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Perceptions of the Effectiveness of Healthcare for Probationers

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Abstract

Purpose: This study sought to investigate the views of commissioners, providers, and criminal justice staff on how effective current healthcare provision is at meeting the health needs of people on probation. Understanding perceptions of what constitutes effective provision, where barriers are encountered, and where improvements could be made, is an important step towards improving access to care for this hard-to-reach group.

Approach: The research was part of a wider study. This article focuses on findings from case studies conducted via semi-structured telephone interviews with 24 stakeholders in a purposive sample of six geographical areas of England. Interviews were conducted by researchers from a variety of backgrounds, and an individual with lived experience of the criminal justice system. Data were analysed using thematic analysis.

Findings: Participants provided examples of effective healthcare provision, which largely involved multi-agency partnership working. It was apparent that there are many barriers to providing appropriate healthcare provision to people on probation, which are underpinned by the complexity of this population's healthcare needs, the complexity of the healthcare landscape, and problematic commissioning processes.

Practical Implications: Improvements are needed to provide appropriate and accessible healthcare that meets the needs of people on probation, and thereby reduce health inequalities. These include shared targets, improved funding, clearer pathways into care, and giving probation a voice in commissioning.

Originality: This is the first study of commissioner, provider, and criminal justice staffs' views on the effectiveness of current healthcare provision at meeting the health needs of people on probation.

Keywords: probation; healthcare; health; commissioning; criminal justice system; offender health

Background

Internationally, there is a paucity of literature on the health needs of people on probation, but the literature that does exist suggests that there is a high level and complexity of health problems within this group when compared to the general population (Sirdifield et al., 2020, Brooker et al., 2020, Sirdifield et al., 2019c). Often people on probation are not registered with a GP, and do not engage with health services until they reach crisis point. Indeed, people on probation encounter barriers to

service access at the personal level (e.g. a lack of motivation to attend, homelessness), service level (e.g. a lack of appropriate provision for people with both a substance misuse problem and a mental illness), and societal level (e.g. stigma) (Lang et al., 2014, Melnick et al., 2008, Plugge et al., 2014, Pomerantz, 2003, Revolving Doors Agency, 2013).

This highlights the need to commission and provide high quality and accessible health services that meet the needs of people on probation to improve the health of these individuals and thereby reduce health inequalities. In addition, this would produce wider community dividends through things like improved compliance with probation, and reductions in both re-offending and in avoidable use of expensive crisis care like Emergency Departments (Revolving Doors Agency, 2017). To date, very little research has been conducted into the most effective ways of improving healthcare outcomes for people on probation (Brooker et al., 2020, Sirdifield et al., 2020, Sirdifield et al., 2019c). Moreover, very few joint strategic needs assessments consider those on probation (Revolving Doors Agency, 2017). Alongside understanding health needs, a first step towards reducing health inequalities and improving access to care is to understand how healthcare is provided, professionals' perceptions of what effective provision looks like, what is working well, and where improvements are needed. To our knowledge, no-one has systematically mapped the availability of healthcare for people on probation, or how effective stakeholders feel that current systems and procedures for providing healthcare for this group are.

This study was part of a wider research study investigating what systems, policies and procedures exist across England to deliver healthcare to people on probation. Figures published for April to June 2019 show that there were 254,165 people on probation in England and Wales during this quarter (Ministry of Justice, 2019b). Alongside public protection, probation providers have a rehabilitative role, which includes consideration of these individuals' health and social care needs (Ministry of Justice, 2013, National Probation Service, 2019). Currently, there are plans for probation provision to be restructured, following what many regard as an ideologically and politically motivated partial privatisation through *Transforming Rehabilitation* (Ministry of Justice, 2013, Kirton and Guillaume, 2019, HC Deb, 2019). However, at the time that the research was undertaken, individuals on probation in England and Wales that were considered as low or medium risk of serious harm were supervised by staff at Community Rehabilitation Companies, whilst those that were high risk were supervised by National Probation Service staff (Ministry of Justice, 2013). This includes individuals that are temporarily housed in probation Approved Premises (controlled accommodation). All three of these settings were included in the definition of probation, and the study considered both physical and mental healthcare provision. The topic was investigated through national surveys, analysis of policy and procedure documents, and case studies based on survey findings and semi-structured

interviews in six areas of the country. Findings from the interviews for the case studies are presented here.

The case studies had three principal aims. Firstly, to increase understanding of stakeholder (commissioner, provider, and criminal justice staff) perceptions of the current systems and procedures in delivering healthcare to individuals on probation. Secondly, to identify any barriers to healthcare service delivery for people on probation. Finally, to establish how improvements to healthcare delivery to this group could be achieved.

Methods

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 Lincoln.

