



**NHS commissioning in probation in England – still on a wing and a prayer**

Journal:	<i>Health &amp; Social Care in the Community</i>
Manuscript ID	HSCC-OA-18-0532.R2
Manuscript Type:	Original Article
Keywords:	Probation Service, Mental Health, Public Health, commissioning, Clinical Commissioning Group, Transforming Rehabilitation

SCHOLARONE™  
Manuscripts

## NHS commissioning in probation in England – still on a wing and a prayer

### Abstract

Policy reforms in England and Wales mean that all individuals released from prison will have some contact with probation services, either serving a community sentence, or being on licence post-release. Despite often having complex health needs, including a higher prevalence of mental illness, substance misuse problems and physical health problems than the general population, this socially excluded group of people often do not access healthcare until crisis point. This is partly due to service-level barriers such as a lack of appropriate and accessible healthcare provision. We conducted a national survey of all Clinical Commissioning Groups (CCGs, n=210) and Mental Health Trusts (MHTs, n=56) in England to systematically map healthcare provision for this group. We compared findings with similar surveys conducted in 2013 and 2014. We had excellent response rates, with the data analysed here representing responses from 75% of CCGs and 52% of MHTs in England. We found that just 4.5% (n=7) of CCG responses described commissioning a service specifically for probation service clients, and 7.6% (n=12) described probation-specific elements within their mainstream service provision. Responses from 19.7% of CCGs providing data (n=31) incorrectly suggested that NHS England are responsible for commissioning healthcare for probation clients rather than CCGs. Responses from 69% (n=20) of MHTs described providing services specifically for probation service clients, and 17.2% (n=5) described probation-specific elements within their mainstream service provision. This points to a need for an overarching health and justice strategy that emphasises organisational responsibilities in relation to commissioning healthcare for people in contact with probation services to ensure that there is appropriate healthcare provision for this group.

**Keywords:** probation, Clinical Commissioning Group, mental health, commissioning, public health, transforming rehabilitation

### What is known about this topic?

- Since 2014 CCGs have been responsible for commissioning healthcare for probation clients (including those in probation Approved Premises) in England
- In 2014, just 1% of CCGs invested in healthcare for probation clients
- In 2014, 61% of MHTs funded healthcare for probation

### What this paper adds

- The proportion of CCGs investing in healthcare for probation clients has increased from 1% to 5%, with an additional 8% describing probation-specific elements within mainstream service provision
- The proportion of MHTs funding healthcare for probation has increased from 61% to 69% overall
- 20% of CCGs providing data incorrectly stated that NHS England are responsible for commissioning healthcare for probation clients

### Introduction

Following reforms introduced by *Transforming Rehabilitation* (2013), the probation service in England and Wales was restructured into a public sector National Probation Service, supervising high-risk offenders; and private sector Community Rehabilitation Companies, supervising medium and low-risk offenders. Over 250,000 offenders are usually managed by the service overall at any one time, and this now includes those who served custodial sentences of less than 12 months (Ministry of Justice, 2018a).

1  
2  
3 Whilst not a homogeneous group, people on probation are often viewed as vulnerable and hard-to-  
4 reach. Research shows that they experience higher rates of mental illness, substance misuse  
5 problems, suicide and self-harm, and physical health problems than the general population (Brooker,  
6 Sirdifield, Blizard, Denney, & Pluck, 2012; Brooker, Syson-Nibbs, Barrett, & Fox, 2009; Geelan, Griffin,  
7 Briscoe, & Haque, 2000; Martyn, 2012; NHS England, 2016; Pluck & Brooker, 2014; Sattar, 2003;  
8 Sirdifield, 2012; Sirdifield et al., 2019; Yu & Sung, 2015). Moreover, they have disproportionately low  
9 access to healthcare and often only access healthcare at crisis point because of numerous personal,  
10 societal and service-level barriers. These include falling through gaps between services due to the  
11 complexity of health issues, lack of GP registration, low levels of literacy and health literacy, transient  
12 lifestyles, poor past experiences of accessing care, uncaring professional demeanours, gaps in service  
13 provision, inaccessible services, poorly designed services, and stigma (Donnelle & Hall, 2014; Flanagan,  
14 2004; Lang, Hillas, Mensah, Ryan, & Glass, 2014; Marlow, White, & Chesla, 2010; Melnick, Coen,  
15 Taxman, Sacks, & Zinsser, 2008; Plugge, Pari, Maxwell, & Holland, 2014; Revolving Doors Agency, 2017;  
16 Rodriguez, Keene, & Li, 2006).

