

Probation Healthcare Commissioning Toolkit

A resource for commissioners and practitioners in health and criminal justice

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Contents

Introduction	3
Policy – Organisations’ Roles and Responsibilities	6
Community orders with implications for health	11
Likely health needs of people in contact with probation	18
Substance Misuse	18
Mental Health	22
Suicide and Self-Harm	25
General Health	27
What services are available, what should be available and how can these services best be provided?	28
Measuring and improving health, and the quality of healthcare that people in contact with probation receive.....	46
Recommendations	50
Contact us	53
References	54

Introduction

On 30th of June 2018 there were 261,196 people on probation in England and Wales¹ (Ministry of Justice 2018). Not all people in contact with probation² are the same. For example, some will have been to prison for serious offences, whilst others will have been convicted of minor offences and will not have been to prison. However, people in this group are often deprived, marginalised, or vulnerable and are more likely to have certain health needs (e.g. mental health, drug and alcohol problems) when compared to the general population.

Many people in contact with probation will experience more than one health problem at any given time and often experience other negative social determinants of health such as unemployment and homelessness. Very little research has been done on this population and their voice is seldom heard by those commissioning healthcare or those providing oversight and scrutiny of healthcare services.

Despite the high level and complexity of health needs in this group, people in contact with probation face both system-level and personal-level barriers to accessing healthcare. Many people in contact with probation are not registered with a GP, and/or only access healthcare during crises (Revolving Doors Agency 2013). Sometimes services simply do not exist to meet their needs, and sometimes services are difficult to access due to things like their location, opening hours, restrictive referral criteria and poorly understood access routes. Moreover, the health needs of people in contact with probation and how best to structure service provision to make healthcare accessible to and appropriate for this group are not always considered by healthcare commissioners.

There are a number of reasons why we need to address the healthcare needs of people in contact with probation. These include:

- This group of people are often marginalised, deprived and in poor health, so improving the health of this population is essential if we are serious about reducing health inequalities in society and achieving equivalence of care. There is a need to reduce the high rates of morbidity and mortality in this group

¹ This figure includes those on community sentences, suspended sentences, pre-release supervision and post-release supervision that are in contact with either the National Probation Service (NPS) or a Community Rehabilitation Company (CRC)

² By 'people in contact with probation' we mean adults on community sentences or supervision in the community and people on licence that are in contact with either the National Probation Service (NPS) or a Community Rehabilitation Company (CRC)

- Good health is a recognised pathway out of reoffending (NOMS 2004), so by addressing people's health problems, we will also be contributing to reducing offending behaviour, and thereby reducing the number of victims of crime, improving safety in society, and saving costs for criminal justice and health services
- Ensuring that people in contact with probation engage with healthcare at an early stage rather than when they reach crisis point can potentially produce cost-savings for the NHS from less unnecessary use of urgent and emergency services and missed appointments (Revolving Doors Agency 2013)
- Being in good health can help people to complete probation and to do other things that reduce their chances of re-offending, such as finding and keeping employment
- Improving the health of an individual in contact with probation may also lead to positive changes for people around them like their family
- Thus improving health produces a 'community dividend' in numerous ways including the potential to reduce communicable diseases in the community and a wider impact on others due to cost savings from reduced re-offending and use of crisis services

Producing this toolkit was the ultimate aim of a two-year research project funded by the National Institute for Health Research (NIHR) Research for Patient Benefit Programme which investigated:

- How healthcare can best be provided to achieve good health outcomes for people in contact with probation
- The current ways that healthcare is delivered to people in contact with probation in England
- The data that are already available that could be used to measure and improve the health of people in contact with probation and the quality of the healthcare that they receive

The toolkit was produced by a team of academics from the University of Lincoln (Dr Coral Sirdifield (lead), Dr Rebecca Marples, Professor Niro Siriwardena) and Royal Holloway, University of London (Professor Charlie Brooker, Professor David Denney) together with service user and probation representatives (Mr Dean Maxwell-Harrison, Ms Sophie Strachan, Mr Tony Connell).

