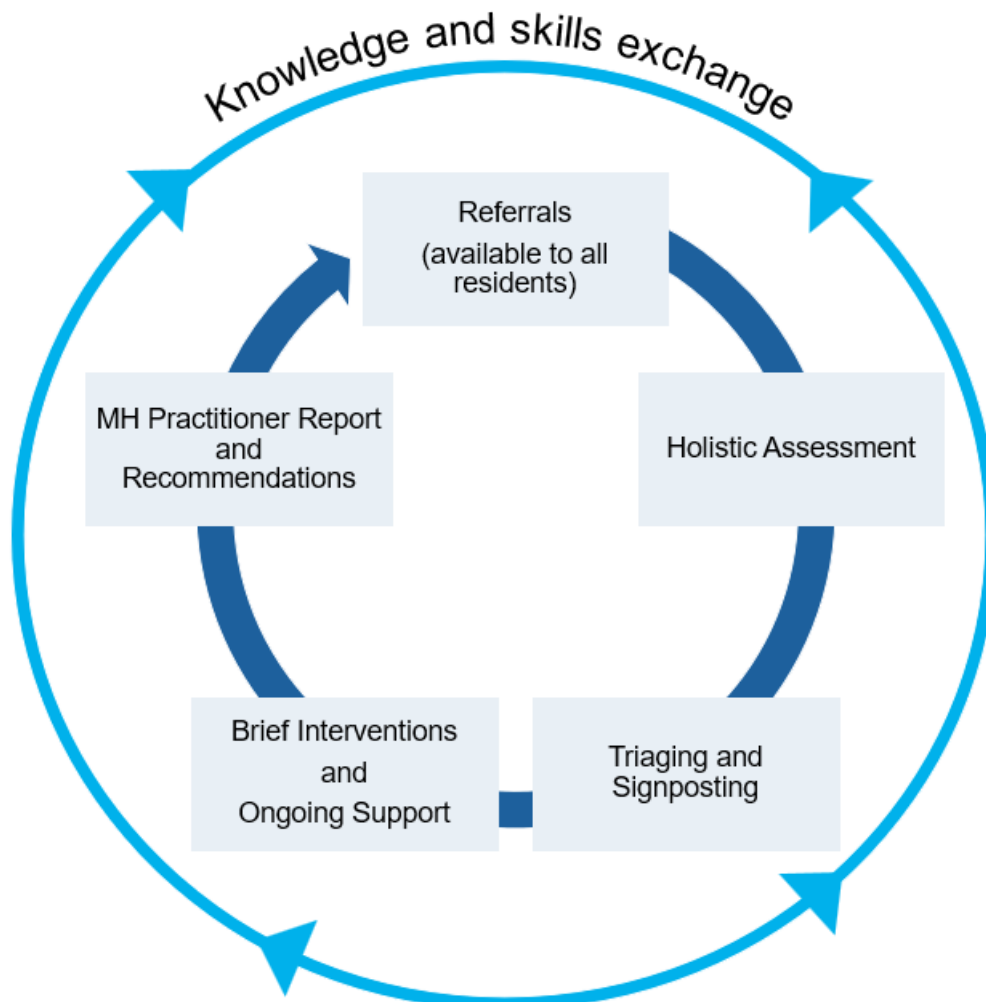
As part of the designing the pilot, staff and MH Practitioners stated that the amount of time co-located mental health support was required would vary across AP sites. In some sites, one day a week would work well, however, this could change to every two weeks depending on the AP. Two factors perceived to influence this were AP bed size where the larger the AP, the higher the demand; and resident background, where there was a perception that higher levels of drug and alcohol dependency amongst residents correlated with higher levels of mental health needs. The time of day was also noted as an important consideration, with two MH Practitioners reporting that demand from residents increased in the afternoon.

Qualitative interviews with AP staff across both pilot sites highlighted perceived overlap and lack of clarity regarding different services. This suggested a need for clearer communication on the different pathways of support available to AP residents. The project team identified this issue during delivery. To address it, both OPD Pathway and RECONNECT stakeholders were invited to the Project's Strategic Board to engage in ongoing service design. Additionally, development days were established with staff across the pilot sites to continuously review issues and clarify roles and responsibilities.

4.1.2 Pilot Model

Interviews with staff covered a description of the pilot model that had been implemented across sites. The descriptions were grouped into six key elements. Figure 3 provides an outline of each element and how they interreacted, with a more detailed description presented below.

Figure 3: Pilot Model of Co-Located MH Support



Referrals: A key feature of the pilot model was that it was a voluntary service, with appointments available to all residents, without the need to meet the clinical thresholds, a clinical assessment for a personality disorder or other mental health diagnosis. Probation Support Officers (PSOs), Residential Workers (RWs), or residents themselves could make referrals. MH Practitioners provided both planned and ad hoc appointments. In some AP pilot sites, however, referrals were only made by PSOs with limited input from RWs.

Holistic assessment: MH Practitioners completed assessments with residents to determine what support was needed. Although the primary focus was mental health, MH Practitioners also addressed wider determinants of health, such as drug and alcohol issues and housing, tailored to individual residents.

Triaging and signposting: The pilot model was distinctly not a clinical service, with the rationale that clinical interventions should be delivered by existing community services. A key feature was that MH Practitioners brokered community referrals either directly or via RECONNECT, based on the outcomes of a resident’s assessment.

Brief interventions and ongoing support: Although MH Practitioners did not “case-hold”, they provided brief interventions on the day if required. The approach aimed to empower residents to take action for themselves. To note, the provision of brief interventions and ongoing support with residents was implemented differently across the AP pilot sites, with different degrees of ongoing appointments provided by MH Practitioners to residents. These variations are explored in the next section of the report.

MH Practitioner report and recommendations: Where possible, MH Practitioners provided key workers with a report as well as recommendations around how key workers could support residents going forward. These included guidance on supporting residents to use self-help booklets around managing anxiety or managing emotions, as well as signposting to various organisations. This also promoted skills and knowledge exchange between probation and health professionals.

Knowledge and skills exchange: A key (and broader) aspect of the pilot was to assess the concept of ‘skills and knowledge exchange’. MH Practitioners contributed to existing staff training, sharing knowledge and information to empower staff, build resilience, increase staff confidence, and develop best practice. Mechanisms of knowledge and skills exchange were via informal conversations with AP staff, structured recommendations, and shared training.

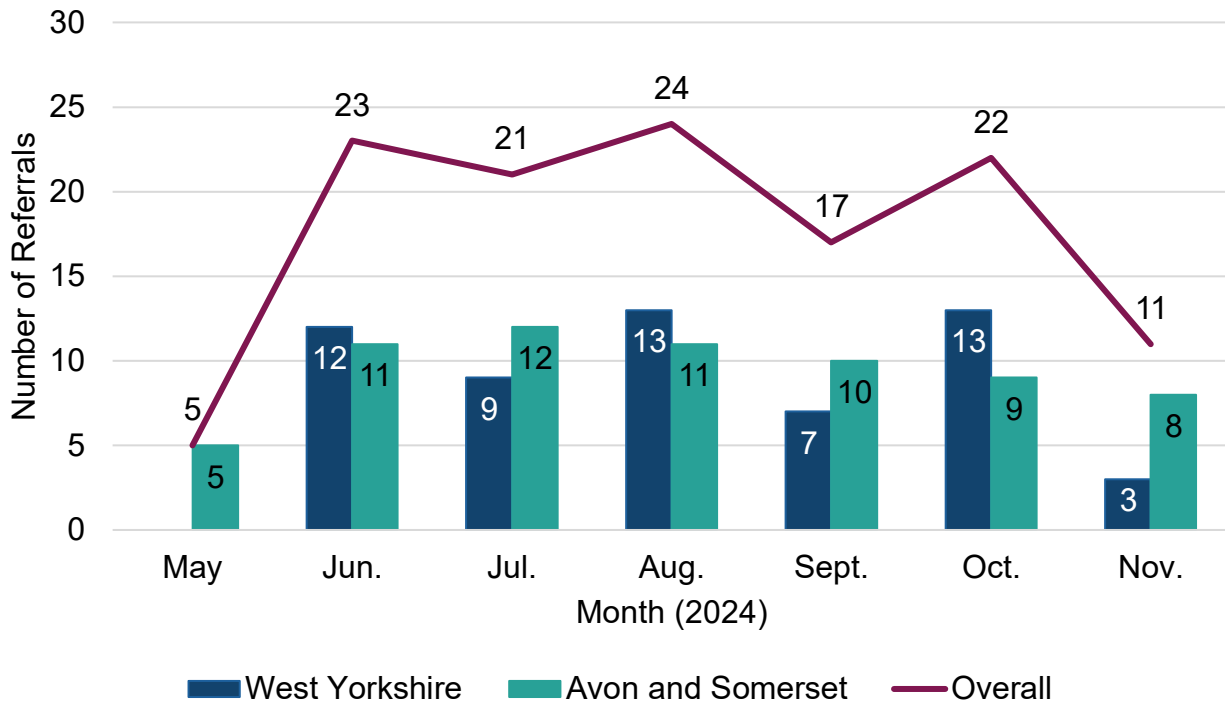
4.1.3 Referrals, Attendance and Ongoing Referrals

To understand pilot activity in terms of the number of referrals, attendance, and referrals to other organisations for further support from pilot sites, monitoring data were analysed. This data was supplemented with qualitative insights from MH Practitioners and other stakeholder interviews to provide context and fill data gaps.

Referrals

Figure 4 outlines the total number of referrals across both pilot areas.