17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35 The implementation of the Health and Social Care Act 2012 introduced changes to the way that  
36 healthcare is commissioned for people in the criminal justice system in England and Wales. NHS  
37 England is responsible for commissioning healthcare for people in secure environments such as  
38 prisons and police custody. However, the majority of healthcare for offenders in the community  
39 should now be commissioned by CCGs (groups of General Practices overseen by NHS England) (Davies,  
40 Charles, & Handscomb, 2013; NHS Commissioning Board, 2012, 2013; NHS England, 2016).

41  
42  
43  
44  
45  
46  
47  
48  
49 In addition to this, MHTs (also commissioned by CCGs) and Local Authorities also play a role. MHTs  
50 are expected to provide health and social care services to those with mental health disorders. Local  
51 Authorities should commission public health services such as treatments for drug and/or alcohol  
52 misuse, however many councils are reducing their spending in this area (Rhodes, 2018). Moreover,  
53 the Health and Care Act 2012 also placed a duty on Local Authorities and CCGs to work in partnership  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 to produce a Joint Strategic Needs Assessment (JSNA) through their local Health and Wellbeing Board.  
4  
5 These assessments are intended to reduce health inequalities by informing the commissioning  
6  
7 priorities set out in Joint Health and Wellbeing Strategies for each region. As part of this exercise,  
8  
9 Health Needs Assessments of 'vulnerable groups' such as people on probation can be conducted to  
10  
11 ensure that their needs are considered when planning local healthcare commissioning priorities  
12  
13 (Department of Health, 2011, 2013).  
14  
15

16  
17 The high level and complexity of health needs and barriers to service access amongst people on  
18  
19 probation, and the benefits of addressing these, have been repeatedly acknowledged in policy  
20  
21 documents in the UK (see for example Home Office, 2004; Ministry of Justice, 2013, 2018b; NHS  
22  
23 England, 2016; Probation Institute, 2017). Assessing and addressing the health needs of people on  
24  
25 probation would arguably contribute not only to improving individuals' health, but also to cost-savings  
26  
27 for the NHS and the criminal justice system, and wider benefits (sometimes referred to as a  
28  
29 'community dividend') from a reduction in the negative impact of health inequalities and offending  
30  
31 behaviour in society (Revolving Doors Agency, 2017; Woodward & Kawachi, 2000). However, previous  
32  
33 research showed that just 1% of CCGs were commissioning healthcare specifically for people on  
34  
35 probation, and a fifth of CCGs believed that NHS England were responsible for funding healthcare for  
36  
37 this group (Brooker, Sirdifield, Ramsbotham, & Denney, 2017).  
38  
39  
40  
41

42 This paper updates and expands on previous research in this area, sharing findings of national surveys  
43  
44 of CCGs and MHTs across England, to provide an up-to-date picture of the extent to which these  
45  
46 organisations commission or provide healthcare specifically for offenders on probation.  
47  
48  
49  
50

## 51 52 53 **Methods**

54  
55 In 2017 a survey was sent to all CCGs and MHTs across England, asking about the types of healthcare  
56  
57 that they commission (CCGs) or provide (MHTs) specifically for probation clients. These organisations  
58  
59  
60

1  
2  
3 received a written reminder approximately two weeks after the initial invitation was sent, and we also  
4  
5 made follow-up telephone calls to a proportion of these organisations.  
6  
7

8 Subsequently, due to low response rates, in the same year, crucial data were acquired from non-  
9  
10 responders via Freedom of Information (FOI) requests which asked similar questions to key survey  
11  
12 questions (Box 1). The questions asked in the FOI requests were comparable to those asked in previous  
13  
14 research conducted in 2013 and 2014 (Brooker & Ramsbotham, 2014; Brooker et al., 2017) and  
15  
16 consequently we focus solely on these responses in this paper.  
17  
18  
19

20 Ethical approval for the study was obtained from the Health Research Authority (17/HRA/1052), the  
21  
22 National Offender Management Service National Research Committee (REF: 2017 – 022), and the  
23  
24 School of Health and Social Care Ethics Committee at the University of BLANKED FOR PEER REVIEW.  
25  
26  
27  
28  
29  
30  
31  
32

### 33 ***The sample***

34  
35 Respondents from 13 CCGs (6.2%), and 21 MHTs (37.5%) completed a survey. We then sent FOI  
36  
37 requests to non-responders, and as shown in Table 1, we received responses from 176 CCGs, and 31  
38  
39 MHTs (89.3% and 88.6% of those receiving an FOI request respectively) within the 20 working days  
40  
41 given for organisations to respond to such requests.  
42  
43  
44  
45