Advice and feedback on the content was received from an external advisory group made up of key stakeholders including the following individuals and organisations:

- Dr Linda Harris FRCGP, Chair, Health and Justice Clinical Reference Group
- NHS England Joint HMPPS/NHS OPD Programme
- Probation Institute

- Public Health (Lincolnshire)
- Lord David Ramsbotham
- Russell Webster
- HM Inspectorate of Probation
- Together Women
- HMPPS
- Public Health England

We hope that this toolkit will assist those working in health and criminal justice environments in England, and in particular commissioners to improve the way in which healthcare is provided for people in contact with probation by providing an overview of:

- The responsibilities of different organisations and how they can work together to contribute to improving both the health of people in contact with probation and their access to health services
- The likely health needs of people in contact with probation so that these can be considered in Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and commissioning decisions
- What research tells us about the best ways of providing healthcare to people in contact with probation and where there are gaps in the evidence base
- How healthcare is currently provided to this group, including models of good practice that could be spread
- What barriers people in contact with probation currently encounter to accessing healthcare, and barriers that criminal justice staff encounter when trying to facilitate access to healthcare for people on their caseloads, so that we can think about how these can be overcome
- How the quality of healthcare that people in contact with probation receive can be measured and improved

Policy – Organisations' Roles and Responsibilities

The health of people in contact with probation is a complex issue, crossing boundaries between health, social care and criminal justice organisations. Moreover, health status is related to other wider determinants of health such as housing and employment. Consequently, addressing the health needs of people in contact with probation supports meeting the aims and objectives set out in policy for health, social care and criminal justice agencies. It contributes to reducing health inequalities, reducing re-offending and building safer communities.

It would not be possible or helpful to attempt to describe all relevant national and local level policies here. Consequently, we have simply set out to summarise the roles and responsibilities of different organisations across the health and justice sectors in England as they are set out in policy.

It is also important to note that communication and information sharing between these different agencies is key in order to support the individual and achieve continuity of care.

The Role of Clinical Commissioning Groups (CCGs)

- Responsible for commissioning healthcare services for offenders being managed in the community (rather than in secure environments which are the responsibility of NHS England). This includes those in contact with probation services (Crime and Disorder Act Section 39 (1) 1998, NHS England 2016, NHS England 2017: 11). This includes provision for Mental Health Treatment Requirements (NOMS undated)
- Expected to assess the healthcare needs of their local population by working with local Health and Wellbeing Boards (an executive decision-making body headed by a committee of the local authority) to develop a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (see below for more on this)
- Required to be part of statutory Community Safety Partnerships consisting of the local authority, police, fire and rescue service, Community Rehabilitation Companies, National Probation Service and aim to reduce crime and disorder (Crime and Disorder Act Section 39 (1) 1998). However, a recent review by the Local Government Association (2018) points to “a mixed picture in engagement by clinical commissioning groups (CCGs) and probation services, despite their statutory obligations” (Local Government Association 2018: 10)
- Have a role to play in making NHS staff available to assess people who may benefit from a Mental Health Treatment Requirement (MHTR) (NOMS undated)
- “Should work to ensure that GP registration is promoted with offenders in the community and that GP practices provide such mental health treatment, dependent on local provision, as may be specified in an MHTR and available at a given GP Practice. Health commissioners should seek to ensure that offenders are not excluded from accessing services and ideally ensure offender mental health treatment is explicitly detailed in contracts” (NOMS undated: 11)

The Role of NHS England

NHS England has a budget of over £100 billion to commission organisations to provide healthcare services. They commission primary care services such as GPs and dental services as well as selected specialised hospital services for the general population.

In relation to offenders, the Health and Justice Teams in NHS England commission health services in *secure* settings including:

- Public sector prisons
- Youth detention centres
- Secure settings for children and young people
- Immigration and detention and removal centres
- Sexual assault referral centres
- Criminal justice liaison and diversion services

NHS England are *not* responsible for commissioning health services for people in contact with probation (see the CCG and Public Health entries for more on this). However, in *Strategic Direction for Health Services in the Justice System 2016-2020* (NHS England, 2016) the government sets out its ambition to “narrow the gap between those in criminal justice and detained settings and the rest of the population in terms of health and care outcomes” (NHS England 2016: 10) and ensure continuity of care post-release. It states that “commissioners and providers need to work together to identify individuals with unmet needs across every setting at the earliest possible point to ensure that children, young people and adults receive timely, person-centred care which takes a holistic view of their individual needs” (NHS England, 2016: 11).