Figure 4: Number of Referrals per Month



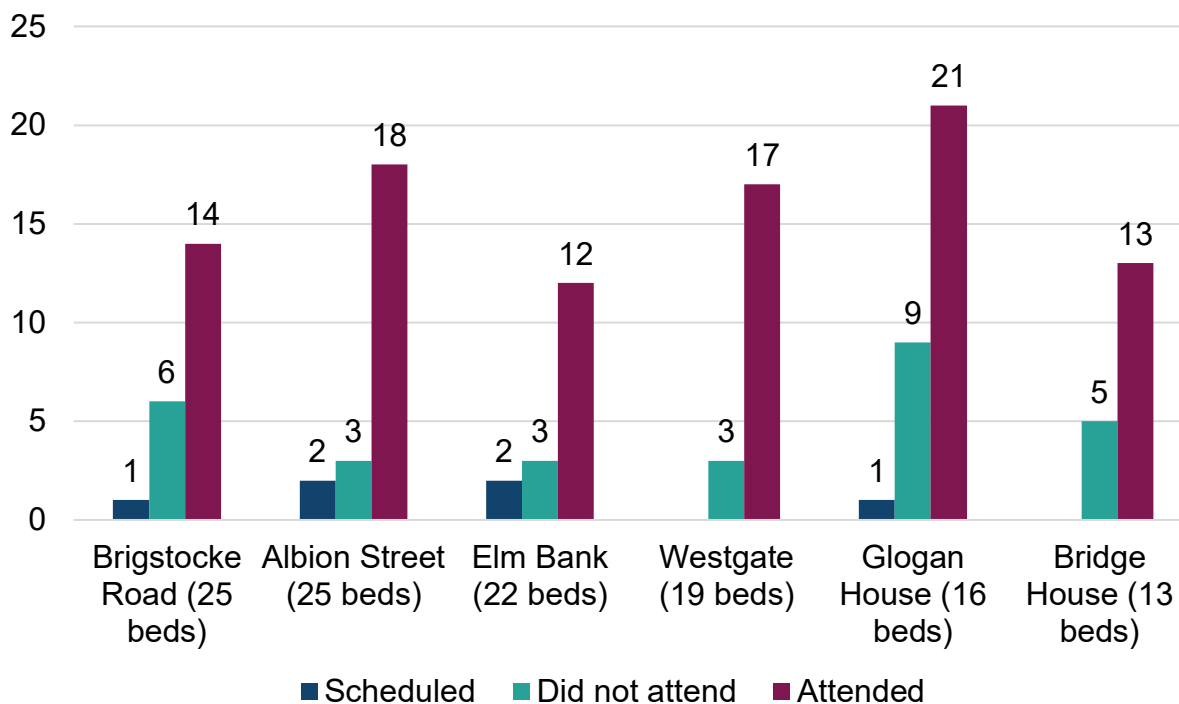
In total, there were 130 referrals for appointments made between 6th May 2024 to 11th November 2024. Overall, referrals remained at around 20 per month from June onwards, with a decline in September to 17, driven by a drop in West Yorkshire.

It should be noted that in West Yorkshire, the MH Practitioner was in post from June 2024, a month after referrals began in the Avon and Somerset pilot sites, therefore data is available from June onwards. Further, there were seven referrals where the date was unknown, with six of these from Bridge House. This may explain the low number of referrals recorded in May, as there were no May records for this AP despite the MH Practitioner being in post. Additionally, data for November was incomplete as the reporting started from 11th November.

Attendance

Figure 5 presents the number of appointment attendances across the six AP pilot sites¹⁵.

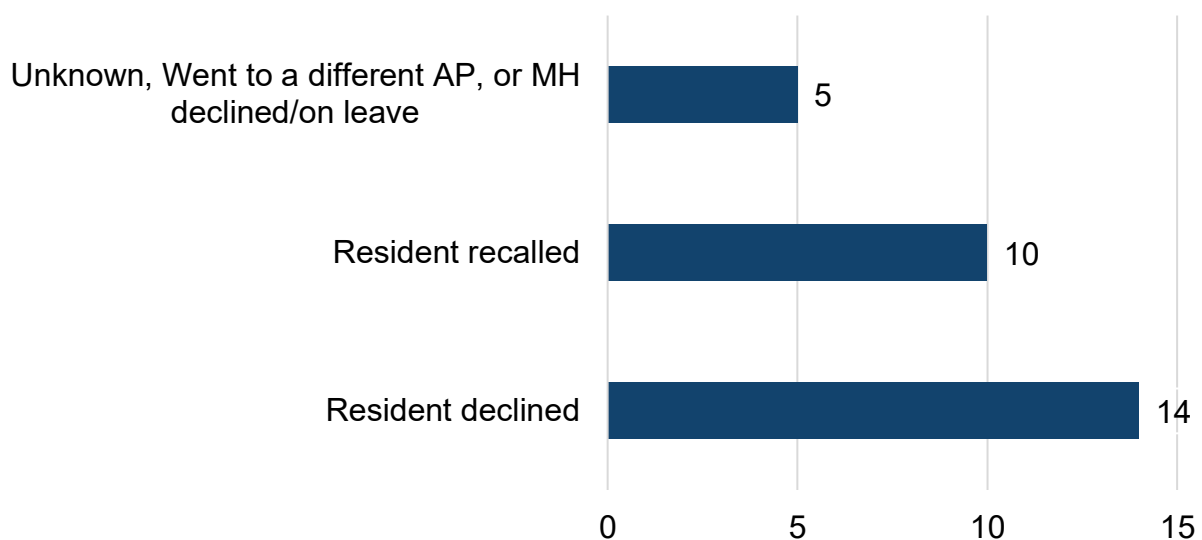
¹⁵ Brigstocke Road, Bridge House, and Glogan House sit within the Avon and Somerset area. Albion Steet, Elm Bank and Westgate sit within West Yorkshire.

Figure 5: Attendance at appointments

Across all sites, 73% (95) of residents attended appointments, with 22% not attending (29). A further 5% of scheduled appointments had not taken place at the time of analysis.

Analysis of the number of bedspaces in an AP with the number of referrals indicated a very weak correlation. This was largely influenced by Glogan House which had the highest rate of referrals despite a relatively low bed size (16 beds). There was also a notable difference between the two pilot areas, with Avon and Somerset pilot sites experiencing, on average, about double the number of referrals for appointments that residents failed to attend compared with West Yorkshire.

Figure 6 presents a summary of reasons for non-attendance.

Figure 6: Reasons for Non-Attendance (n=29)

Of the 29 non-attendances, just under half (n=14) of residents declined the appointment, whereas around a third (n=10) were recalled to prison prior to the appointment taking place.

Ongoing Support

MH Practitioners recorded ongoing referrals made during the pilot, providing an indication of the level of continued support required by residents. **Table 2** presents an analysis of cases where ongoing referrals were made, noting only the primary referral in instances where multiple referrals were made.

Table 2: Ongoing referrals

Ongoing Referral Organisation	Number Of Referrals
Community Mental Health Team (CMHTs)	14
GP - Medication	8
GP - Talking Therapies	6
GP - ADHD	5
Crisis Team	3
CGL (Change, Grow, Live)	3
GP (unknown)	2
RECONNECT	2
Turning Point	1

Ongoing Referral Organisation	Number Of Referrals
PREVENT	1
Forward Leeds	1
Drug and Alcohol Service	1
MIND Somerset	1
MH Enhanced Team	1

There were eighteen referrals made to Community Mental Health Teams (CMHTs), the Crisis Team, or MH Enhanced Team. This suggested that approximately 19% of residents who attended their first appointment may have required access to secondary mental health care. In addition, there was evidence that MH Practitioners were also supporting residents in accessing GP services, particularly for accessing or reviewing medication, Talking Therapies, and ADHD support. MH Practitioners have also provided links to social prescribing pathways and wider rehabilitative support.

Efforts were made to capture the number of follow-up appointments offered to residents, specifically through follow-up appointments. Twenty-six residents were recorded as having been offered some form of continued support, ranging between 1-3 sessions, to weekly or fortnightly appointments. However, the duration of these sessions remained unclear.

The majority of ongoing support was provided in APs in West Yorkshire, while limited ongoing support provided to residents in Avon and Somerset. One AP in Avon and Somerset did not record any ongoing appointments. Across both pilot areas, brief interventions were provided, including Cognitive Behavioural Therapy booklets focused on managing anxiety, emotions, depression, and post-traumatic stress disorder.

The MH practitioner in West Yorkshire also attended GP visits with residents and provided out-of-area support despite the resident moving into non-AP accommodation. Monitoring data also indicated MH Practitioners provided advice and guidance to PSOs to take

forward in key work sessions with residents. This included support with understanding risk factors and processing ADHD referral paperwork.

4.1.4 Perceptions on Early Implementation

Qualitative interviews highlighted some early implementation challenges within pilot areas. These mainly related to the communication of the service specification proposal and its status as a non-clinical service, despite providing brief interventions and some follow-up support. For example, there were instances of:

- At one pilot site, AP staff believed residents would be provided with secondary level care and more intensive ongoing support, rather than primarily a liaison service.
- Lack of clarity and inconsistency regarding the level of ongoing support provided to residents amongst AP staff and MH Practitioners. This led to further work by the project lead to ensure briefings for MH practitioner as per the service level agreement.

Additional implementation challenges included difficulties in coordinating meetings across AP sites in both pilot areas. These were attributed to competing workloads, differing priorities, and shift patterns, which hindered effective multi-site collaboration. Further, monitoring procedures for capturing project activities and outputs had not been established prior to implementation, making early data collection challenging.