46 [Table 1: Response rates here]  
47  
48  
49  
50

51 As stated above, we chose to focus specifically on the FOI responses here. Within the FOI responses,  
52  
53 two MHTs and 19 CCGs stated that they did not have the information needed to respond to the  
54  
55 request. These organisations were therefore excluded from further data analysis. Consequently, the  
56  
57  
58  
59  
60

1  
2  
3 data analysed here represent responses from 75% (n=157) of CCGs and 52% (n=29) of MHTs in  
4  
5 England.  
6  
7  
8  
9

### 10 11 **Data analysis** 12

13  
14 The responses were entered into SPSS version 22 for descriptive statistical analysis. Firstly, an  
15 overarching variable of 'any health service' was created, to represent that an organisation reported  
16 commissioning or providing at least one form of healthcare either specifically for people on probation  
17 or containing probation-specific elements (see below).  
18  
19  
20  
21  
22

23 Secondly, variables were created representing the broad categories of healthcare directly referred to  
24 in the FOI questions: 'any mental health service' (for both CCGs and MHTs), 'any substance misuse  
25 service' (for MHTs only), and 'any physical health service' (for CCGs only).  
26  
27  
28  
29  
30

31 The free text responses were coded to these variables by CS and categorised as either a) a service was  
32 commissioned or provided specifically for people on probation, or b) there were probation-specific  
33 elements within a service that was accessible to a wider group (e.g. a specific referral route was  
34 provided for probation staff or clients to use). RM independently coded every fifth entry for  
35 comparison.  
36  
37  
38  
39  
40  
41  
42

43 Thirdly, variables were created for the specific types of service provision reported within the  
44 responses. These were simply coded as this type of service was 'reported' or 'not reported'. This  
45 enabled comparison between the 2017 responses and those provided in previous research in 2013  
46 and 2014 (Brooker et al., 2017).  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## Findings

### *The Clinical Commissioning Groups*

Previous research, comparing data from 2013 and 2014, showed “a disappointing decline in the proportion of CCGs who directly commissioned healthcare in probation (from 7% to 1%)” (Brooker et al., 2017: 140). The data from 2017 point to a slight improvement, with 12.1% of CCG responses describing either commissioning a service specifically for probation service clients (4.5%), or describing probation-specific elements within mainstream service provision (7.6%). However, this still means that nearly 90% of CCGs did not report commissioning probation-specific services, or providing probation-specific elements (such as a referral route for probation) within their mainstream provision (Table 2).

[Table 2: Overarching categories of services commissioned by CCGs in 2017 here]

Just 10.2% of CCGs reported commissioning any kind of mental health service for people on probation (either specifically for people on probation (1.3%), or with probation-specific elements (8.9%)). Three CCGs reported commissioning a physical health service.

As shown in Table 3, just 4.5% of CCG responses were coded as reporting commissioning a diversion service, 3.2% as reporting involvement with Multi-Agency Public Protection Arrangements, and 1.3% as reporting contributing to a Criminal Justice Mental Health Team. No CCGs reported commissioning



1  
2  
3 an Improving Access to Psychological Therapies (IAPT) service or a personality disorder service or  
4 programme for people on probation.  
5  
6

7  
8 Three CCGs reported commissioning a clinic in probation offices, and no CCGs reported commissioning  
9 any kind of support in probation Approved Premises. Additionally, two CCGs reported commissioning  
10 substance misuse services, and two CCGs reported contributing to Integrated Offender Management.  
11  
12  
13  
14

15  
16  
17  
18 Just 5.7% of CCG responses indicated that they directly facilitated access to services for people on  
19 probation. Additionally, 14% of responses were coded as indicating that they did so via another  
20 organisation that they commission or work with. In many cases CCGs reported that this was done by  
21 the service providers - through their websites and working in partnership with criminal justice agencies  
22 in joint arrangements such as Multi-Agency Public Protection Arrangements (MAPPA) meetings  
23 (through which the risks posed by violent and sexual offenders in the community are managed). One  
24 CCG reported that arrangements were made via the Community Safety Partnership, others reported  
25 that access would be supported by GPs and/or criminal justice liaison services.  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35

36  
37 [Table 3: Sub-categories of services commissioned by CCGs in 2017 here]  
38  
39

40 Nearly a fifth of CCG responses (19.7%) were coded as (incorrectly) stating that NHS England are  
41 responsible for commissioning healthcare for probation clients.  
42  
43  
44  
45  
46  
47

### 48 ***The Mental Health Trusts***

49  
50  
51  
52  
53

54 Previous research reported a reduction in the proportion of MHTs providing any kind of healthcare in  
55 probation from 70% in the 2013 survey to 61% in 2014 (Brooker et al., 2017). The most recent data  
56 showed an improvement, with 86.2% of MHT FOI responses describing either providing some kind of  
57  
58  
59  
60