This document also emphasises the need to focus on improving mental health, reducing substance misuse and having appropriate pathways to achieve continuity of care. In order to achieve these aims, those commissioning and providing healthcare in the community will need to liaise with NHS England and organisations across the criminal justice pathway to ensure continuity of care.

Similarly, NHS England are committed to supporting continuity of care and improving data collection and information sharing around the health of people in their care in the *National Partnership Agreement for Prison Healthcare in England 2018-2021* (HM Government and NHS England 2018).

The Role of Public Health England

Public Health England (PHE) is an Executive Agency of the Department of Health. PHE exists to protect and improve the nation's health and wellbeing and reduce health inequalities. It does this through world class science, knowledge and intelligence, advocacy, partnerships, the delivery of specialist public health services, and through providing expert advice to Government and policy makers.

Public Health England have a National Health and Justice Team that aims to:

“improve health, reduce health inequalities and drive down offending and reoffending behaviour by understanding and meeting the health and social care needs of people in contact with the criminal justice system (in custody and in the community) through collaborative work with statutory and voluntary sector partners and with service users” (Public Health England 2018: 5).

It does this through:

- Gathering and providing evidence and intelligence to inform and support the work of local and national commissioners and service providers
- Providing expertise at local and national level on a broad range of health protection, health promotion and disease prevention activities working in close partnership with local commissioners and service providers
- Supporting partners, including commissioners and providers of health and social care, in the development of care pathways which account for the movement of people around the detention estate and between prescribed detention settings and the community
- Developing the evidence-base to support commissioning and service provision through primary research, audit, collection and analysis of data, publication and dissemination of information, reports and research studies
- Identifying emerging health threats to detainees and staff working in prescribed places of detention (PPDs) and providing advice on their management or mitigation
- Leading international engagement on prison health through its work as the UK Collaborating Centre to the World Health Organisation Health in Prisons Programme (WHO HIPPP) (Europe)
- Supporting collaborative working for health across the devolved administrations of the UK and with the Republic of Ireland through the Five Nations' Health & Justice Collaboration

The Role of Her Majesty's Prison and Probation Service (HMPPS) – National Probation Service (NPS) and Community Rehabilitation Companies (CRCs)

HMPPS is responsible for carrying out sentences given by the courts in both prison and the community and rehabilitating people in their care. They are committed to supporting continuity of care post-custody, and improving collection and sharing of data about the health of people in their care (HM Government and NHS England 2018). Good planning and communication between prisons, the NPS and CRCs at transition points is essential to ensure that people receive and engage with healthcare.

Transforming Rehabilitation, A Strategy for Reform (2013) and the Offender Rehabilitation Act (2014) introduced changes to the way that the probation part of this service is provided in England and Wales, splitting the previous service into 21 'Community Rehabilitation Companies' (CRCs) that manage low-risk and medium-risk cases, and the public sector National Probation Service (NPS) that manages high-risk cases. This white paper and Act also extended probation supervision to everyone on release from prison, including those sentenced to 12 months or less (who previously would not have been managed by probation).

The role of the NPS and the CRCs in relation to the health of people on their caseloads includes:

- CRCs aiming to make the transition from prison to the community seamless through providing 'Through the Gate' services to prisoners. Ideally, this would include identifying a need for (continuing) health care and ensuring that arrangements are in place to facilitate this e.g. GP registration, appointments with substance misuse services
- Staff discussing offenders' health and social care needs with them, identifying and recording health needs using tools like OASys (offender assessment system for prisons and probation services), monitoring behaviours such as patterns of substance misuse, considering the relationship between health and offending behaviour, and facilitating offenders' access to services e.g. through increasing GP registration and partnership working (National Probation Service 2018)
- Working with local healthcare commissioners to create clear pathways into treatment for people in contact with probation and ensure that there is adequate service provision to meet their needs (National Probation Service 2018)
- Managing people's risk of suicide and reducing the rate of self-inflicted death amongst people in contact with probation (National Probation Service 2018)
- NPS and CRC staff working in partnership with other agencies to promote offenders' mental health needs and ensure appropriate recommendation and delivery of Alcohol Treatment Requirements, Mental Health Treatment Requirements and Drug Rehabilitation Requirements (see below)
- Work with partners to deliver the Offender Personality Disorder Pathway