The wider study incorporated both qualitative and quantitative methodological techniques. Surveys about healthcare provision were sent out to lead staff in all Clinical Commissioning Groups (CCGs), Mental Health Trusts (MHTs), Public Health Departments, National Probation Service (NPS) areas, Community Rehabilitation Companies (CRCs), and probation Approved Premises across England. To improve the initial overall response rate of 23.9%, non-participating CCGs, Public Health Departments and MHTs received a freedom of information (FOI) request asking key questions from the surveys. This increased the response rate on these questions to 78.8%. Findings from the surveys provided a broad picture of the healthcare available across the country (Sirdifield et al., 2019a, Sirdifield et al., 2019b).

After the survey and FOI responses were analysed, six regions were selected in which to conduct case studies to build a more in-depth picture of stakeholders' perceptions of healthcare provision in these areas. Regions were selected based on the survey findings to achieve maximum variation in the amount and nature of healthcare provision reported in the responses. That is, regions reporting very little probation-specific healthcare availability were selected to explore potential barriers, and regions reporting some probation-specific provision were selected to explore perceptions of the effectiveness of this provision.

Data were collected through semi-structured follow-up telephone interviews with criminal justice staff, and senior staff from organisations commissioning and providing care in each region. Participants were largely individuals who had participated in the surveys. These individuals had originally been selected on the basis of appropriateness (having professional roles and knowledge

relevant to the study), and adequacy (ensuring that sufficiently rich data were collected for no new themes to be emerging) (Morse and Field, 1996). In addition, these participants were given the option of suggesting frontline staff and/or representatives from any relevant partner organisations to take part in the interviews to inform the case studies. This resulted in additional interviews being conducted with a Police and Crime Commissioner and frontline staff as shown in Table 1.

[Table 1 here]

Table 1: Participants (n=24)

Area	National Probation Service	Probation Approved Premises	Community Rehabilitation Company	Public Health Department	Mental Health Trust	Police Crime Commissioner
1	2	1	1	1	0	0
2	1	1	0	1	1	0
3	1	0	1	1	0	1
4	1	1	1	1	0	0
5	1	1	0	1	1	0
6	2	0	0	1	0	0

Interviews were conducted by researchers from a variety of backgrounds, including social policy, mental health, and researchers with experience of working in the criminal justice system; and an individual with lived experience of the criminal justice system. All interviewers contributed to the development of the interview schedule.

Interviews were recorded, anonymised, and transcribed verbatim. They were analysed using thematic analysis, a method appropriate to studies of perceptions and views (Braun and Clarke, 2006, Braun and Clarke, 2014), using NVivo 11 software. The researchers familiarised themselves with the data by reading through the transcripts. Then fragments of text were coded based on their meaning independently by three members of the research team and then compared. Thus, as detailed in Nowell et al., (2017), the credibility of the analysis was enhanced through ensuring that all data received equal attention and each excerpt was independently coded into as many categories as were relevant (Nowell et al., 2017: 7). Following discussion amongst the researchers, the initial codes were then organised into initial over-arching themes in line with the above aims. The researchers met regularly to reflect on the coding and revise it as needed - combining or splitting themes. The themes were iteratively developed into a thematic map (Figure 1). This was built through an iterative process of discussion and diagramming that explored the content of, and relationships between themes

(Nowell et al., 2017). Attention was paid to negative cases throughout, and coding was compared across different geographical areas and types of organisation to look for similarities and differences. The transferability of findings was considered through comparison to the wider literature.

Results

Perceptions of the effectiveness of current systems and procedures

The research aimed to increase understanding of stakeholders' perceptions of the current systems and procedures for delivering healthcare to individuals on probation. Responses indicated that participants often perceived effective provision as involving multi-agency partnership working (Figure 1), and that partnerships improved organisations' understanding of each other's roles and responsibilities. Numerous examples of partnership working were provided, including local Public Health Boards, Integrated Offender Management Boards, Integrated Health and Justice Commissioning Groups, Integrated Care Systems, Multi-Agency Public Protection Arrangements (MAPPA), the Offender Personality Disorder Pathway, partnerships between primary care and probation that provide a dedicated GP for Approved Premises, and multi-agency approaches to commissioning healthcare.

The latter was seen as a way of ensuring that money was used well and that partners could shape the nature of healthcare provision:

> The Police and Crime Commissioner is taking a heavy lead on what that looks like; how it is going to work; and on the back of that, we, as in the multi-agency approach, we are all getting involved in the early discussions: what does this look like; what's the best way to use the money [Area 3, CRC]

> Participants discussed gaps in healthcare provision that people on probation may fall through. Third sector organisations were cited as effective as they plugged these gaps. Some third sector provision was cited as effective by probation staff because, it provided timely, accessible support. In some cases, these services were accessible for longer than services provided by other organisations. Also, these services were viewed positively because they provided feedback to probation on service users' attendance and progress made.