Despite these challenges, several positive aspects of early implementation were identified which included:

- MH Practitioners described becoming increasingly embedded within APs and felt welcomed and valued in their role, supporting collaborative working to meet resident needs. MH Practitioner attendance at AP staff meetings was identified as a successful mechanism in building these relationships.
- The collaborative development of the referral form between AP managers, PSOs and MH Practitioners was highlighted as a successful element in the implementation of the pilot. This promoted a sense of shared responsibility and ownership and was a way to promote knowledge exchange between MH practitioners and AP staff, particularly around differing approaches to risk between health and probation professionals.

- The project teams' commitment to the ongoing development of the pilot and sharing best practice across agencies. This was through the delivery of pilot 'development days', which were used to address the early implementation challenges.

4.1.5 Mechanisms of Change

The process evaluation aimed to understand how the pilot may have created mechanisms required to achieve the intended outcomes outlined in the logic model.

Interviews with AP and NHS staff indicated **improved collaboration and partnership working** as a result of the pilot. For example, NHS training was made available to AP staff on topics such as self-harm and neurodiversity. The pilot also supported a more "systems-based" approach to mental health support for AP residents', particularly through alignment with L&D and RECONNECT services that may support clearer pathways of care. MH Practitioners in both pilot areas also reported benefits in the communication between APs and NHS prison mental health teams which could be challenging, particularly around information sharing. This was because MH Practitioners were members of the NHS and therefore better positioned to broker information sharing **with prison mental health teams**.

The pilot also aimed to assess the concept of '**knowledge & skills exchange**' through co-location of staff and services. This approach was intended to improve staff knowledge and skills, as well as understanding of each other's roles. There were examples of successful knowledge sharing, including increased understanding of medication, deprivation of liberty and risk from a health perspective. Other examples included crisis planning, information sharing (clinical records), and local services.

"[the pilot] is giving us a better insight into how triaging works and priority lists and stuff like that. And it's also teaching me ...she sends links of stuff and documents and stuff, um, that I can then use for another resident later down the line. So, yeah, it's just expanded our knowledge really." **Probation Support Officer, interview**

Despite these examples, interviewees across both pilot areas stated knowledge exchange had been limited to date, largely due to early implementation challenges. A key enabler was the existing mental health knowledge and experience of AP staff, which varied across

sites. This implied a need for greater consistency in mental health knowledge and confidence among AP staff in APs nationally.

There was some indication via interviews with AP staff in two sites, that **staff confidence** could be improving due to the pilot. This was particularly evident in having a point of contact available, and greater reassurance in their practice.

“It [MH Practitioners in the AP] helps you. I think the more understanding you have of a person, the better you can work with them. They're also not going to tell you that's a trigger...And you know, all these things that unless you get told you're not going to know, you can't just guess it...I think having as much information as possible is vital to be able to rehabilitate them and help them as much as you can.”

AP Residential Worker, Interview

As the pilot had not been running long enough to fully capture outcomes related to staff confidence at the time of the evaluation, it remains unclear how this may have impacted practice in supporting residents.

4.1.6 Perceived Short-Term Outcomes

While this process evaluation did not measure the impact of the pilot, it explored perceptions of short-term outcomes through interviews with staff and practitioners. This aimed to provide early insights and indicators of potential outcomes for staff and residents.

AP Managers in two pilot sites perceived that, as a result of the pilot, residents had been able to access MH primary care services more quickly. In particular, direct referrals into community mental health services had meant bypassing the need for GP services.

In addition, MH Practitioners across both pilot areas believed that the provision of co-located support improved residents' confidence. MH Practitioners and AP staff within two APs described how residents could sometimes be more open with health staff, as opposed to probation staff who hold more of an “authoritative role.” AP staff across three pilot sites also described how the presence of MH practitioners provided residents with a “sense of being heard” and reassurance that support was available. MH practitioners specifically referenced positive feedback from residents, including examples of support helping

individuals manage anxiety. This, however, was based on the perceptions of staff and practitioners, not the residents themselves.

There was also an instance of an AP Manager describing a decision **not to recall a resident** due to the support available from the MH Practitioner. This was because of improved confidence in their ability to manage the individual within the community.

“And trying to prevent the main thing is just trying to prevent sort of unnecessary recalls. I think that is the main thing because I'm seeing that a lot and it's nice to be able to be part of the process to be able to guide them and help them and see if the people can be managed in the community as opposed to, you know, being recalled back to prison.” **Mental Health Practitioner, Interview**

Despite these positive indications, some AP staff and managers across pilot areas reported that they had **not experienced short-term outcomes**. This may be expected as the evaluation took place at an early stage of the pilot.

4.1.7 Challenges

Interviews with AP and NHS staff indicated that there were various challenges in implementing the pilot. These were in relation to commissioning processes, gaps in wider mental health provision, AP workforce, and resident engagement and locations.

Commissioning

Commissioning of the pilot service presented several challenges, including an unsuccessful attempt to commission the pilot in Wales in 2023 where no providers submitted bids. The short duration of the contract (12 months) was viewed as unviable for potential providers. Similarly, in the South West, the initial MH Practitioner recruitment exercise failed to attract a suitable candidate, linked again to the limited length of the appointment.

Gaps in Mental Health Provision

A key assumption underpinning the commissioning of MH liaison support within APs was that adequate community-based mental health services were available. A joint thematic report (Criminal Justice Joint Inspection, 2021), however, highlighted gaps in community

MH provision, noting ‘in one area, we were told there was a 24-month wait for a community mental health team appointment’. The NHS Health and Justice Mental Health Pathway (Future NHS, 2024) also identified a gap in MH treatment requirements for those released into the community.

The broader mental health commissioning landscape had variation in local approaches, and this fragmentation has been noted to impact both the efficiency of service delivery and the continuity of care by (Fuller, 2020). Alongside this, the wider labour market and rate of growth in the mental health workforce generally has been insufficient to meet increasing demand and planned expansion of services (Gilbert & Mallorie, 2024).

AP Staff Shift Patterns and Turnover

Both AP staff and MH practitioners described challenges related to AP staff shift patterns. Many AP staff were not working on the day in which a MH Practitioner is on site, limiting opportunities for interaction and knowledge exchange. High staff turnover in some APs further complicated relationship-building and hindered the retention of shared learning.

Resident Engagement

While AP staff and MH Practitioners believed that many residents could benefit from mental health support, referral data showed that some residents declined to engage. Staff perceived this to be a result of the perceived stigma of mental illness, and some distrust of professionals, both of which are potential barriers to residents engaging with support.

The short duration of AP placements (3 months) and a relatively high turnover of residents also made it difficult to predict referral volumes and sustain engagement.

Resident Location

Many residents were placed in APs outside their home area. This created barriers to accessing local services and reduced motivation to engage with support, as they and professionals were aware that they would not remain in the area. These concerns echoed findings from previous inspections (HM Inspectorate of Probation, 2017).

Linked to challenges in the caps in mental health provision, there were also concerns reported about the ability of local community mental health services to meet the needs of

residents. This was particularly for the those placed in an AP that was not in the area that they intend to resettle in after their time in the AP.

MH Practitioners also reported challenges in coordinating information amongst community mental health teams for out-of-area residents, presenting additional barriers for ongoing support.

“So, the AP is out of area for them in terms of their mental health information. It's not travelled with them.” **MH Practitioner, Interview**

4.2. AP Workforce Development

This chapter outlines findings related to mental health training offered nationally to AP staff. It summarises findings from a national survey sent to all AP staff that covered self-reported knowledge, confidence, and awareness in relation to the provision of mental health support. Findings from a multiple regression analysis are also presented to explore factors that may have influenced AP staff self-reported competency.

The chapter also presents high-level findings on the introduction of Rehabilitative Activities (RA) from staff nationally via the survey and interviews with a sample of AP staff in pilot areas.

4.2.1 Mental Health Training

Training Offer and Attendance

Dedicated funding was provided to deliver mental health training for AP staff, including AP Managers, PSOs, and residential workers. The training offered was the Adult Mental Health Awareness Course, a half day course delivered by Mental Health First Aid (MHFA) England¹⁶. Between July and September 2024, eighteen half-day sessions were delivered, with additional sessions scheduled for October and November, for groups of up to twelve staff.

Training records indicated that, of the total 216 training places accepted by staff between July and September 2024, 77 AP staff withdrew in advance or failed to attend on the day. Two of these individuals did then go on to attend the training on a different day in that period. This represented a high non-attendance rate of 34%. Where advance notice was given, the reasons provided were around shift patterns and the need to cover colleagues away on the day. A sizeable number, however, failed to provide a reason and did not turn up on the day. This was raised by the project team with senior leaders who were looking at ways to address this issue at the regional level.