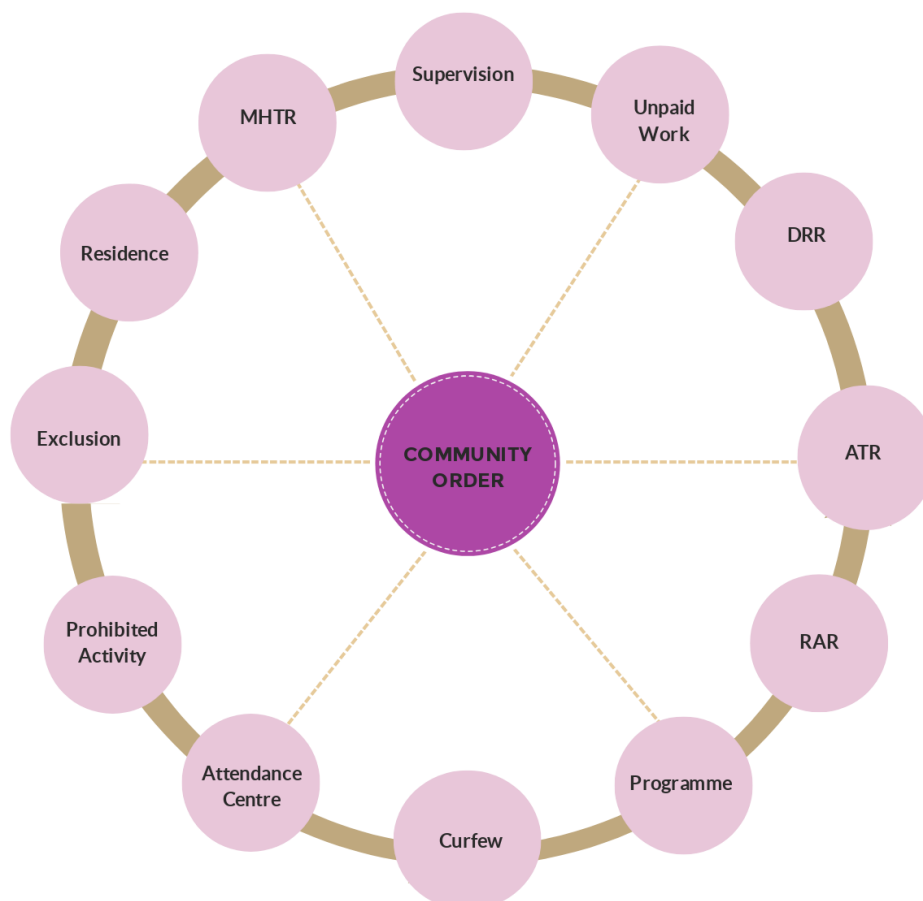
Community orders with implications for health

There are 12 possible requirements that can be added to a community order, some of which have a focus on health issues that may be related to or influence offending behaviour. These are highlighted in the graphic below. Some of these requirements are currently under-used. For example, despite a high prevalence of mental illness amongst people in contact with probation, mental health treatment requirements are added to a very low proportion of community orders (Khanom, Samele et al. 2009, Scott and Moffatt 2012).

Health and criminal justice agencies can improve this by working together to identify those with a mental health need. CCGs commissioning mental health services can ensure that appropriate service provision is in place to enable sentencers to have confidence in adding these requirements to community orders.

In addition, Community Sentence Treatment Requirements are being piloted in Birmingham, Plymouth, Sefton, Milton Keynes and Northampton with a view to increasing engagement with mental health, drug and alcohol treatment. The government has committed to expanding provision for this in the *NHS Long Term Plan* published in 2019.