Providing counselling services to address mental health or emotional wellbeing needs was also thought to be an effective way of meeting the needs of some service users:

> We have people with low risk of serious harm who have significant issues, and counselling is really appropriate for them. We have very high-risk people where counselling is absolutely what they need [Area 3, CRC]

Finally, participants discussed effectiveness in relation to monitoring of health needs and the impact of healthcare provision. Some data were reported to be collected by probation and other agencies on service users' health needs, and probation sought feedback on treatment outcomes. In some cases, providing feedback was part of a service's contract. However, it was apparent that ideally more resources would be provided to enable public health staff to make more use of the information available to them to better understand how well services are performing.

A number of participants considered that extra data analytical resources could assist in helping probation to demonstrate the health needs of their caseload to commissioners:

> What I struggle to do is how can I give a really good account of the story of our service user health; and I don't have the tools to do that; I don't have the resources to do that anymore. [Area 1, NPS]

Participants highlighted a need to consider exactly what quality indicators of an effective service would look like. Different agencies may have targets for different things, for example, re-offending outcomes versus health outcomes. The desirability of specific outcomes and how they should be measured ideally needed to be agreed on a cross-agency basis as part of the commissioning process.

Barriers to ensuring accessible and appropriate healthcare provision

GPs were described as being the gateway to accessing many healthcare services, particularly mental health services, which often will not accept self-referrals, or referrals from other agencies. However, our participants stated that some people on probation encounter barriers to registering with GPs, which may include being unable to register until after release for those transitioning from custody. This can cause problems with continuity of care, including with securing continued access to medication:

> Residents can't register with a local GP until they come out of prison, which then means that once they get to (Approved Premises) they fill in the registration forms as anybody else in the local town would, go across to the local GP centre and register, and then wait for their initial appointment which is usually within three or four weeks. So, people coming out of a prison with a maximum of two weeks medication which is the norm, will then be at risk of running out of medication [Area 5, Approved Premises]

Some respondents also reported that GPs do not always have access to medical history prior to an individual's release, and probationers may not know their NHS number, or have a permanent address.

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In some areas, GPs were reluctant to register people on probation - sometimes due to concerns about behaviour difficulties, or due to people having previously been banned from a service. However, in other areas, there appeared to be a good relationship between probation and GPs:

> Certain GPs can be very sympathetic to the residents and the health needs and will make it their priority to make sure that everybody gets the same treatment whether they are in [Approved Premises] or in the community [Area 5, Approved Premises]

There were examples of work to overcome problems with continuity of care. For example, substance misuse services employing their own medical practitioners to write prescriptions - thereby avoiding possible obstacles caused by prescriptions having to be given by a GP; and the same organisation providing a service in both prison and community settings making it easier to achieve continuity of care.

Sometimes people on probation are perceived by health and justice staff as lacking motivation to attend health services, and some may be demotivated if they had to wait too long for an appointment:

> If people don't 'rock up' for the appointed times, and they miss a couple of appointments, they are deemed not willing to engage [Area 1, NPS]

> They are not often not motivated, and when they do have a splurge of motivation, they need to be seen then [Area 5, NPS]

Whether or not an appointment is voluntary or part of probation conditions was also perceived as impacting on levels of motivation:

> If it is a licensed condition, it is a bit easier because you have the warning of enforcement if they don't attend; but if it is a voluntary thing then motivation can be a big obstacle because obviously they don't have to go [Area 4, NPS]

Opening hours could also be a barrier to service access sometimes, as was evident in relation to both mental and physical health:

> So mental health is a bit of a problem; and physical health can be a bit of a problem here, because in [county] we don't have an A&E facility after I think 9.00 pm…that is a real problem for many…because they don't always, or very rarely have the support network around us to be able to get to the hospital in [county] [Area 5, NPS]

Whilst there were some efforts to provide appropriate pathways for those with complex health problems to access care, problematic referral processes were still reported as a barrier to effective provision. This encompassed difficulties with access to GPs, and problems experienced as a result of reduced funding. This resulted in people falling through the cracks between services as they did not meet the thresholds for access, or were excluded due to the complexity of their health problems:

> I think the big struggle for a lot of CRCs/probation clients is the threshold around mental health. I think quite often we are getting people identified as having contributory, personality disorder issues or low level mental health issues that whilst in prison may be dealt with through the in-reach or existing mental health provision in the prison, because of the different risks associated with custody. Whereas once they are back out in the community, they may not reach the threshold for primary or secondary mental health services [Area 6, Public Health]

For probation, it can be necessary to prioritise risk management over addressing health problems. Consequently, probation systems were necessarily focused primarily on this. Significantly health was not always viewed as an integral part of the Offender Assessment System (OASys) assessment with the probation service:

> Health is discussed and looked at as part of the OASys assessment, but it isn't an integral part of it, I suspect because primarily because it is not about risk. We cover things like suicide and self-harm; those sorts of things but again it comes back to the mental health side. The actual everyday health things like you were saying about GPs, maybe dentists those sorts of things are not things that are necessarily covered [Area 1, NPS]