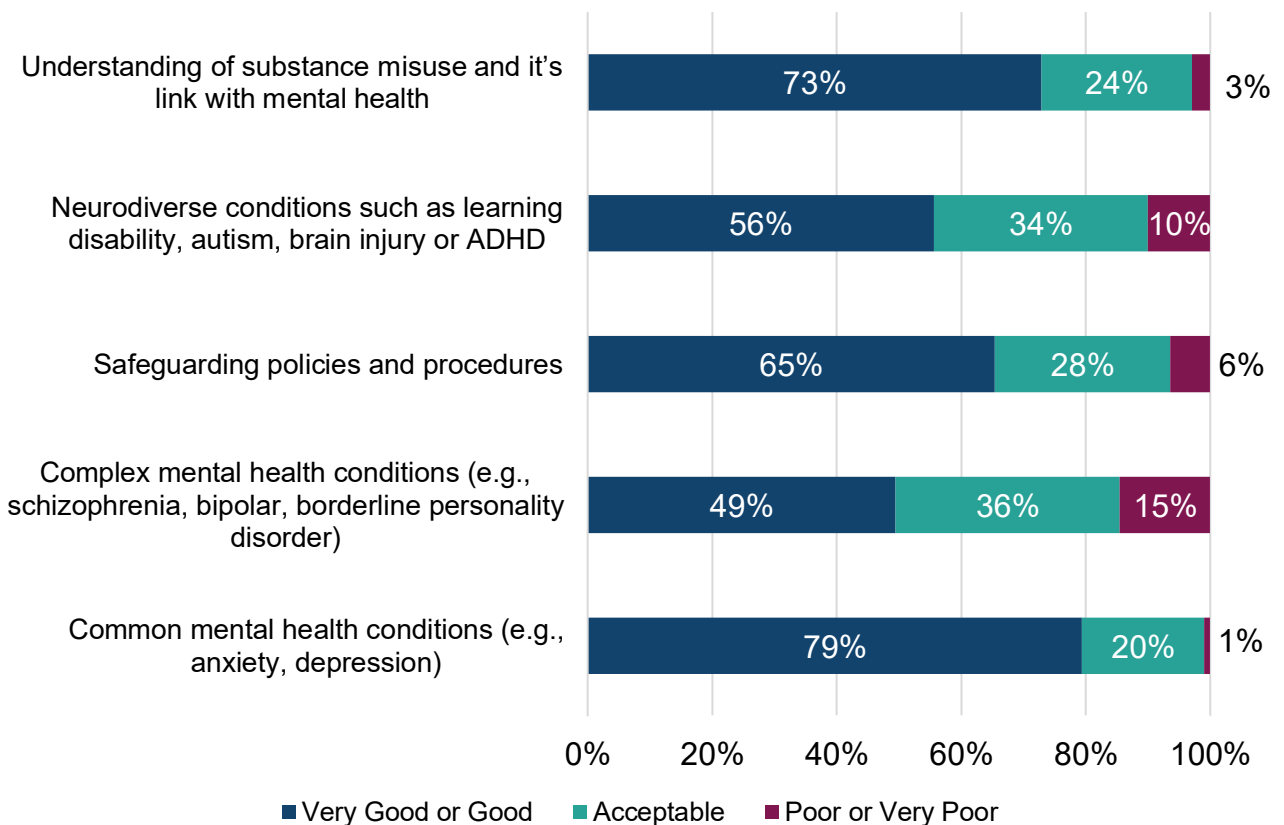
¹⁶ Prior to selecting this course, the project team trialled two other training courses with involvement from AP staff. The selected course was found to be interactive and well facilitated.

It is important to note that high attrition rates are common across other training programmes offered to AP staff, suggesting systemic changes may be required to improve attendance and engagement with professional development opportunities.

Staff Self-Reported Competency

The national survey of AP staff included five items related to **knowledge** around mental health as shown in **Figure 7**. Responses marked as ‘don’t know’ or ‘prefer not to say’ were excluded from the analysis, accounting for less than 1% of responses across items.

Figure 7: Staff Self-Reported Mental Health Knowledge



Across all **knowledge** indicators, between 49% - 79% of respondents rated their knowledge as either ‘very good’ or ‘good’.

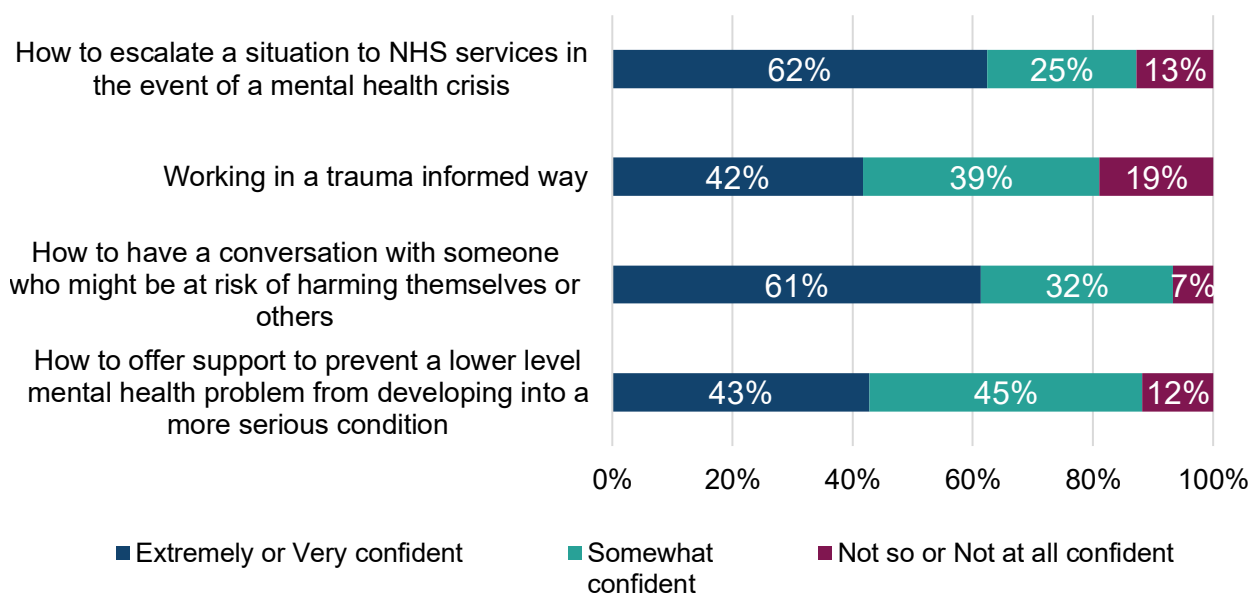
Table 3 presents the mean of staff self-reported mental health knowledge scores in ascending order.

Table 3: Staff Self-Reported Mental Health Knowledge (Mean Scores)

Indicators	Mean Score
Complex mental health conditions (e.g., schizophrenia, bipolar, borderline personality disorder)	3.41
Neurodiverse conditions such as learning disability, autism, brain injury, or ADHD	3.56
Safeguarding policies and procedures	3.73
Understanding of substance misuse and its link with mental health	3.92
Common mental health conditions (e.g., anxiety, depression)	4.06

Across the knowledge indicators, respondents demonstrated the highest average score in ‘common mental health conditions’ (mean score: 4.06; $n = 467$), while the lowest was observed in ‘complex mental health conditions’ (mean score: 3.41; $n = 467$).

Figure 8 presents a breakdown of staff self-reported **confidence** levels across four indicators. Responses indicating ‘don’t know’ or ‘prefer not to say’ have been excluded, which accounted for less than 1% of responses across the items.

Figure 8: Staff Self-Reported Confidence

Across all **confidence** indicators, between 42% and 62% of respondents reported feeling either ‘extremely’ or ‘very’ confident in supporting residents that are experiencing mental health issues.

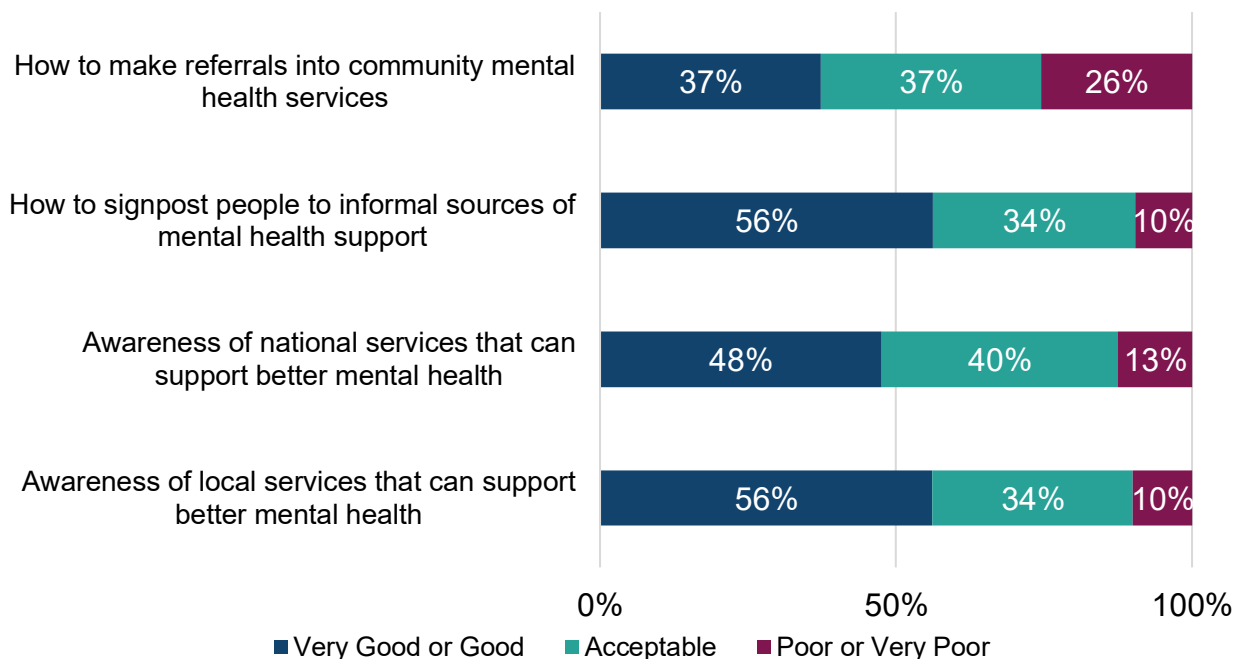
Table 4 presents the mean of staff self-reported mental health **confidence** scores in ascending order.