Possible Order Requirements



Drug Rehabilitation Requirement

An individual is required to attend treatment to reduce or eliminate illicit drug use and associated offending behaviour. Duration is 6-36 months as part of a community order or 6-24 months as part of suspended sentence order. Requires an individual's consent and an appropriate service to provide treatment

Alcohol Treatment Requirement

An individual is required to attend treatment to reduce or eliminate alcohol use and associated offending behaviour. Duration is 6-36 months as part of a community order or 6-24 months as part of a suspended sentence order. Requires an individual's consent and an appropriate service to provide treatment

Mental Health Treatment Requirement

An individual may consent to attending treatment for a mental health problem as part of their order. Duration is up to 36 months as part of a community order, or up to 24 months as part of a suspended sentence order. Requires an individual's consent and an appropriate service to provide treatment

Rehabilitation Activity Requirement

This may include health-focused activities but there should not be a requirement for the individual to receive treatment. Duration is up to 60 days

The Role of Mental Health Trusts

Mental Health Trusts (or Foundation Trusts) are commissioned by Clinical Commissioning Groups to provide services for people with mental ill health. Care for offenders with mental illness is provided by forensic services at three levels of security: low, medium and high. Please see a guide here around commissioning of these services: (Joint Commissioning Panel for Mental Health 2013).

Staff from Mental Health Trusts can play a role in Multi-Agency Public Protection Arrangements (MAPPA – see later section outlining this), supporting liaison and diversion teams and the use of Mental Health Treatment Requirements as part of community sentences.

The Bradley Report was instrumental to the introduction of liaison and diversion teams, which now cover over 80% of the population in England. These services are designed to identify people with mental illness and divert them away from the criminal justice system and into treatment as and when this is appropriate. The government is aiming to ensure that they are available in all parts of the country in the near future (NHS England, 2016).

Mental Health Treatment Requirements are currently under-used (Khanom, Samele et al. 2009, Scott and Moffatt 2012), and Mental Health Trust staff can play a role in working in partnership with probation to identify people that may benefit from these requirements, and ensuring that sufficient provision is in place to enable these requirements to be used.

The Bradley Report also highlighted problems with silo working between and within health and criminal justice services, and difficulties that probation staff can encounter in managing cases with mental illness due to a lack of mental health awareness training and/or knowledge of available care pathways and how to access them. Trust staff can help to overcome these problems through working in partnership with probation, providing training and information about care pathways to probation staff.

In addition, staff from Mental Health Trusts can work alongside probation staff as part of the Offender Personality Disorder pathway (see the examples of good practice section for more about this).

The Role of Public Health Departments and Local Authorities

- Public Health departments are situated in Local Authorities and aim to improve and protect the health of the population and to reduce health inequalities. The impact of their work is monitored through the Public Health Outcomes Framework which includes indicators that are likely to have high significance to many of those in contact with probation (e.g. indicators around successful completion of drug treatment and alcohol treatment and continuity of care)
- Local Authorities have a non-mandated function as a condition of the public health grant for commissioning substance misuse services, and are an integral part of the development of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) (see below for more on this) which are used to inform decisions around healthcare service commissioning in their local area (NHS England 2016)
- Local Authorities also have a duty to assess and address social care needs amongst people in contact with probation (The Care Act 2014, Social Services and Well-Being Act 2014 (Wales))

The Role of Police Crime Commissioners

All police forces in England and Wales are now represented by a Police and Crime Commissioner (PCC) apart from London and Greater Manchester where the Mayor performs this role. PCCs have been encouraged to work with health partners, including voluntarily participating in Health and Wellbeing boards. There are now many examples of joint working including (jointly) commissioning services related to substance misuse and mental health (e.g. street triage), and involvement in community partnerships for mental health and custody (e.g. the Association of Police and Crime Commissioners is a signatory to the Mental Health Crisis Care Concordat (Revolving Doors Agency 2017)).

They are in a unique position to bring different agencies together to try innovative approaches to tackling issues such as substance misuse that are linked to crime in their area as described in a recent report from the Revolving Doors Agency (Revolving Doors Agency 2018).

Multi-Agency Public Protection Arrangements (MAPPA)

Current MAPPA arrangements are detailed in the Criminal Justice Act 2003. MAPPA is a process whereby agencies work together to protect people from harm by sexual and violent offenders living in the community.