Whilst participants pointed to partnership working as a characteristic of effective service provision, it could be difficult for some services to engage in partnership working. This was particularly apparent in relation to CCGs:

> One of the gaps on our patch has been the CCG having the capacity to engage with the Community Safety Partnership…and that is not necessarily a criticism of CCG. I think one of the things to note is that CCG are very underpowered; not like the primary care trusts; not that size; they haven't got the expertise; they are very stretched [Area 5, Public Health]

Finally, under this theme, participants discussed the under use of requirements such as drug rehabilitation requirements (DRR), alcohol treatment requirements (ATR) and mental health treatment requirements (MHTR) as a potential barrier to service access and health improvement.

Improvements in service delivery

One of the main areas for improvements that participants raised was funding, which had been reduced over time with the onset of austerity:

> Funding! Nothing comes for free…The problem is that psych services are not necessarily cheap to run. And actually, it is making sure that we do fund it. I think if we take it away from the offender population, actually just accessing treatment for the general population is quite difficult [Area 3, CRC]

Participants made suggestions about ways of addressing the problems that they had identified around continuity of care and access to medication post-release from prison. These included establishing pathways around GP registration, and that medication should be delivered to Approved Premises as it is in care homes, to be securely kept and administered as required.

Drop-in services at Approved Premises were suggested as a way of improving working between GPs, mental health services, and AP residents. Having a GP visiting the premises was seen as being potentially beneficial:

> I think it would be useful if we could have some sort of drop in surgery type service here at the hostel…I think they have had that historically in the past where someone from mental health would come and you know, just to meet with people, do a drop in type service so that, and also for staff as well, they say listen I'm concerned about this guy, can you just have a chat with him and give us your opinion, that would be an improvement for service users and staff [Area 2, Approved Premises]

Co-commissioning and shared targets were supported widely as a means of improving service provision, monitoring of the effectiveness of services, and partnership working.

Along with shared targets there was recognition of a need to continue to provide and improve inter-agency training as a way of increasing the knowledge of different professionals and building mutual respect.

For some participants there needed to be a change in how services were offered, having a one-stop shop for assessment and referrals:

> I briefly mentioned that whole thing around a holistic assessment of offender needs. I think that is really key; and it is something we are really keen to build into the service that we are commissioning. We know that the drug and alcohol issues that offenders may be experiencing are not in isolation, and we are very keen to have the offender assessed based on whatever needs that they may have [Area 3, OPCC]

Finally, it was apparent that work was underway regarding new ways of working to overcome some of the existing barriers to effective healthcare provision for probation clients. This included an NPS-based pilot project around autism, considering the idea of specialist mental health probation officers; integrated models of care; learning about the benefits of interventions by peer professionals in GP practices and A&E; work to create a digital wellbeing service; employing Community Navigators; multi-agency working within a hostel for the homeless; and co-working between probation and public health via an Offenders with Complex and Additional Needs Service.

Commissioning and Complexity

The data analysis highlighted two over-arching themes that influenced many of the other areas described here. These were the commissioning process, and complexity. Several aspects of the commissioning process made ensuring that there is appropriate healthcare provision for people on probation complicated. Firstly, the number of organisations involved in commissioning healthcare. Those discussed by participants included CCGs, MHTs, CRCs, Public Health, and Police and Crime Commissioners. Some participants felt that the commissioning landscape was too fractured and would benefit from more joined up working:

> I think this is one of the issues that localism has highlighted, that it has fractured the whole commissioning landscape in the last five or six years. That is the key problem: people are doing things in their area; so, NHS England are doing their prisons; we've been commissioning drug services; and everybody hasn't got time to think about what the connection is with the other area and what the crossovers are. We need some quite clear, national steer as to what it is [Area 4, Public Health]

However, one participant argued that it was actually regionalism that was the problem, and the focus needed to be on smaller geographical areas:

> My abiding frustration is that NHS England still have a regional commissioning responsibility with regard to health and justice, and it is not sensitive to the needs of specific localities [Area 6, Public Health]

Secondly, the short-term nature of funding arrangements could also be problematic:

> Locally we know there has been definitely a loss of confidence due to a number of things such as the change in providers; and having this service funded through an annual grant, has meant that there have been periods where the service actually wasn't available because one service was shutting up shop, and the next service wasn't able to get up and running [Area 3, OPCC]

Thirdly, changing approaches to commissioning services such as substance misuse provision. This may previously have been commissioned specifically for people on probation, but was now often commissioned as a generic offer, with provision for court orders as part of this. Some viewed this positively as it should mean that those in contact with probation are able to access the same things as those in the wider community. However, other participants felt that this made it harder for probation to build relationships with substance misuse service staff, and that services needed to be made more aware of the need to share information with probation about the attendance and progress of clients that were subject to drug rehabilitation or alcohol treatment requirements.