Table 4: Staff self-reported confidence (mean scores)

Indicators	Mean score
Working in a trauma informed way	3.27
How to offer support to prevent a lower-level mental health problem from developing into a more serious condition	3.38
How to escalate a situation to NHS services in the event of a mental health crisis	3.67
How to have a conversation with someone who might be at risk of harming themselves or others	3.69

Analysis of the average scores across the confidence indicators demonstrated that respondents felt most confident in ‘How to have a conversation with someone who might be at risk of harming themselves and others’ (mean score 3.69, n = 467). The lowest confidence was reported in ‘Working in a trauma informed way’ (mean score 3.27, n = 467). A comparison between overall knowledge and confidence scores indicated that confidence scores were significantly lower ($p < 0.001$) suggesting a greater gap in respondents’ confidence in supporting residents than there is in mental health knowledge generally.

Figure 9 presents the distribution of staff self-reported **awareness** levels across four indicators. Responses indicating ‘don’t know’ or ‘prefer not to say’ have been excluded, which accounted for less than 1% of responses across the items.

Figure 9: Staff Self-Reported Awareness of Services

Of the survey items assessing respondents' **awareness** of national and local services, and staff ability to signpost and refer individuals into community mental health services, between 37% and 56% of respondents reported that their awareness was either 'very good' or 'good'.

Table 5 presents the mean of staff self-reported **awareness** of mental health service scores in ascending order.

Table 5: Staff Self-Reported Awareness of Services (Mean Scores)

Indicators	Mean score
How to make referrals into community mental health services	3.16
Awareness of national services that can support better mental health	3.45
Awareness of local services that can support better mental health	3.59
How to signpost people to informal sources of mental health support	3.60

The average scores across the awareness indicators were similar, with one exception. Respondents reported significantly lower awareness in relation to 'how to make referrals into community health services,' ($p < 0.001$).

Factors Associated with Self- Reported Competency

A multiple regression analysis was conducted to explore factors that may influence AP staff self-reported knowledge, confidence, and awareness scores. The internal consistency of responses across the 13 survey items was high, with a Cronbach Alpha¹⁷ of 0.91, indicating strong reliability. Based on this, an overall mean score was created for the multiple regression, which is referred to as the 'competency score.' The model included key job role factors (Job Title, Length of Service, Work Pattern) as well as AP-specific factors (AP resident sex, PIPE, and AP bed space). See Appendix D for more information on the regression analysis and results.

The number of bed spaces in an AP was the most significant factor associated with the self-reported competency score. Specifically, for every additional bed space, staff members reported a 0.012 decrease in the self-reported competency score, suggesting that larger APs have poorer scores. AP staff working in Psychologically Informed Planned Environments (PIPEs) had a higher self-reported competency score compared with those not working in PIPEs. Job Title also appeared to influence scores, with managers scoring more highly than residential workers; though, there was no significant difference observed between managers and PSOs.

AP staff length of service, which averaged 5.5 years (ranging from less than one month to nearly 33 years), and work pattern (full or part time) were not found to be significant factors. Similarly, alongside AP resident sex and Enhanced Environments (EE) Award status did not show a significant association with competency scores.

While other factors may have influence the competency score, the analysis has highlighted some promising results in the potential for PIPEs to promote greater AP staff self-reported competency. These findings suggest the training staff in PIPEs receive could be shared and built upon when considering enhancing mental health support to residents.

¹⁷ A test for the consistency of respondents' answers across multiple survey items

4.2.2 Rehabilitative Activities (RA)

Background

In 2024, additional funding was provided to support the policy change from 'Purposeful Activity' to 'Rehabilitative Activity' (RA), a key performance measure for Approved Premises (APs). In this context, HMPPS defines rehabilitation as a structured set of actions, interventions, and support mechanisms within APs to assist individuals in addressing the underlying causes of offending behaviour. These actions, which residents engage in with AP staff, can include cognitive-behavioural therapy, skills development, substance misuse support, psychological support, meaningful conversations, and the cultivation of prosocial attitudes and behaviours. All these are to occur within a controlled, supportive, and supervised environment with the primary aim to promote personal change, reduce the risk of reoffending, and support successful reintegration into society. A more detailed description of RAs can be found in annex D.

To support residents' mental health, a range of worksheets were available to staff to support them in one-to-one or group work sessions with residents. Grounded in cognitive behavioural therapy techniques, these resources included topics such as countering negative thoughts, building happiness, challenging anxious thoughts, and coping with anxiety. This formed part of a wider initiative aimed at improving the mental health support available to residents.

RAs were officially launched in July 2024 alongside the online RA Resource Library (accessible via SharePoint) developed by the project team. Given the timing and connection to workforce mental health training and development involved in the policy change, the research used this opportunity to gain an improved understanding of RA implementation, including the delivery of RA development days and staff confidence in delivering RAs. Roll-out, however, was still underway at the time of the research therefore the findings are unlikely to represent the full picture of early implementation.

RA Development Days

To support the introduction of RAs, the project team delivered a programme of RA development days, attended by a total of 503 AP staff over nineteen regional events. The

development days covered RAs broadly, not just mental health and aimed to build staff understanding and confidence in delivering and recording RAs.

As part of this research, the analytical team explored staff experiences of the policy area through qualitative interviews with AP staff at the pilot sites only. As this was a sample of perspectives, some views will be missed. Therefore, further research would be required to understand the change in more detail.

Interview Findings

In interviews, AP staff in pilot areas highlighted the usefulness of development days for group discussions across APs. These discussions supported shared learning in how to communicate with residents. Staff also noted how the development days supported them to improve how they record activities in nDelius.

There were some perceived barriers, however, and these included some uncertainty around what constitutes as RA. Workload pressures were a recurring theme, with staff highlighting the time required to properly record RAs, alongside other key performance measures. Interviews with AP staff across both pilot areas also mentioned limited resident engagement and interest in mental health-related RAs. Additionally, some AP staff reported the considerable time needed to manage new referrals, with resident risk management taking much of their time. This left them with limited time to support RAs.

“I think the new way of working is better as in, it will be more rehabilitative, but at the moment it's not my highest priority because I've got other issues going on that I'm having to kind of put my focus and attention”. **(AP staff member, interview)**

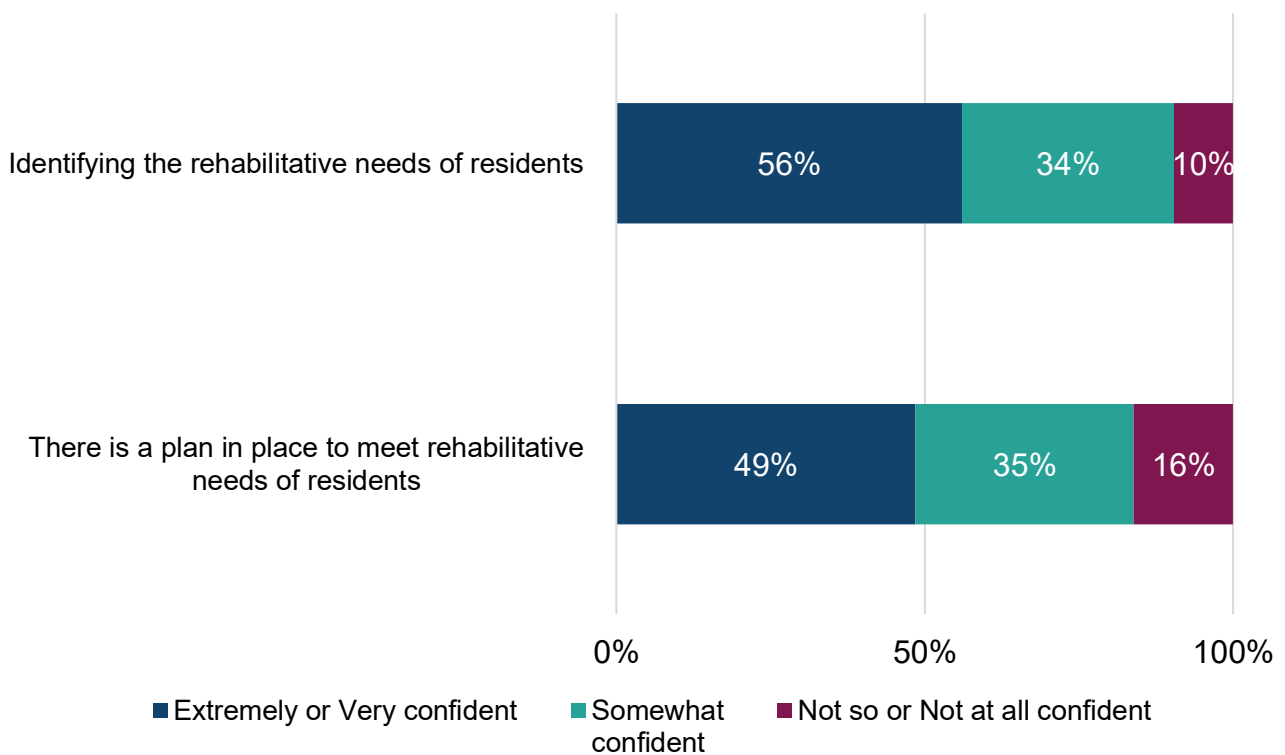
AP Staff Confidence in RA Delivery

The national AP staff survey included two questions on staff self-reported confidence in identifying and meeting the rehabilitative needs of residents. Again, this was a sample of perspectives so some views will be missed.