MAPPA consists of:

- A 'responsible authority' made up of representatives from the local police, prison service and national probation service
- Representatives from agencies that have a 'duty to co-operate' with MAPPA, which at the time that this legislation was introduced included the local Health Authority or Strategic Health Authority, the Primary Care Trust (now Clinical Commissioning Group) and the NHS Trust
- A Strategic Management Board (which should include representatives from the 'duty to co-operate agencies')
- Lay advisors

A key focus of MAPPA is on information sharing between all of these agencies in relation to offenders' risk of harm to self or others, and the recording of information on a database called ViSOR. Each Strategic Management Board will produce an information-sharing agreement, and all information-sharing must be lawful, necessary and proportionate. In some cases (depending on the outcome of risk assessments), cases may be discussed at multi-agency case meetings.

Some organisations have specific roles within this process. For example:

- Representatives from the National Probation Service must attend all Level 2 and 3 meetings
- CRC Offender Managers may also attend meetings if a case that they managed has recently been transferred due to an escalation in risk
- Health and Social Services authorities must provide after-care services to offenders subject to hospital orders under section 37 of the Mental Health Act 1983 who are discharged from hospital, for as long as they need them (National MAPPA Team 2018)
- Mental Health Services
 - Must provide a consistent core representative at MAPPA meetings that can commit resources on behalf of their organisation, and may also ask relevant members of clinical teams to attend to comment on individual cases within their care
 - May be required to provide clinical risk assessments or "an insight into the mental health of an offender, how it relates to risk and risk to self, and the relevant clinical interventions available" (National MAPPA Team 2018: 62). Other health professionals such as GPs may also contribute to risk assessment by sharing relevant information
 - Must provide relevant information to update ViSOR cases

Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs)

The Health and Social Care Act 2012 established Health and Wellbeing Boards to enable services to be commissioned locally to meet the needs of the local people and to reduce health inequalities. They now exist in all upper tier Local Authorities in England. Through these Boards, Local Authorities and Clinical Commissioning Groups have equal and joint responsibility to produce:

- Joint Strategic Needs Assessments (JSNAs) – assessments of current and future health and social care needs in the local population, and
- Joint Health and Wellbeing Strategies (JHWSs) – strategies for meeting the needs identified in the JSNAs

In relation to JSNAs the government stated that

“each health and wellbeing board is likely to approach them according to their own local circumstances. It would not therefore be appropriate for central Government to be prescriptive about the process or to monitor the outputs (P4 Statutory Guidance 2013).