Commissioning was further complicated by the complexity of the system as commissioning processes could be further complicated by geographical boundaries, which were subject to change:

> We've had people quite clearly unwell who [place 1] are refusing to take responsibility for, and their home area [place 2] are refusing to take responsibility for because [place 2] are saying they are in [place 1], they are not on our patch if you like, [place 1] are saying they are temporary, they don't belong to us…so people effectively fall through the cracks...and that happens…not just with mental health, but that will happen with people…with significant disabilities…people who have had strokes; people who are unable to walk; people who have been directed to APs who quite obviously shouldn't have been directed to APs [Area 2, Approved Premises]

As well as the complexity of geographical boundaries, participants discussed the complexity of the health landscape:

> Well, we have one large STP [sustainability and transformation partnership] and then we have two others that cross over into two other top tier authorities. So, we have an increasingly complex health landscape [Area 6, Public Health]

Multi-agency public protection arrangements (MAPPA), which inform the management of those convicted of violent and sexual offences, were cited as an example of effective service provision. They were also seen as providing an opportunity for health care staff to work with criminal justice staff to help them to navigate through the complexities of the health landscape:

> I think we really need proper engagement of health care professionals and specialists with the MAPPA process to help us navigate treatment channels and referral routes [Area 3, NPS]
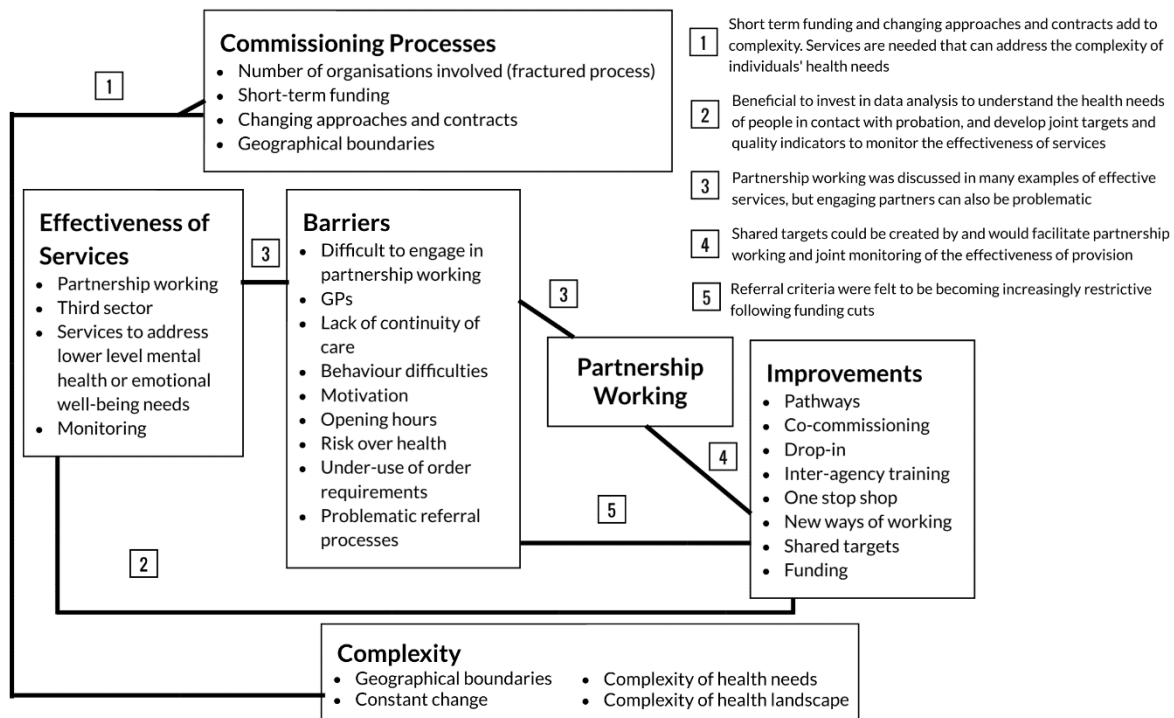
Complexity also resulted from constant change within service provision – in terms of what was provided, which staff and organisations provided it, who was eligible to access the service, and where it was available. This was difficult for staff to keep up with:

> It was really hard to maintain a handle on what was out there; who was eligible in terms of the variable criteria; building good rapport with those services so you get the communication flow right; so you get feedback also and support for people to engage…I think that is more complicated now [Area 1, NPS]

Moreover, providing healthcare for those on probation was challenging due to the complexity of their health needs. Current provision could be inadequate to address this, and work was being undertaken around this:

> So, the mental health team is split into very specialised groups: learning needs or autism spectrum; everything gets split up into very specific areas. If you have someone with very specific complex needs, either they fall through the gaps of these specific areas, or they can't be referred [Area 5, Mental Health Trust]