Survey Findings

Figure 10 presents staff self-reported **confidence** in delivering the provision of RAs. Responses indicating ‘don’t know’ or ‘prefer not to say’ have been excluded from the analysis, which accounted for less than 1% of responses across the items.

Figure 10: Staff Confidence in the Provision of Rehabilitative Activities



The results suggest almost half (44%) of AP staff lacked some confidence in identifying the rehabilitative needs of residents reporting they were either “not at all”, “not so” or “somewhat” confident. Further, around half (51%) lacked some confidence in whether there was a plan in place to meet the rehabilitative needs of residents, again reporting they were either “not at all”, “not so” or “somewhat” confident in response to this survey question.

4.3. Perceptions of the AP Physical Environment and Social Climate

The chapter outlines the delivery funding made available nationally for improvements in the physical environment of APs (4.3.1). It also outlines staff perceptions of the social climate within APs nationally, using data from EssenCES¹⁸ (4.3.2.). Multiple regression analysis was conducted to establish factors that may have influenced staff perceptions of the social climate.

4.3.1 Funding for Improvements to the Physical Environment

Projects Funded

Nationally, all AP Managers were invited to bid for funding to improve the physical environment of their AP to better support the mental health needs of residents. Following a review of bids and award of funding, around half of APs accessed this funding. The funded projects included:

- Storage and furniture that reduced clutter and mess,
- Re-decoration using calming colours,
- Indoor plants, complementary pictures, and soft furnishing,
- Blinds and curtains to let in more light,
- Supplies for creative rehabilitative activities, such as art, cookery, and exercise, and
- Additional indoor and outdoor spaces for wellbeing.

Survey Findings

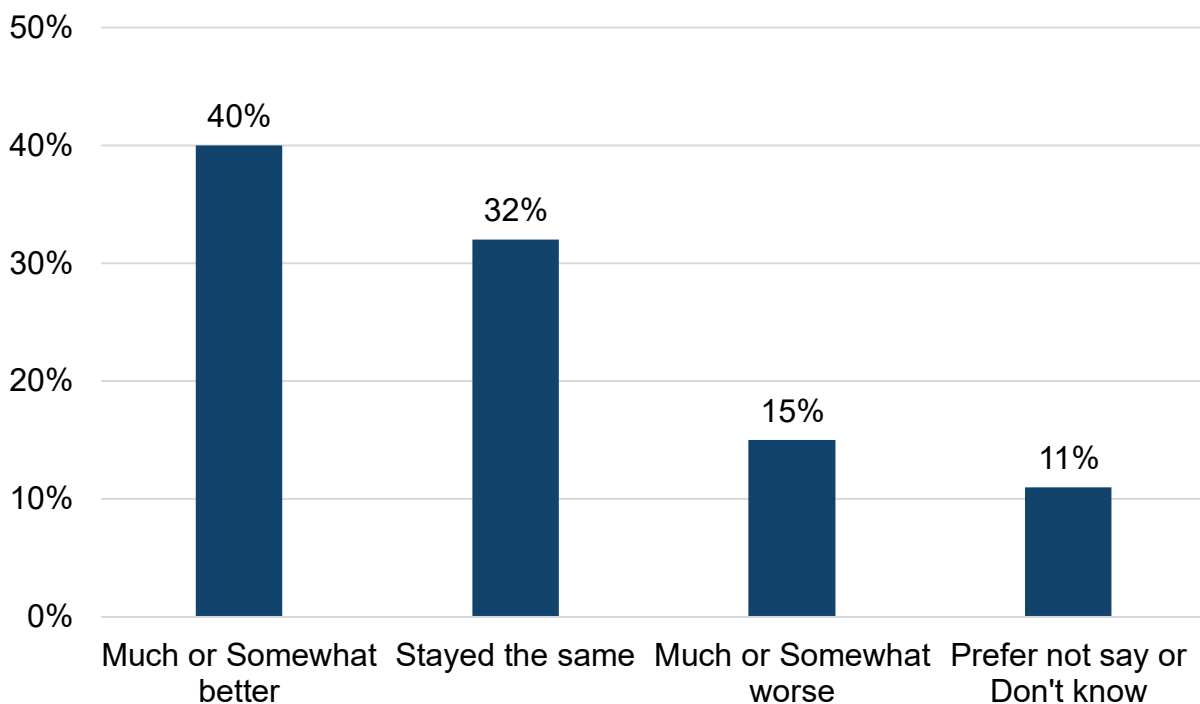
To understand perceptions of the physical environment, the national AP staff survey asked respondents whether they believed the physical environment in their AP had changed over the last year. This aimed to develop an understanding of the link between the AP and its

¹⁸ The Essen Climate Evaluation Schema (EssenCES) assesses the social and therapeutic environment of institutions. It is used in correctional and psychiatric settings, including Approved Premises. EssenCES consists of 15 items on a 5-point Likert scale, divided into three subscales: social cohesion, experienced safety, and therapeutic hold.

physical environment in terms of supporting residents’ mental health. The survey was issued to all AP staff, regardless of whether the AP in which they were based had accessed funding for physical environment improvements.

Figure 11 presents staff self-reported perceptions of changes in physical environment between July 2023 and July 2024.

Figure 11: Staff Perception of Change in Physical Environment between July 2023 and July 2024



Around 40% of respondents reported the environment was “much” or “somewhat better”, suggesting that funding had a positive effect within some APs. This was supported by open-text responses in the survey, such as:

“TV room was renovated and made more comfortable where residents can spend a quiet time. We have also had new beds and mattresses and new wardrobes. Our dining area was also replaced with new furniture.” **AP Staff Survey**

Around one-third (32%) believed the environment had remained the same, while 15% felt it had worsened. A relatively high proportion of respondents selected “don’t know,” particularly among those who had been in post for less than a year. Many in this group, however, still commented on observed changes and were therefore retained in the

analysis. Some responses highlighted poor conditions in certain APs, indicating that further investment in the physical environment may be needed.

4.3.2 Perceptions of the Social Climate

Approach

To provide a broader understanding of staff perceptions of the social climate in APs, the Essen Climate Evaluation Schema (EssenCES) tool was used (see Appendix B for further details). Multiple regression analysis was conducted to establish factors that may have influenced staff perceptions. Factors included in the regression model were AP resident sex, AP bed space, PIPE and AP region, and Enabling Environment (EE) status. Full details of the regression analysis and results are available in Appendix D.

Findings

Findings from the analysis showed:

- **Resident Cohesion:**
 - **PIPE** was the most significant factor influencing resident cohesion. Staff working in PIPEs reported stronger perceptions of resident cohesion compared with those in non-PIPE APs.
 - **AP size** (in terms of bed spaces) also influenced cohesion, with each additional bed space, associated with a 0.015 decrease in resident cohesion score.
 - APs with **EE status** were associated with **lower** perceived resident cohesion. Resident sex and AP region were not significantly associated with cohesion.
- **Experienced Safety:**
 - **PIPE status** again was the most significant factor in influencing staff experienced safety in the model. Staff in PIPEs reported higher safety scores compared with those not in a PIPE.
 - In contrast, **AP size, resident sex, AP region, and EE status** were not significantly related to staff experienced safety.

5. Conclusion

This process evaluation aimed to develop the evidence on the early implementation of a pilot of co-located MH practitioners within APs. This was to generate learning to inform decisions on future service delivery and wider rollout of the pilot. This was conducted alongside research into two complementary strands of national investment: AP workforce training and improvements to the physical environment, which sought to aid ongoing policy development of mental health support within APs.

Overall, the research and evaluation presented a complex picture, partly due to the early stages of implementation and delivery. Perceptions of key benefits included improved staff collaboration and partnership working, improvements to resident access to mental health support, staff knowledge exchange, access to wider mental health materials, as well as enhancements to physical environments. Perceived challenges highlighted were in relation to commissioning barriers, a lack of clarity around provision and implementation into the wider mental health and AP landscape, lower levels of staff awareness of mental health support, and high non-attendance rates at training due to capacity.

5.1. Pilot of Co-Located Mental Health Support

Despite the findings only assessing the early pilot implementation, evidence from interviews with AP staff and MH practitioners indicated several perceived benefits, including:

- **Improved Collaboration and Partnership Working:** The pilot was described as enabling better collaboration between AP staff and NHS Mental Health Practitioners. This led to improved communication and information sharing, particularly with NHS prison mental health teams.
- **Knowledge and Skills Exchange:** The co-location of staff was described as facilitating knowledge sharing and enhancing AP staff's understanding of mental health issues.

- **Increased Access to Mental Health Services:** The pilot was perceived to enable faster referrals to Community Mental Health Teams for residents, particularly for those with higher levels of mental health needs.
- **Resident Engagement:** The presence of MH Practitioners was thought to provide residents with a sense of being heard and reassurance that support was available.

There were, however, challenges outlined in interviews and as part of the project delivery, which included:

- **Commissioning Issues:** The commissioning process faced challenges, including an unsuccessful attempt to commission the pilot in Wales and difficulties in recruiting MH practitioners potentially due to the short duration of the contract.
- **AP Staff Shift Patterns and Turnover:** High staff turnover and shift patterns were viewed as limiting opportunities for interaction and knowledge exchange between AP staff and MH Practitioners.
- **Resident Engagement:** Staff highlighted that some residents declined to engage with mental health support due to stigma and distrust in professionals. Residents placed in APs outside their home area were also said to face further barriers to accessing support.
- **Gaps in Mental Health Provision:** The gaps in community-based mental health support, and fragmented and workforce challenges more broadly presented barriers to wider mental health support needs beyond the pilot.