1  
2  
3 service specifically for probation service clients (69%), or probation-specific elements within  
4  
5 mainstream service provision (17.2%) (Table 4).  
6  
7

8 [Table 4: Overarching categories of services provided by Mental Health Trusts in 2017 here]  
9  
10

11  
12  
13  
14 As shown in Table 5, 20.7% of MHTs reported providing a substance misuse service either specifically  
15  
16 for people on probation (6.9%), or with probation-specific elements (13.8%); and 82.6% reported  
17  
18 providing a mental health service.  
19

20  
21 As Table 5 shows, 17.2% of MHT responses were coded as contributing to Alcohol Treatment  
22  
23 Requirements, and 17.2% as contributing to Drug Rehabilitation Requirements. Over half (55.2%) of  
24  
25 responses were coded as a MHT providing a diversion service, compared to just 9.8% (n=4) in 2014.  
26  
27 The proportion reporting providing a personality disorder service or programme had increased from  
28  
29 17.1% (n=7) in 2014 to 48.3% in 2017. The proportion reporting contributing to MAPPA stayed stable:  
30  
31 27.6% in 2017, compared to 26.8% in 2014.  
32  
33

34  
35 The proportion of MHTs reporting providing services within probation offices increased by 16.6% from  
36  
37 2014 to 48.3%. The same proportion reported providing support in probation Approved Premises.  
38  
39

40  
41 In addition 1.3% reported contributing to Integrated Offender Management and 13.8% reported  
42  
43 contributing to Criminal Justice Mental Health Teams. No MHTs reported providing IAPT or through  
44  
45 the gate services.  
46  
47

48  
49 When asked whether they facilitate access to mainstream services for people on probation, 75.9% of  
50  
51 MHTs stated that they did, with an additional MHT reporting that they did so via another organisation.  
52

53  
54 In contrast to the CCGs, none of the MHT responses suggested that they believed NHS England to be  
55  
56 responsible for commissioning healthcare for probation clients.  
57

58 [Table 5: Sub-categories of services commissioned by MHTs in 2017 here]  
59  
60

## Discussion

Internationally there is a paucity of research on the health needs of people on probation, however, the literature that does exist repeatedly points to a high level and complexity of health needs in this group when compared to the general population (Brooker et al., 2012; Brooker et al., 2009; Mair & May, 1997; Sirdifield et al., 2019). Improving the health of this group and ensuring provision of appropriate and accessible healthcare to meet their needs is important, not only for improving the health of these individuals, but also in terms of reducing health inequalities in society. Improving health is a pathway to reducing re-offending, and there is potential to achieve cost savings through people accessing healthcare before they get to crisis point, and through reduced criminal justice costs associated with re-offending.

We conducted national surveys of all CCGs and MHTs in England. Whilst initially employing surveys, due to low response rates, we used FOI requests to obtain the required data. We focused solely on the FOI data here for consistency and to enable direct comparison with the previous research. In doing so, we have limited our analysis to responses from 75% of CCGs and 52% of MHTs. Respondents were asked what services their organisation commissioned or provided for probation clients in relation to mental health, physical health (CCGs only) and substance misuse (MHTs only). Free text responses were coded to these categories and to sub-categories reflecting the nature of the services described in the response. We acknowledge that potentially neglecting to mention a particular type of service in response to the FOI request may be an oversight, rather than demonstrably showing that such a service is not commissioned or provided by an organisation. However, given the resources dedicated

1  
2  
3 to answering FOI requests and the fact that this is the third year in which these questions have been  
4  
5 asked, we anticipated that responses would be thorough.  
6  
7

8 There had been some improvement since 2014 in the proportion of CCGs commissioning healthcare  
9 specifically for people on probation, and the proportion of MHTs providing healthcare specifically for  
10 this group. The mechanisms behind this improvement remain unclear and further research is needed  
11 to unpick these and understand for example, whether they are simply a result of a higher proportion  
12 of CCGs responding to the FOI requests, and what impact the introduction of Community  
13 Rehabilitation Companies may have had. Although things are improving it is clear that despite the  
14 health inequalities experienced by people on probation, nearly 90% of CCGs providing data for our  
15 study did *not* report commissioning services specifically for this population or offering a probation-  
16 specific element such as a referral pathway within their mainstream healthcare provision.  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

29 In comparison, 86.2% of MHTs reported providing some form of healthcare either specifically for  
30 people on probation or containing probation-specific elements. Over two-fifths of MHTs provided  
31 diversion services, personality disorder services or clinics in probation offices. Despite the Criminal  
32 Justice Act (2003) imposing a duty on health and social care services to 'co-operate' with MAPPA, just  
33 27.6% of MHTs discussed contributing to this.  
34  
35  
36  
37  
38  
39  
40