Figure 1: Thematic Map

Commissioning Processes
- Number of organisations involved (fractured process)
- Short-term funding
- Changing approaches and contracts
- Geographical boundaries

Effectiveness of Services
- Partnership working
- Third sector
- Services to address lower level mental health or emotional well-being needs
- Monitoring

Barriers
- Difficult to engage in partnership working
- GPs
- Lack of continuity of care
- Behaviour difficulties
- Motivation
- Opening hours
- Risk over health
- Under-use of order requirements
- Problematic referral processes

Partnership Working

Improvements
- Pathways
- Co-commissioning
- Drop-in
- Inter-agency training
- One stop shop
- New ways of working
- Shared targets
- Funding

Complexity
- Geographical boundaries
- Constant change
- Complexity of health needs
- Complexity of health landscape

1 Short term funding and changing approaches and contracts add to complexity. Services are needed that can address the complexity of individuals' health needs

2 Beneficial to invest in data analysis to understand the health needs of people in contact with probation, and develop joint targets and quality indicators to monitor the effectiveness of services

3 Partnership working was discussed in many examples of effective services, but engaging partners can also be problematic

4 Shared targets could be created by and would facilitate partnership working and joint monitoring of the effectiveness of provision

5 Referral criteria were felt to be becoming increasingly restrictive following funding cuts

Discussion

This study investigated the perceptions of commissioners, providers, and criminal justice staff of the effectiveness of the current systems and procedures for providing healthcare to people on probation, what (if any) barriers were encountered to ensuring accessible and appropriate healthcare provision for this group, and where improvements could be made.

Findings were based on interviews with staff from a variety of organisations in six areas of England and provide insight into their views of the effectiveness of provision in these areas. Whilst interviews were only conducted in six areas of England, findings reflect the wider literature, which shows that people on probation have complex health needs and may encounter many system-level barriers to accessing healthcare, including problematic referral pathways, limited opening hours, difficulties in accessing GPs, and problems around continuity of care (Lang et al., 2014, NHS England, 2016, Plugge et al., 2014, Revolving Doors Agency, 2017, Ministry of Justice, 2019a). Thus whilst some findings may be a result of the particular time and context within which the research was conducted, others may be more broadly applicable to probation elsewhere and/or the wider issues around how best to provide healthcare that meets the needs of marginalised and underserved populations.

Many of the issues identified in this study are perennial system-level problems. For example, GP registration and continuity of care still appeared to be problematic for some people on probation in our participants' experience, despite the fact that GP practices have been required to accept requests to pre-register prisoners approaching the end of their sentence since 2017 (Ministry of Justice, 2019a: 9). The data show that probation staff struggle to navigate an increasingly complex and ever-changing health landscape, where building and maintaining relationships with service commissioners and providers, and identifying which services are available, how they can be accessed, and by whom, are difficult and ongoing challenges. It is also noteworthy that the research was undertaken at a time when the probation service was split into CRCs and the NPS. The philosophical opposition to the changes that had been made could also have led to a lowering of morale and questions amongst some participants over their professional roles and responsibilities, which may have impacted on findings (Kirton and Guillaume, 2019).

People on probation may also experience personal-level barriers to accessing care, such as a lack of motivation. In some cases, participants believed that this could be addressed through more timely access to care to capitalise on moments when people are motivated, and through improved use of requirements from the courts. This is supported to an extent by the wider literature (Gregoire and Burke, 2004, Hearnden, 2000, Martin et al., 2003, Martin et al., 2004), although compulsory treatment does not always result in better treatment retention (McSweeney et al., 2007). These system and

personal-level barriers were consistent across the case study areas and were recognised by participants based in a variety of different organisations.

The participants were able to provide examples of what they perceived to be effective service provision. These included examples of multi-agency working, third sector provision, and a suggestion that counselling is an effective way of meeting the needs of both high and low-risk probationers' mental health and emotional wellbeing needs. A recent systematic review suggests there is a dearth of evidence on the most effective ways of producing good health outcomes and improving access to care for people on probation in the literature (Brooker et al., 2020, Sirdifield et al., 2020), making it difficult to assess the transferability of these findings. Consequently, whilst participants may indeed have provided examples of effective practice, there is a clear need for research to investigate, and, (where it is found), provide and share evidence of this to inform future investment and practice. Moreover, the wider literature points to the need to investigate the specific characteristics of the examples of effective practice that participants cited in more detail to inform commissioning. For example, to ascertain which therapeutic approaches within counselling are most effective and for whom; and which type, level and duration of condition different counselling models can best support (see for example Gibbard and Hanley, 2008). There is a clear case for investment in research to support evidence-based and cost-effective practice.