5.2. AP Workforce Development

As of 30th September 2024, 141 AP staff out of a total of 1,393¹⁹ had received Mental Health Awareness training. There was a high non-attendance rate (34%), however, this is common across other training programmes offered to AP staff and is linked to systemic issues including capacity.

¹⁹ Total staff MI data received in May 2024.

An analysis of the national staff survey highlighted findings related to self-reported knowledge, confidence, and awareness in providing mental health support of AP staff.

These included:

- **Staff Knowledge:** Indicators related to mental health knowledge were reported highest among the three factors, with between 49% and 79% (depending on the indicator) of respondents rating their knowledge as either 'very good' or 'good'.
- **Staff Confidence:** Although confidence scores were lower than knowledge scores, indicators showed that between 42% and 62% of respondents felt 'extremely' or 'very' confident in supporting residents experiencing mental health issues.
- **Staff Awareness:** Staff self-reported awareness of services was lowest rated across indicators, with between 37% and 56% of respondents reporting their awareness was either 'very good' or 'good'.

The gap between knowledge and confidence scores may suggest that while staff may be knowledgeable, they could have lower levels of confidence in applying this knowledge in practice. This may be further amplified by lower scores of awareness in other places to direct residents to support.

Multiple regression analysis was conducted to further explore this and found that factors that most influenced scores were size of an AP (with larger APs having lower scores), staff working in PIPEs scoring more highly, and managers scoring higher than residential workers. These findings could suggest that training provided in PIPEs could be beneficial more widely. The analysis could also suggest the need for targeted training and support to improve staff confidence and awareness of mental health support.

As RAs were also introduced in July 2024, AP staff in pilot sites outlined positive feedback in relation to development days delivered to support the policy change. These days were cited as useful for group discussions across APs and supporting shared learning in how to communicate with residents. There was still some uncertainty, however, related to workload pressures, resident engagement in mental health support, and lower levels of self-reported confidence from staff in identifying and meeting the rehabilitative needs of residents. While these findings align with the Reeves & Marston report, 'Realising the

Rehabilitative Potential of Approved Premises' (2023), further research would be required to understand this in more detail, given findings were based on a small sample size within the research.

5.3. Improving the Physical Environment and Social Climate

The evaluation provided some evidence on perceptions of the physical environment between July 2023 and July 2024 to develop an understanding of the link between an AP and its physical environment in supporting residents' mental health.

The national survey highlighted a mixed picture regarding staff self-reported perceptions of whether the physical environment had improved. Around 40% of staff perceived an improvement in their AP physical environment, approximately one-third (32%) believed the environment had remained the same, and 15% felt it had worsened. This makes it difficult to fully determine whether staff perceived the physical environment improvements positively.

The multiple regression analysis conducted to explore staff perceptions of the social climate in APs found an unexpected finding in that APs with the Enabling Environment Award had lower scores. This could be explored further as it is possible that other factors, such as higher levels of need or complexity among residents, are influencing results.

5.4. Considerations

Based on the findings in this report, this section outlines several considerations for further delivery and potential research and evaluation. It is not exhaustive, and it is anticipated that there are many more insights to be gained given the extensive scope of the work.

5.4.1 Delivery

- **Pilot Continuation and Expansion:** Positive early evidence, particularly around staff knowledge exchange and improved resident access to mental health support, informed the decision to continue the pilot in the North West area and expand into two additional locations from March 2025. Further delivery of MH Practitioners should also consider some of the challenges highlighted in this report, particularly around commissioning and early implementation.

- **Workforce Capacity:** AP staff capacity was referenced as a challenge across projects. This included references to high staff turnover in pilot areas, low attendance at training due shift patterns and cover, and workload pressures were a recurring theme for recording RAs. While this is likely a result of systemic workforce challenges, future projects within APs and mental health support should take this into account.
- **Staff Training:** The national staff survey has shown high scores in terms of self-reported knowledge, but lower scores in confidence to support residents. This suggests more practical, hands-on training may be required to increase confidence. Consideration should be given to piloting the provision of more in-depth training to AP staff, particularly on awareness of other services.
- **Staff Collaboration and Partnerships:** Improved collaboration and knowledge sharing between AP staff and MH Practitioners was perceived as a benefit of the pilot, and the group discussions during RA development days were said to have supported shared learning. Consideration on opportunities to enable joint working and knowledge exchange to build on this could be considered in future delivery.
- **Environmental Factors:** AP size, and PIPE status were found to have influenced the self-reported competency, and confidence of staff. Consideration to these factors in future projects in the area should be as they are a significant influence on, which affect mental health support in APs.

5.4.2 Research and Evaluation

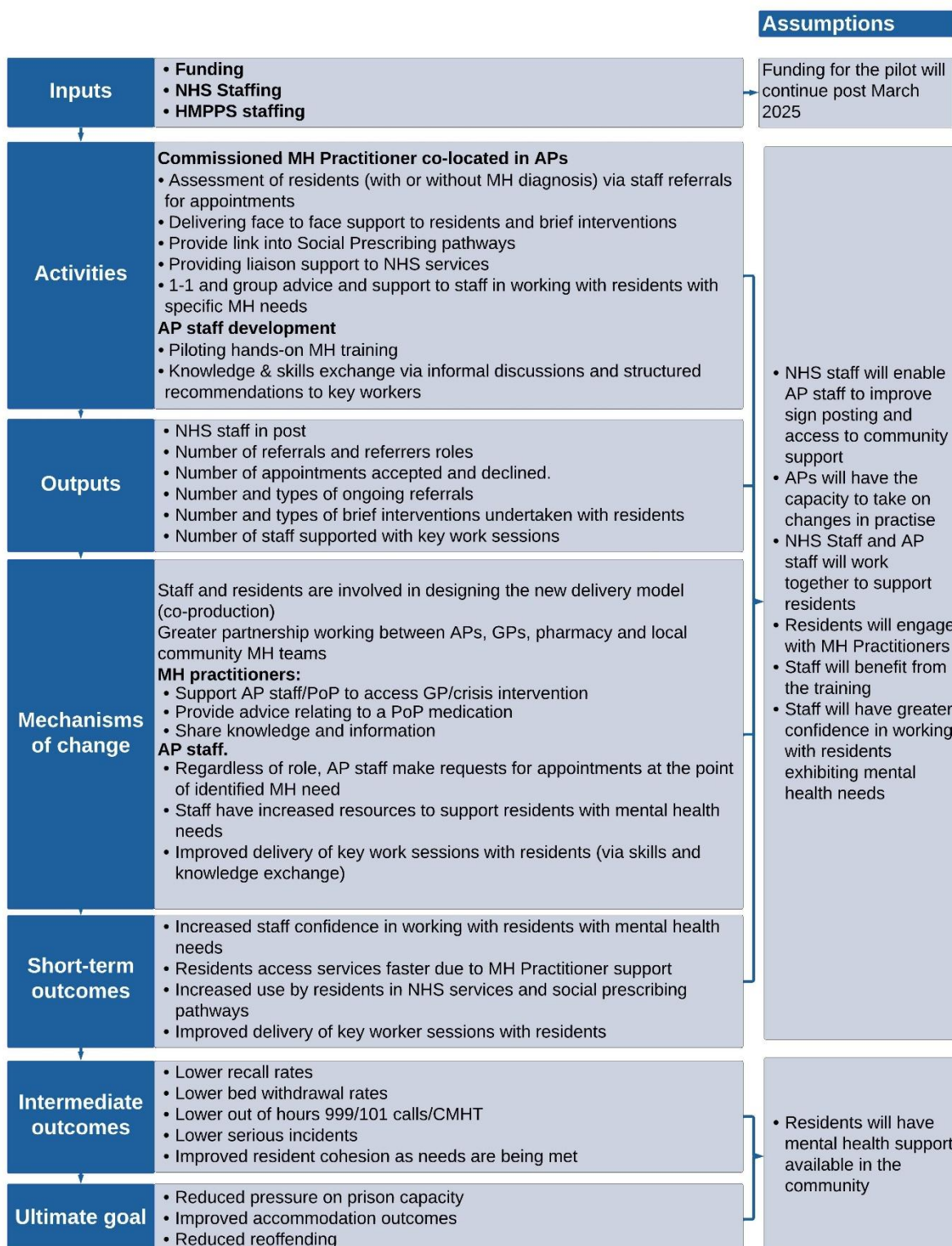
- **Continued evaluation:** A structured programme of follow-up evaluation could be developed to address the limitations identified in this evaluation. This would include a defined evaluation plan setting out the aims, methods, measures, qualitative enquiry with residents and staff, and continued routine monitoring of suppliers. These steps would enable a robust assessment of the implementation and impact of the MH Practitioner model before any wider rollout. Engaging residents would enable a broader understanding of their experiences and the impact of mental health support within APs from their perspective. This would align with outcomes outlined in the theory of change.

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Appendix A

Theory of Change (pilot model only)



Appendix B

EssenCES

The Essen Climate Evaluation Schema (EssenCES) is a questionnaire used to assess the social and therapeutic environment of an institution (not yet published). The EssenCES was initially developed for forensic psychiatric wards but has been validated for use in correctional institutions and general psychiatric settings, including Approved Premises. EssenCES is a 15-item, 5-point Likert scale, with the items divided equally into three subscales:

- Social cohesion – whether mutual support among the residents is typically present.
- Experienced safety – the level of perceived tension and threat of aggression or violence.
- Therapeutic hold – the extent to which the climate is perceived as supportive of resident's therapeutic needs.