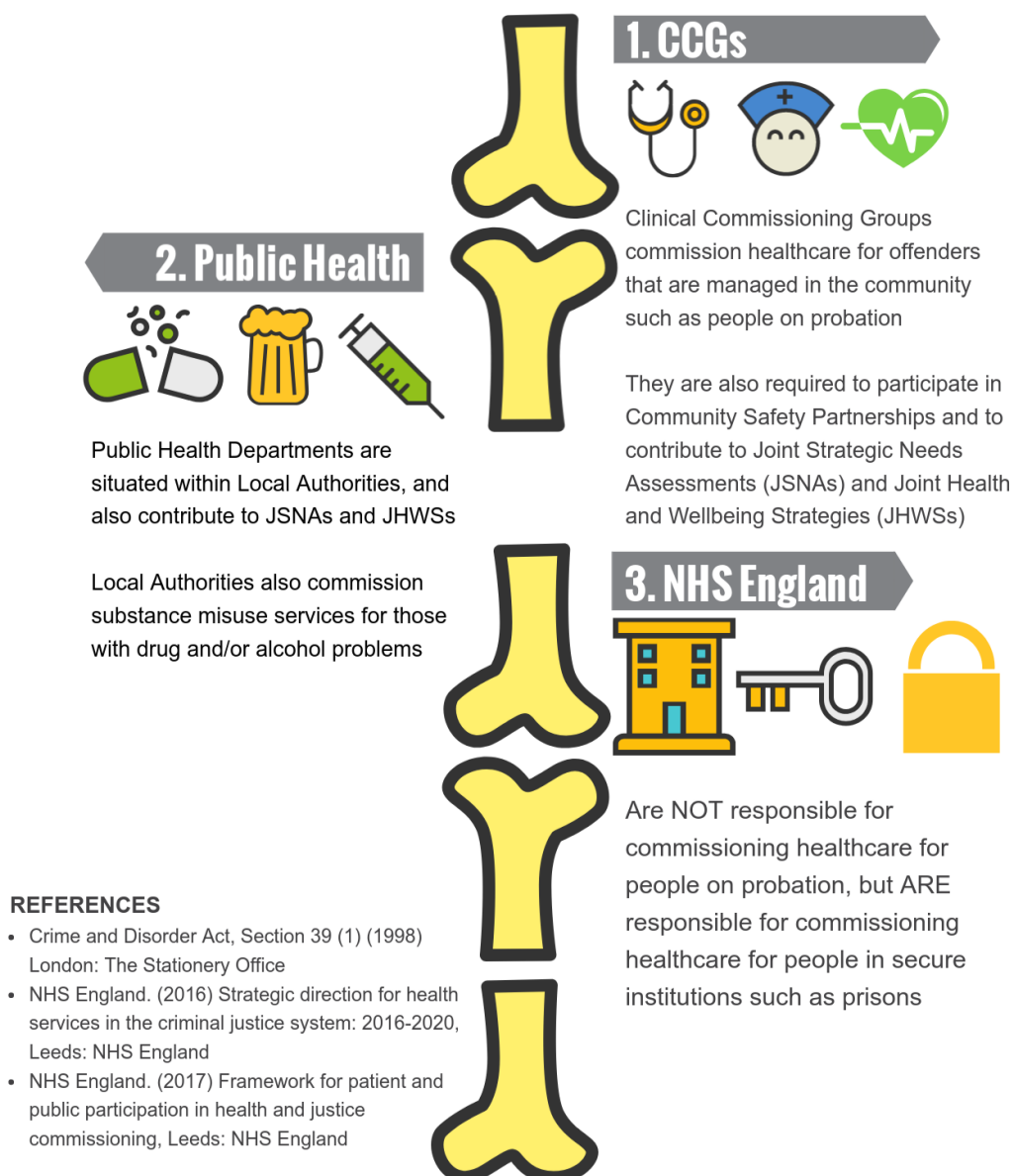
However, guidance encourages Health and Wellbeing Boards to assess the needs of disadvantaged groups that are likely to be in poor health such as offenders as part of this work. This is vital if we are serious about reducing health inequalities in society and ensuring that we have healthcare that is truly accessible to all. Indeed offenders are specifically named within the guidance as a socially excluded and vulnerable part of the population that commissioners should engage with (Department of Health 2013).

Despite this, *Rebalancing Act* notes that those in contact with the criminal justice system are often “not ‘visible’ in Joint Strategic Needs Assessments of Health and Wellbeing Strategies published by DsPH [Directors of Public Health] although clearly were among groups included among those experiencing health inequalities” (Revolving Doors Agency 2017: 4). Moreover, our own research showed that very few JSNAs mentioned offenders in any way and even fewer made any recommendations on how to address their health needs.

The role of organisations in *commissioning* healthcare for people in contact with probation is summarised below:

OFFENDER HEALTHCARE: WHOSE RESPONSIBILITY IS IT ANYWAY?

Responsibility for *commissioning* healthcare for people in the criminal justice system is divided amongst several organisations:



We would also like to acknowledge that currently many of the services that work closely with people in contact with probation are provided by the third sector – voluntary and community organisations and social enterprises.

Likely health needs of people in contact with probation

We conducted a systematic review of the literature, which showed that overall, the health needs of people in contact with probation services (the National Probation Service or Community Rehabilitation Companies) in England is a relatively under-researched area. More research is needed to help us to build an evidence-base to enable research informed decisions to be made on how to commission and provide healthcare that meets the needs of this group. This should include consideration of how needs may vary across different groups, for example, women in contact with probation may be more likely to need access to some types of services than men.

The little research that has been conducted about the health needs of people in contact with probation in England shows that although they live in the community, they are likely to have different health needs from the general population.

This is something that needs to be considered by healthcare service commissioners as part of their role in reducing health inequalities and ensuring that services are commissioned that meet the needs of the whole population.

Findings from our systematic review about the health needs of people in contact with probation are summarised below. Where possible, we have also included up-to-date government statistics.