On the whole it is apparent from the interview data that access to health services for those on probation continues to be problematic. The wider literature suggests that this results in poor outcomes for many, such as breach of orders and re-imprisonment, poor physical and mental health, self-harm and suicide (Revolving Doors Agency, 2017, Social Exclusion Unit, 2002, Yu and Sung, 2015).

Changes to practice are required - criminal justice staff should not be left to take responsibility for facilitating access to care for unwell individuals. When participants' provided examples of effective services at a local level, this largely involved multi-agency partnership working. However, establishing and maintaining partnerships is not always easy. More still needs to be done to improve inter-agency communication to ensure that practitioners have access to the types of information that they most need. There needs to be a sustained and centrally driven effort to develop partnership working between health and criminal justice agencies, in particular to improve the relationship with Clinical Commissioning Groups, who often appear to be hard to engage.

The findings of this study suggest that there is a need for system reform on a wide scale to create clearer referral routes from probation into healthcare, improve communication between criminal justice and health agencies to ensure that probation staff receive information on attendance and progress made; and to create more joined up systems that enable partnership working at all levels

including commissioning, training, co-location of staff, shared targets and quality indicators, and regular meetings. Arguably, these reforms could be particularly beneficial in times of reduced funding where innovative thinking can enable staff to make the best use of scarce resources.

Many of the above recommendations have been called for, and in some cases shown to be effective before now (Hatfield et al., 2004, Alemi et al., 2006, Hearnden, 2000, Skeem and Eno Louden, 2006). However, take up is piecemeal at best. It may be that the new Combined Authorities and Integrated Care Systems will facilitate the changes called for. There is a need for dedicated funding for effectiveness research, and for an overarching policy supported by appropriate investment to move this agenda forward.

Conclusion

Whilst very little formal research has been conducted into the most effective ways of improving healthcare outcomes for people on probation, participants in this study provided examples of what they perceived to be effective healthcare provision. These examples largely involved multi-agency partnership working and timely access to care. However, it was apparent that there are many system and personal-level barriers to providing effective healthcare provision to people on probation. These are underpinned by the complexity of this population's healthcare needs, the complexity of the healthcare landscape, and problematic commissioning processes.

The probation service at the time of writing is once again likely to be subjected to major structural reform as the partial privatisation process is reversed. This will undoubtedly have an impact on the ability of the service to engage effectively with the providers of healthcare for this particular user group. At a point where changes are being made it is important for policy makers to note the crucial need for reform and improvements in order that appropriate and accessible healthcare can be provided that meets the needs of people on probation, and thereby reduce health inequalities. These include changes to individuals' practice – for example, GPs accepting requests to register individuals prior to release from prison; and wider system-level reforms. The latter include establishing shared targets and quality indicators across organisations; improved, and ideally stable, funding; clearer pathways into care; appropriate opening hours; giving probation a voice in commissioning, and services that can address complex health needs. Such change needs to be backed by appropriate overarching policy documents, and investment in both resources and robust effectiveness research. Ultimately, this may lead to improved health for people on probation, reductions in re-offending, and savings for the NHS from a reduction in avoidable use of crisis care.

References

Alemi, F., Taxman, F., Baghi, H., Vang, J., Thanner, M. and Doyon, V. (2006), "Costs and benefits of combining probation and substance abuse treatment", *The Journal of Mental Health Policy and Economics,* Vol. 9 No. 2, pp. 57-70.

Braun, V. and Clarke, V. (2006), "Using thematic analysis in psychology", *Qualitative Research in Psychology,* Vol. 3 No. 2, pp. 77-101.

Braun, V. and Clarke, V. (2014), "What can "thematic analysis" offer health and wellbeing researchers?", *International Journal of Qualitative Studies on Health and Well-being,* Vol. 9 No. 1.

Brooker, C., Sirdifield, C. and Marples, R. (2020), "Mental health and probation: a systematic review of the literature", *Forensic Science International: Mind and Law,* Vol. 1 No. 100003, pp. 1-9.

Gibbard, I. and Hanley, T. (2008), "A five-year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care", *Counselling and Psychotherapy Research,* Vol. 8 No. 4, pp. 215-222.

Gregoire, T. K. and Burke, A. C. (2004), "The relationship of legal coercion to readiness to change among adults with alcohol and other drug problems", *Journal of Substance Abuse Treatment,* Vol. 26, pp. 35-41.

Hatfield, B., Ryan, T., Pickering, L., Burroughs, H. and Crofts, R. (2004), "The mental health of residents of approved premises in the Greater Manchester probation area: A cohort study", *The Probation Journal (The Journal of Community and Criminal Justice),* Vol. 51 No. 2, pp. 101-115.

HC Deb (2019), "Probation Reform".

Hearnden, I. (2000), "Problem drug use and probation in London: an evaluation", *Drugs: education, prevention and policy,* Vol. 7 No. 4, pp. 367-380.