Appendix C

Survey Results – Background Information

An online survey was distributed to all AP staff between in July 2024. The survey included staff self-reported mental health knowledge, confidence and awareness and questions related to the physical environment and social climate, including the Essen Climate Evaluation Schema (EssenCES) (Milson et al, 2013).

In total, 513 responses were received (37% response rate), covering 84 APs in total (see appendix C for information on the survey respondent background). The table below outlines details of the sample alongside the response rate against the factor variables used in the regression analysis outlined in Appendix C. These changes led to a total sample of 447 individuals, with 84 APs represented in the sample (out of a total of 100 APs). Workforce data could not be matched to AP resident sex and EEA status due to inconsistencies with AP addresses (linking variable).

Table 6: Staff Self-Reported Survey: Characteristics of Sample and Response Rate

Factor		Sample	Response rate
Job Title	Approved Premises Manager	32	44%
	Approved Premises Residential Worker	330	38%
	Probation Services Officer	85	41%
Work Pattern	Full time	342	35%
	Part time	105	26%
AP Region	London	27	24%
	Midlands	112	35%
	North East	80	36%
	North West	100	39%
	South East and Eastern	52	27%
	South West & Central	76	32%
PIPE	Staff working in an AP without PIPE	382	38%
	Staff working in an AP with PIPE	85	43%
AP Resident Sex	Staff working in an AP housing male residents	426	
	Staff working in an AP housing female residents	21	
EE Status	Staff working in an AP without EE Status	189	
	Staff working in an AP holding EE status	258	

Appendix C

Multiple Regression Analysis – Assumptions Tests and Summary Models

Multiple regression analysis allows for investigation of the relationship between variables. The resulting 'coefficients' indicate the effect of each factor variable on the dependent variable, whilst controlling for the other factor variables in the model.

The following factors were included in models following linking staff workforce data with AP performance data:

Individual level:

- **Job roles:** assessed differences observed across job roles to potentially support tailoring of resources in terms of staff training and development (predictive).
- **Length of service:** assessed whether newer or more longstanding staff had different levels of MH training needs and perceptions of social climate (not predictive).
- **Work pattern:** determined if the amount of time spent working within APs was a factor in the model (not predictive).

AP level:

- **Resident sex:** assessed if differences were observed by AP staff working with female or male residents to inform potential resourcing decisions (not predictive).
- **PIPE:** assessed if PIPE environments impacted staff self-reported competency and perceptions of the social climate (predictive).
- **Bed space:** assessed if resident bed space may have impacted staff self-reported competency and perceptions of the social climate to inform potential resourcing decisions (predictive).

- **EEA status:** assessed if EEA status impacted staff self-reported competency and perceptions of the social climate (predictive).

To strengthen the statistical modelling, in terms of job titles, only responses that received >20 responses were included in the regression analysis. This included AP Managers, Probation Support Officers (PSOs) and Residential Workers (RWs) (see table 6 in Appendix C). These changes led to a total sample of 447 individuals, with a total of 84 APs represented in the sample (out of a total 100 APs).

Assumptions Tests

Several assumptions tests can ensure the validity and reliability of regression analysis results:

- **Sample Size:** the general guide is that there is a minimum of twenty cases per independent variable.
- **Linear Relationship:** The analysis requires the relationship between the independent and dependent variables to be linear, which was assessed via inspecting the Residuals vs Fitted plot.
- **Multivariate Normality:** The analysis assumes that the residuals (the difference between observed and predicted values) are normally distributed. For each model, this was assessed via examining histograms and the Q-Q plot of the residuals.
- **No Multicollinearity:** It is also essential that independent variables are not too highly correlated (multicollinearity), and this was assessed using variance inflation factor.

For each of the models presented in this report, these assumptions were met, except for therapeutic hold, which did not meet the assumption of normally distributed residuals. Further, the Cronbach Alpha score across the therapeutic hold indicators was only 0.41, which indicates poor consistency. The reasons for this remained unclear. Therefore, findings related to therapeutic hold could not be reported.

Staff Competency

The overall regression was statistically significant ($p < 0.001$), suggesting at least one predictor was significant in explaining variance in the resident cohesion score. The

adjusted R- squared value suggested only the model explained 2% variability. Such low scores are common within the social sciences, and this study was exploring relationships rather than attempting to make predictions.

Table 7: Factors Influencing Resident Cohesion Score

Factors	Coefficient	SE	T-Statistic	P-Value	VIF
(Intercept)	3.979	0.171	23.257	0.000	
Residential Worker	-0.238	0.117	-2.035	0.042	1.0
Probation Services Officer	-0.161	0.128	-1.264	0.207	1.0
Length of Service	0.006	0.007	0.947	0.344	1.1
Work Pattern (part time)	0.018	0.071	0.260	0.795	1.0
Resident Sex (female)	-0.052	0.149	-0.347	0.729	1.1
PIPE (yes)	0.192	0.082	2.338	0.020	1.1
Bed Space	-0.012	0.005	-2.390	0.017	1.1
EE Status (No)	0.006	0.061	0.102	0.919	1.1
Model Summary					
R squared					0.0379
Adjusted R-squared					0.0203
Residual standard error					0.6076 on 439 Degrees of Freedom
F-statistic					2.1560
p-value					0.0298

Resident Cohesion

The overall regression was statistically significant ($p < 0.001$), which suggest at least one predictor is significant in explaining variance in the resident cohesion score. The R-squared value suggests 10% variability is explained by the model.

Table 8: Factors Influencing Resident Cohesion Score

Factors	Coefficient	SE	T-Statistic	P-Value	VIF
(Intercept)	2.15	0.14	15.37	0.00	
Resident Sex (female)	-0.05	0.17	-0.31	0.76	1.13
PIPE (yes)	0.58	0.09	6.10	0.00	1.10
South East and Eastern	0.03	0.12	0.24	0.81	1.03
South West & Central	-0.21	0.10	-1.96	0.05	1.03
North East	-0.21	0.11	-1.93	0.05	1.03
North West	0.08	0.10	0.79	0.43	1.03

London	-0.08	0.16	-0.47	0.64	1.03
Bed Space	-0.02	0.01	-2.70	0.01	1.12
EE Status (No)	0.17	0.07	2.35	0.02	1.09
Model Summary					
R squared					0.1187
Adjusted R-squared					0.1005
Residual standard error					0.692 on 437 Degrees of Freedom
F-statistic					6.5380
p-value					<0.001

Experienced Safety

The overall regression was statistically significant ($p < 0.01$), which suggest at least one predictor is significant in explaining variance in the resident cohesion score. The R-squared value suggests 3% variability is explained by the model.

Table 9: Experienced Safety Regression Analysis

Factors	Coefficient	SE	T-Statistic	P-Value	VIF
(Intercept)	1.99	0.16	12.17	0.00	
Resident Sex (female)	-0.34	0.20	-1.69	0.09	1.13
PIPE (yes)	0.41	0.11	3.69	0.00	1.10
South East and Eastern	0.19	0.14	1.39	0.17	1.03
South West & Central	0.12	0.12	1.01	0.32	1.03
North East	-0.06	0.12	-0.51	0.61	1.03
North West	0.07	0.12	0.59	0.55	1.03
London	-0.04	0.19	-0.19	0.85	1.03
Bed Space	-0.01	0.01	-1.67	0.10	1.12
EE Status (No)	0.02	0.08	0.26	0.79	1.09
Model Summary					
R squared					0.0475
Adjusted R-squared					0.0278
Residual standard error					0.8091 on 437 Degrees of Freedom
F-statistic					2.4200
p-value					0.0109

Appendix D

Background to Rehabilitative Activities (RA)

During the project delivery period (2024), additional funding was provided to support the policy change from 'Purposeful Activity' to 'Rehabilitative Activity' (RA), a key performance measure for Approved Premises (APs). HMPPS defines rehabilitation as follows:

Rehabilitation refers to the structured set of actions, interventions, and support mechanisms implemented within Approved Premises to assist individuals in addressing the underlying causes of their offending behaviour. The primary aim is to promote personal change, reduce the risk of reoffending, and support successful reintegration into society.

These actions can include cognitive-behavioural therapy, skills development, substance misuse support, psychological support, and the cultivation of prosocial attitudes and behaviours, all within a controlled, supportive, and supervised environment. Within Approved Premises, staff will engage residents within Rehabilitative Activities which will incorporate some of the above approaches, however, can include engagement in Meaningful Conversations, as well as activities designed to support the residents to act pro-socially – At the end of this document we have included several examples of Rehabilitative Activities and how these may be recorded'.

A Rehabilitative Activity can help residents feel better, live a healthier life, build on their strengths, give hope which all can lead to the individual realising their potential and lowering the risk of re-offending.

- A Rehabilitative Activity is an activity to help residents live a better, healthier life so there is less likelihood of risk of re-offending.
- A Rehabilitative Activity is an activity to help residents live a better, healthier life so there is less likelihood of risk of re-offending.
- RA can be planned or unplanned in small groups or on a one to one.

The RA can be delivered by staff, residents, or other organisations in or out of the AP. The length of the activity can vary as it is based on the quality of the sessions rather than fixed time.

RAs align with the eight pathways for reducing reoffending, including health; education; employment and training; attitudes thinking and behaviour; finances, benefits, and debt; drug and alcohol abuse; accommodation; and relationships.

In terms of supporting residents' mental health, worksheets were also made available to staff to support them in one-to-one or group work sessions with residents, grounded in cognitive behavioural therapy techniques, including topics such as countering negative thoughts, building happiness, challenging anxious thoughts, and coping with anxiety. Therefore, this formed part of a wider initiative aimed at improving the mental health support available to residents.