41 Findings also showed that nearly a fifth (19.7%) of CCGs incorrectly believed that responsibility for  
42 commissioning healthcare for people on probation lies with NHS England – showing that there had  
43 been no improvement since 2014.  
44  
45  
46  
47

48 It appears that many CCGs are either a) unaware of their responsibilities to understand the needs of  
49 probation clients and commission appropriate healthcare to meet those needs, b) believe that  
50 responsibility for this lies elsewhere, or c) believe that as probation clients are in the community, they  
51 have the same needs and ability to access services as the wider community.  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 However, the small volume of research that has been conducted around the world demonstrates that  
4 the health needs of those on probation are different to those of the general population. The higher  
5 prevalence of many health problems amongst probation clients is rarely considered when services are  
6 commissioned (Brooker & Ramsbotham, 2014; Brooker et al., 2017). Moreover people on probation  
7 face many barriers to accessing care and often do not engage with healthcare services until they reach  
8 crisis point due to numerous personal, societal and *service-level* barriers (Brooker et al., 2009;  
9 Cumming, Troeung, Young, Kelty, & Preen, 2016; Donnelle & Hall, 2014; Flanagan, 2004; Howerton et  
10 al., 2007; Marlow et al., 2010; Plugge et al., 2014).

11  
12 The commissioning landscape is complex and fragmented, and the challenges involved in achieving  
13 effective partnership working to provide appropriate, evidence-based and continuing care across the  
14 criminal justice pathway are multiple. Nevertheless, if we are serious about having an NHS that is  
15 accessible and meets the needs of *all*, improvements are needed. We need to ensure that we provide  
16 probation-specific services, or appropriate elements within, and clear routes through to broader  
17 services that understand and meet the needs of this group.

18  
19 To do this, firstly, we need clarity from policy makers on where different organisations' responsibilities  
20 lie within this landscape.

21  
22 Secondly, commissioning needs to be informed by an understanding of the needs and experiences of  
23 the *whole* community, including those that may be considered hard to reach. This necessitates the  
24 development of clear and practical mechanisms for measuring and monitoring the health of people  
25 on probation, and sharing data on their health needs at an aggregate level with commissioners, and/or  
26 improving use of existing strategies such as conducting JSNAs and 'gap' analyses.

27  
28 Thirdly, research should be funded a) to support qualitative investigation to improve our  
29 understanding of what is preventing CCGs from commissioning healthcare for probation clients or  
30 with probation-specific elements, and b) to trial new ways of working in response to findings from the  
31 above – to simplify or create pathways into services from the NPS and CRCs and improve partnership

1  
2  
3 working at all levels including co-commissioning, co-location of staff and shared monitoring and  
4  
5 feedback mechanisms.  
6  
7

8 This could be informed by previous research and policy papers, which have already highlighted the  
9  
10 need to overcome gaps in service provision where services simply don't exist to meet some health  
11  
12 needs, reduce long waiting lists, change restricted opening times so that services are open when  
13  
14 people need them most, change referral criteria or models of service provision so that those with  
15  
16 complex healthcare needs do not fall through the gaps between services, treat service users as people  
17  
18 rather than problems, and consider co-location of criminal justice and health services to improve  
19  
20 access to healthcare (Cumming et al., 2016; Donnelle & Hall, 2014; NHS England, 2016; Sirdifield &  
21  
22 Owen, 2016). These papers also suggest potential approaches that could be formally trialled such as  
23  
24 GP registration schemes, specialty probation, and models of partnership working and co-production  
25  
26 (Lang et al., 2014; Revolving Doors Agency, 2017; Sirdifield et al., 2019; Skeem & Eno Loudon, 2006).  
27  
28  
29  
30

31 There is a clear need to build on current strategies such as *Strategic Direction for Health Services in*  
32  
33 *the Justice System: 2016-2020* (NHS England, 2016) and the NPS Health and Social Care Strategy 2019-  
34  
35 2022 to ensure that we have an overarching health and justice strategy that clarifies organisational  
36  
37 responsibilities with regards to commissioning and providing healthcare for people on probation and  
38  
39 provides mechanisms through which accessible and appropriate healthcare can be provided.  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## References