Kirton, G. and Guillaume, C. (2019), "When welfare professionals encounter restructuring and privatization: The inside story of the probation service of England and Wales", *Work, Employment and Society,* Vol. 33 No. 6, pp. 929-947.

Lang, N., Hillas, A., Mensah, M., Ryan, S. and Glass, L. (2014), "Linking probation clients with mainstream health services: Experience in an outer London borough", *Probation Journal,* Vol. 61 No. 3, pp. 278–285.

Martin, B. K., Clapp, L., Alfers, J. and Beresford, T. P. (2004), "Adherence to court-ordered disulfiram at fifteen months: A naturalistic study", *Journal of Substance Abuse Treatment,* Vol. 26, pp. 233-236.

Martin, B. K., Clapp, L., Bialkowski, D., Bridgeford, D., Amponsah, A., Lyons, L. and Beresford, T. P. (2003), "Compliance to supervised disulfiram therapy: A comparison of voluntary and court-ordered patients", *The American Journal on Addictions,* Vol. 12, pp. 137-143.

McSweeney, T., Stevens, A., Hunt, N. and Turnbull, P. J. (2007), "Twisting arms or a helping hand? Assessing the impact of 'coerced' and comparable 'voluntary' drug treatment options", *British Journal of Criminology,* Vol. 47, pp. 470-490.

Melnick, G., Coen, C., Taxman, F. S., Sacks, S. and Zinsser, K. M. (2008), "Community-based co-occurring disorder (COD) intermediate and advanced treatment for offenders", *Behavioral Sciences and the Law,* Vol. 26, pp. 457-473.

Ministry of Justice (2013), "Transforming Rehabilitation. A revolution in the way we manage offenders", London, Ministry of Justice.

Ministry of Justice (2019a), "Government response to the ACMD report on custody-community transitions", London, Ministry of Justice.

Ministry of Justice (2019b), "Offender Management Statistics Bulletin, England and Wales. Quarterly April to June 2019", London, Ministry of Justice.

Morse, J. M. and Field, P. A. (1996), *Nursing Research: The Application of Qualitative Approaches,* Chapman and Hall, London.

National Probation Service (2019), "National Probation Service Health and Social Care Strategy 2019-2022", London, National Probation Service.

NHS England (2016), "Strategic direction for health services in the justice system: 2016-2020", Leeds, NHS England.

Nowell, L. S., Norris, J. M., White, D. E. and Moules, N. J. (2017), "Thematic analysis: Striving to meet the trustworthiness criteria", *International Journal of Qualitative Methods,* Vol. 16, pp. 1-13.

Plugge, E., Pari, A. A. A., Maxwell, J. and Holland, S. (2014), "When prison is "easier": probationers' perceptions of health and wellbeing", *International Journal Of Prisoner Health* Vol. 10 No. 1, pp. 38-46.

Pomerantz, J. M. (2003), "Treatment of mentally ill in prisons and jails: Follow-up care needed", *Drug Benefit Trends,* Vol. 15 No. 6, pp. 20-21.

Revolving Doors Agency (2013), "Balancing Act. Addressing health inequalities among people in contact with the criminal justice system. A briefing for Directors of Public Health", London, Revolving Doors Agency, Probation Chiefs Association, Public Health England.

Revolving Doors Agency (2017), "Rebalancing Act. A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users", London, Revolving Doors Agency.

Sirdifield, C., Brooker, C. and Marples, R. (2020), "Suicide and Probation: a systematic review of the literature", *Journal of Mind and Law (In press),* Vol. 100012.

Sirdifield, C., Denney, D., Marples, R. and Brooker, C. (2019a), "Researching healthcare availability for probation clients: An illustration of methodological challenges and lessons in surveying organisations", *British Journal of Community Justice,* Vol. 15 No. 2, pp. 41-58.

Sirdifield, C., Marples, R., Brooker, C. and Denney, D. (2019b), "NHS commissioning in probation in England – still on a wing and a prayer", *Health and Social Care in the Community,* Vol. 27 No. 5, pp. e697-e704.

Sirdifield, C., Marples, R., Brooker, C., Denney, D., Siriwardena, N., Maxwell-Harrison, D., Strachan, S. and Connell, T. (2019c), "Probation Healthcare Commissioning Toolkit, A resource for commissioners and practitioners in health and criminal justice", Lincoln, University of Lincoln.

Skeem, J. L. and Eno Louden, J. (2006), "Toward evidence-based practice for probationers and parolees mandated to mental health treatment", *Psychiatric Services,* Vol. 57 No. 3, pp. 333-342.

Social Exclusion Unit (2002), "Reducing re-offending by ex-prisoners - Report by the Social Exclusion Unit", London, Office of the Deputy Prime Minister.

Yu, S.-S. V. and Sung, H.-E. (2015), "Suicidal Ideation of Probationers. Gender Differences", *Crisis,* Vol. 36 No. 6, pp. 424-432.