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

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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

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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

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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).

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

The implementation of the Health and Social Care Act 2012 introduced changes to the way that healthcare is commissioned for people in the criminal justice system in England and Wales. NHS England is responsible for commissioning healthcare for people in secure environments such as prisons and police custody. However, the majority of healthcare for offenders in the community should now be commissioned by CCGs (groups of General Practices overseen by NHS England) (Davies, Charles, & Handscomb, 2013; NHS Commissioning Board, 2012, 2013; NHS England, 2016).

In addition to this, MHTs (also commissioned by CCGs) and Local Authorities also play a role. MHTs are expected to provide health and social care services to those with mental health disorders. Local Authorities should commission public health services such as treatments for drug and/or alcohol misuse, however many councils are reducing their spending in this area (Rhodes, 2018). Moreover, the Health and Care Act 2012 also placed a duty on Local Authorities and CCGs to work in partnership

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

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

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

Methods

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

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

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

Ethical approval for the study was obtained from the Health Research Authority (17/HRA/1052), the National Offender Management Service National Research Committee (REF: 2017 – 022), and the School of Health and Social Care Ethics Committee at the University of BLANKED FOR PEER REVIEW.

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The sample

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

[Table 1: Response rates here]

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

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data analysed here represent responses from 75% (n=157) of CCGs and 52% (n=29) of MHTs in England.

Data analysis

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

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

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

Thirdly, variables were created for the specific types of service provision reported within the responses. These were simply coded as this type of service was 'reported' or 'not reported'. This enabled comparison between the 2017 responses and those provided in previous research in 2013 and 2014 (Brooker et al., 2017).

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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).

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[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

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an Improving Access to Psychological Therapies (IAPT) service or a personality disorder service or programme for people on probation.

Three CCGs reported commissioning a clinic in probation offices, and no CCGs reported commissioning any kind of support in probation Approved Premises. Additionally, two CCGs reported commissioning substance misuse services, and two CCGs reported contributing to Integrated Offender Management.

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

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

Nearly a fifth of CCG responses (19.7%) were coded as (incorrectly) stating that NHS England are responsible for commissioning healthcare for probation clients.

The Mental Health Trusts

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

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3 service specifically for probation service clients (69%), or probation-specific elements within
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5 mainstream service provision (17.2%) (Table 4).
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8 [Table 4: Overarching categories of services provided by Mental Health Trusts in 2017 here]
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14 As shown in Table 5, 20.7% of MHTs reported providing a substance misuse service either specifically
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16 for people on probation (6.9%), or with probation-specific elements (13.8%); and 82.6% reported
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18 providing a mental health service.
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21 As Table 5 shows, 17.2% of MHT responses were coded as contributing to Alcohol Treatment
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23 Requirements, and 17.2% as contributing to Drug Rehabilitation Requirements. Over half (55.2%) of
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25 responses were coded as a MHT providing a diversion service, compared to just 9.8% (n=4) in 2014.
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27 The proportion reporting providing a personality disorder service or programme had increased from
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29 17.1% (n=7) in 2014 to 48.3% in 2017. The proportion reporting contributing to MAPPA stayed stable:
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31 27.6% in 2017, compared to 26.8% in 2014.
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35 The proportion of MHTs reporting providing services within probation offices increased by 16.6% from
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37 2014 to 48.3%. The same proportion reported providing support in probation Approved Premises.
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40 In addition 1.3% reported contributing to Integrated Offender Management and 13.8% reported
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42 contributing to Criminal Justice Mental Health Teams. No MHTs reported providing IAPT or through
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44 the gate services.
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48 When asked whether they facilitate access to mainstream services for people on probation, 75.9% of
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50 MHTs stated that they did, with an additional MHT reporting that they did so via another organisation.
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53 In contrast to the CCGs, none of the MHT responses suggested that they believed NHS England to be
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55 responsible for commissioning healthcare for probation clients.
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58 [Table 5: Sub-categories of services commissioned by MHTs in 2017 here]
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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

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to answering FOI requests and the fact that this is the third year in which these questions have been asked, we anticipated that responses would be thorough.

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

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

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

It appears that many CCGs are either a) unaware of their responsibilities to understand the needs of probation clients and commission appropriate healthcare to meet those needs, b) believe that responsibility for this lies elsewhere, or c) believe that as probation clients are in the community, they have the same needs and ability to access services as the wider community.

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

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

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

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

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

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working at all levels including co-commissioning, co-location of staff and shared monitoring and feedback mechanisms.

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

There is a clear need to build on current strategies such as *Strategic Direction for Health Services in the Justice System: 2016-2020* (NHS England, 2016) and the NPS Health and Social Care Strategy 2019-2022 to ensure that we have an overarching health and justice strategy that clarifies organisational responsibilities with regards to commissioning and providing healthcare for people on probation and provides mechanisms through which accessible and appropriate healthcare can be provided.

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Tables

Table 1: Response Rates

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

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

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

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

Figures

Box 1: FOI Request Questions

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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?

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Table 1: Response Rates

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

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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 commission 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%)

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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%)

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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%)

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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 (MAPPA)	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%)

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