- Brooker, C., & Ramsbotham, D. (2014). Probation and mental health: who cares? *British Journal of General Practice*, 64(621), 170-171. doi:[10.3399/bjgp14X677743](https://doi.org/10.3399/bjgp14X677743)
- Brooker, C., Sirdifield, C., Blizard, R., Denney, D., & Pluck, G. (2012). Probation and mental illness. *The Journal of Forensic Psychiatry and Psychology*, 23(4), 522-537. doi:<https://doi.org/10.1080/14789949.2012.704640>
- Brooker, C., Sirdifield, C., Ramsbotham, D., & Denney, D. (2017). NHS commissioning in probation in England - on a wing and a prayer. *Health and Social Care in the Community*, 25(1), 137-144. doi:[10.1111/hsc.12283](https://doi.org/10.1111/hsc.12283)
- Brooker, C., Syson-Nibbs, L., Barrett, P., & Fox, C. (2009). Community managed offenders' access to healthcare services: Report of a pilot study. *Probation Journal*, 56(1), 45-59. doi:<https://doi.org/10.1177/0264550509102401>
- Cumming, C., Troeung, L., Young, J. T., Kelty, E., & Preen, D. B. (2016). Barriers to accessing methamphetamine treatment: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, 168, 263-273. doi:[10.1016/j.drugalcdep.2016.10.001](https://doi.org/10.1016/j.drugalcdep.2016.10.001)
- Davies, N., Charles, S.-A., & Handscomb, K. (2013). Commissioning Healthcare for Offenders. *Nursing Management*, 20(5), 18-22. doi:[10.7748/nm2013.09.20.5.18.e1087](https://doi.org/10.7748/nm2013.09.20.5.18.e1087)
- Department of Health. (2011). *Joint Strategic Needs Assessments and joint health and wellbeing strategies explained*. London: Department of Health.
- Department of Health. (2013). *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies*. London: Department of Health.
- Donnelle, L., & Hall, J. (2014). An Exploration of Women Offenders' Health Literacy. *Social Work in Public Health*, 29, 240-251. doi:<https://doi.org/10.1080/19371918.2013.776415>
- Flanagan, N. A. (2004). Transitional health care for offenders being released from United States prisons. *The Canadian Journal of Nursing Research*, 36(2), 38-58.
- Geelan, S., Griffin, N., Briscoe, J., & Haque, M. S. (2000). A bail and probation hostel for mentally disordered defendants. *The Journal of Forensic Psychiatry*, 11(1), 93-104. doi:<https://doi.org/10.1080/095851800362382>
- Home Office. (2004). *Reducing Re-offending National Action Plan*. London: Home Office.
- Howerton, A., Byng, R., Campbell, J., Hess, D., Owens, C., & Aitken, P. (2007). Understanding help seeking behaviour among male offenders: qualitative interview study. *BMJ Open*, 334(303). doi:<https://doi.org/10.1136/bmj.39059.594444.AE>
- Lang, N., Hillas, A., Mensah, M., Ryan, S., & Glass, L. (2014). Linking probation clients with mainstream health services: Experience in an outer London borough. *Probation Journal*, 61(3), 278-285. doi:<https://doi.org/10.1177/0264550514536757>
- Mair, G., & May, C. (1997). *Offenders on probation*. London: Home Office.
- Marlow, E., White, M. C., & Chesla, C. A. (2010). Barriers and Facilitators: Parolees' Perceptions of Community Health Care. *Journal of Correctional Health Care*, 16(1), 17-26. doi:[10.1177/1078345809348201](https://doi.org/10.1177/1078345809348201)
- Martyn, M. (2012). Drug and alcohol misuse among adult offenders on probation supervision: Findings from the drugs and alcohol survey 2011. *Irish Probation Journal*, 9, 75-93.
- Melnick, G., Coen, C., Taxman, F. S., Sacks, S., & Zinsser, K. M. (2008). Community-based co-occurring disorder (COD) intermediate and advanced treatment for offenders. *Behavioral Sciences and the Law*, 26, 457-473. doi:<https://doi.org/10.1002/bsl.827>
- Ministry of Justice. (2013). *Transforming Rehabilitation. A revolution in the way we manage offenders*. London: Ministry of Justice.
- Ministry of Justice. (2018a). *Offender Management Statistics Bulletin, England and Wales. Quarterly April to June 2018*. London: Ministry of Justice.
- Ministry of Justice. (2018b). *Strengthening probation, building confidence*. London: Ministry of Justice.

- 1  
2  
3 NHS Commissioning Board. (2012). *Commissioning fact sheet for clinical commissioning groups*.  
4 London: NHS Commissioning Board. Retrieved from [https://www.england.nhs.uk/wp-](https://www.england.nhs.uk/wp-content/uploads/2012/07/fs-ccg-respon.pdf)  
5 [content/uploads/2012/07/fs-ccg-respon.pdf](https://www.england.nhs.uk/wp-content/uploads/2012/07/fs-ccg-respon.pdf)  
6  
7 NHS Commissioning Board. (2013). *Securing Excellence in Commissioning in Offender Health*.  
8 London: NHS Commissioning Board. Retrieved from [http://www.england.nhs.uk/wp-](http://www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf)  
9 [content/uploads/2013/03/offender-commissioning.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf)  
10  
11 NHS England. (2016). *Strategic direction for health services in the justice system: 2016-2020*. Leeds:  
12 NHS England.  
13  
14 Pluck, G., & Brooker, C. (2014). Epidemiological survey of suicide ideation and acts and other  
15 deliberate self-harm among offenders in the community under supervision of the Probation  
16 Service in England and Wales. *Criminal Behaviour and Mental Health*, 24(5), 358-364.  
17 doi:[10.1002/cbm.1909](https://doi.org/10.1002/cbm.1909)  
18  
19 Plugge, E., Pari, A. A. A., Maxwell, J., & Holland, S. (2014). When prison is "easier": probationers'  
20 perceptions of health and wellbeing. *International Journal Of Prisoner Health*, 10(1), 38-46.  
21 doi:<https://doi.org/10.1108/IJPH-01-2013-0001>  
22  
23 Probation Institute. (2017). *Offender Health. PI Position Paper 2/17*. London: Probation Institute.  
24  
25 Revolving Doors Agency. (2017). *Rebalancing Act. A resource for Directors of Public Health, Police*  
26 *and Crime Commissioners, the police service and other health and justice commissioners,*  
27 *service providers and users*. London: Revolving Doors Agency.  
28  
29 Rhodes, D. (2018). Drug and alcohol services cut by £162m as deaths increase. Retrieved from  
30 <https://www.bbc.co.uk/news/uk-england-44039996>  
31  
32 Rodriguez, J., Keene, J., & Li, X. (2006). A pilot study of assessed need and service use of offenders  
33 and frequent offenders with mental health problems. *Journal of Mental Health*, 15(4), 411-  
34 421. doi:<https://doi.org/10.1080/09638230600808061>  
35  
36 Sattar, G. (2003). The Death of Offenders in England and Wales. *Crisis*, 24(1), 17-23.  
37 doi:[10.1027//0227-5910.24.1.17](https://doi.org/10.1027//0227-5910.24.1.17)  
38  
39 Sirdifield, C. (2012). The prevalence of mental health disorders amongst offenders on probation: A  
40 literature review. *Journal of Mental Health*, 21(5), 485-498.  
41 doi:[10.3109/09638237.2012.664305](https://doi.org/10.3109/09638237.2012.664305)  
42  
43 Sirdifield, C., Marples, R., Brooker, C., Denney, D., Siriwardena, N., Maxwell-Harrison, D., . . . Connell,  
44 T. (2019). *Probation Healthcare Commissioning Toolkit, A resource for commissioners and*  
45 *practitioners in health and criminal justice*. Lincoln: University of Lincoln. Retrieved from  
46 [www.probhct.blogs.lincoln.ac.uk](http://www.probhct.blogs.lincoln.ac.uk)  
47  
48 Sirdifield, C., & Owen, S. (2016). Probation's role in offender mental health. *International Journal Of*  
49 *Prisoner Health*, 12(3), 185-199. doi:[10.1108/IJPH-10-2015-0034](https://doi.org/10.1108/IJPH-10-2015-0034)  
50  
51 Skeem, J. L., & Eno Louden, J. (2006). Toward evidence-based practice for probationers and  
52 parolees mandated to mental health treatment. *Psychiatric Services*, 57(3), 333-342. doi:  
53 [10.1176/appi.ps.57.3.333](https://doi.org/10.1176/appi.ps.57.3.333)  
54  
55 Woodward, A., & Kawachi, I. (2000). Why reduce health inequalities? . *Journal of Epidemiology and*  
56 *Community Health*, 54, 923-929. doi:<http://dx.doi.org/10.1136/jech.54.12.923>  
57  
58 Yu, S.-S. V., & Sung, H.-E. (2015). Suicidal Ideation of Probationers. Gender Differences. *Crisis*, 36(6),  
59 424-432. doi:[10.1027/0227-5910/a000336](https://doi.org/10.1027/0227-5910/a000336)  
60



1  
2  
3 **Tables**  
4  
5

6 Table 1: Response Rates  
7

8  
9 Table 2: Overarching categories of services commissioned by CCGs in 2017 (N=157)  
10

11  
12 Table 3: Sub-categories of services commissioned by CCGs in 2017  
13

14  
15 Table 4: Overarching categories of services provided by Mental Health Trusts in 2017 (N=29)  
16

17  
18 Table 5: Sub-categories of services commissioned by MHTs in 2017  
19  
20  
21  
22

23 **Figures**  
24

25  
26 Box 1: FOI Request Questions  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

For Peer Review

**Box 1: FOI Request Questions****CCGs**

- 1) What health services does the CCG commission specifically for probation service clients (those seen by the National Probation Service, Community Rehabilitation Companies, or housed in probation Approved Premises) for: A) Mental health, B) Physical health? Please describe each service (e.g. 'a one-off health clinic in a probation office'), and give grade and hours of work for staff at the service(s)
- 2) Does the CCG facilitate access to mainstream (non-offender-specific) healthcare for probation service clients in any way (e.g. directly making probation staff aware of the services that it commissions and referral procedures)? If so, please could you describe how you do this?

**MHTs**

- 1) What health services does the Trust provide specifically for probation service clients (those seen by the National Probation Service, Community Rehabilitation Companies, or housed in probation Approved Premises) for: A) Substance misuse (drugs, alcohol and dual diagnosis), B) Mental health? Please describe each service (e.g. 'a one-off clinic in a probation office', offender personality disorder pathway work, or liaison and diversion work), and give grade and hours of work for staff at the service(s)
- 2) Does the Mental Health Trust facilitate access to mainstream (non-offender-specific) healthcare for probation service clients in any way (e.g. directly making probation staff aware of the services that it provides and referral procedures)? If so, please could you describe how you do this?

Peer Review

**Table 1: Response Rates**

<b>Organisation</b>	<b>Target (Total Number of This Organisation Across England)</b>	<b>FOI Requests Submitted</b>	<b>FOI Requests Completed</b>
Clinical Commissioning Groups	210	197	176
Mental Health Trusts	56	35	31
<b>TOTAL</b>	<b>266</b>	<b>232</b>	<b>207</b>

For Peer Review

**Table 2: Overarching categories of services commissioned by CCGs in 2017 (N=157)**

Type of service	A probation-specific service was commissioned or provided n (%)	Probation-specific elements within a mainstream service n (%)	CCGs that commissioned this type of service n (%)
Any health service	7 (4.5%)	12 (7.6%)	19 (12.1%)
Any mental health service	2 (1.3%)	14 (8.9%)	16 (10.2%)
Physical health service	2 (1.3%)	1 (0.6%)	3 (1.9%)

For Peer Review

**Table 3: Sub-categories of services commissioned by CCGs in 2017**

Type of service	CCGs reporting commissioning this type of service (N=157) n (%)
Diversion service	7 (4.5%)
Contribution to Multi-Agency Public Protection Arrangements (MAPPA)	5 (3.2%)
Any kind of clinic in probation offices	3 (1.9%)
Contribution to a Criminal Justice Mental Health Team	2 (1.3%)
Contribution to Integrated Offender Management (IOM)	2 (1.3%)
Substance misuse service	2 (1.3%)
Improving Access to Psychological Therapies (IAPT) service	0 (0.0%)
Personality disorder service/programme	0 (0.0%)
Any kind of service or intervention in probation Approved Premises	0 (0.0%)
Through the gate services	0 (0.0%)

**Table 4: Overarching categories of services provided by Mental Health Trusts in 2017 (N=29)**

Type of service	A probation-specific service was commissioned or provided n (%)	Probation-specific elements within a mainstream service n (%)	MHTs that provide this type of service n (%)
Any health service	20 (69.0%)	5 (17.2%)	25 (86.2%)
Any mental health service	16 (55.2%)	8 (27.6%)	24 (82.6%)
Any substance misuse service	2 (6.9%)	4 (13.8%)	6 (20.7%)

**Table 5: Sub-categories of services commissioned by MHTs in 2017**

Type of service	MHT reporting providing this type of service (N=29) n (%)
Diversion service	16 (55.2%)
Any kind of clinic in probation offices	14 (48.3%)
Any kind of service or intervention in probation Approved Premises	14 (48.3%)
Personality disorder service/programme	14 (48.3%)
Support for/contribution to Multi-Agency Public Protection Arrangements (MAPPAs)	8 (27.6%)
Alcohol Treatment Requirement (ATR) provision	5 (17.2%)
Drug Rehabilitation Requirement (DRR) provision	5 (17.2%)
Support for/contribution to Integrated Offender Management	5 (17.2%)
Through the gate services	5 (17.2%)
Support for/contribution to a Criminal Justice Mental Health Team	4 (13.8%)
Improving Access to Psychological Therapies (IAPT) service	0 (0.0%)