Substance Misuse

- Research points to a high rate of drug misuse and alcohol misuse amongst people in contact with probation
- Uptake of substance misuse treatment on release from prison has been shown to be low (Public Health England 2018). In 2017, just 6.6% of women and 3.9% of men on community orders received a drug treatment requirement, and 3.7% of women and 2.7% of men on community orders received an alcohol treatment requirement (Ministry of Justice 2018)
- Research by Mair and May (1997) with 1213 people on probation in the UK found that when asked about drug use in the last 12 months, reported rates were as follows: cannabis 42%, amphetamines 24%, temazepam 15%, LSD 14%, ecstasy 12%, magic mushrooms 10%, heroin 8%, cocaine 8%, methadone 8%, crack 8%, none of these drugs taken 42%, and 10% did not answer this question
- Often, people misuse both drugs and alcohol
- Substance misuse can also be combined with mental illness (dual diagnosis). In fact this is the case for many people in contact with probation

- Currently, such dual diagnosis can mean that people struggle to access healthcare as they are bounced between mental health and substance misuse services
- Local Authorities need to commission services that are able to work with people with this type of complex need

Link: Drug misuse info-graphic: <https://my.visme.co/projects/n06q6pdn-ke7lp9q1zmeg29mw>

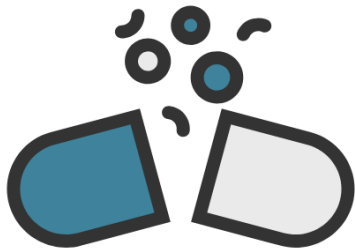
Link: Alcohol misuse info-graphic: <https://my.visme.co/projects/1jox07g3-ke7lp9q1zm6429mw>

Drug Misuse

Research suggests that there is a high rate of drug misuse amongst people on probation. Often this is also combined with misuse of alcohol and/or mental illness

A study of the prevalence of non-prescription opioid use amongst a sample of 406 women on probation or parole in the USA found that those using non-prescription opioids were more likely to:

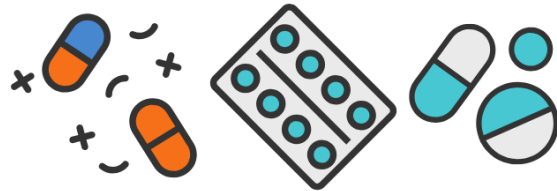
- Report poor health than non-users
- Have experienced physical violence from an intimate or non-intimate partner
- Meet diagnostic criteria for post-traumatic stress disorder
- Be experiencing bodily pain, and
- Have higher levels of psychiatric distress than those that were not using these drugs (Hall et al., 2016)



Findings from the Probation Service's Drugs and Alcohol Survey 2011, completed by Probation Officers in Ireland showed that:

- 27% of cases had misused only drugs, and
- 42% had misused both drugs and alcohol
- The most commonly misused drug was cannabis
- 25.9% of cases had misused opiates in the past
- 33.8% had misused stimulants in the past (Martyn, 2012)

In a study of a stratified random sample of 173 offenders on probation in Lincolnshire (UK), 12.1% of the sample scored 11+ on the DAST screening tool — indicating either a 'substantial' or 'severe' level of drug abuse (Brooker et al., 2012)



There are also high rates of poly substance misuse amongst people on probation:

42%

Findings from the Probation Service's Drugs and Alcohol Survey 2011 completed by Probation Officers in Ireland showed that 42% had misused both drugs and alcohol, and 20% had misused only alcohol (Martyn, 2012)

35%

A study of Approved Premises residents in the UK found that 35% had a history of both alcohol and drug misuse (Geelan et al., 2000)

In the Lincolnshire study, 72% of those with a current mental illness also had a substance misuse problem (Brooker et al., 2011)

Alcohol Misuse



There are high rates of alcohol misuse amongst people on probation in the UK. Often researchers measure this using the Alcohol Use Disorders Identification Test (AUDIT)

- In a study of 132 people on probation in Reading and Newbury "about 44% of female and 43% of male probationers were deemed to be hazardous drinkers (AUDIT >8)" (p21) (Pari et al., 2012)

55.5%

In a study of a stratified random sample of 173 offenders on probation in Lincolnshire, 55.5% (95% CI [48.1, 62.9]) scored positive for alcohol abuse (8+ on AUDIT). Many people that misused alcohol also had a mental illness (Brooker et al., 2012)

- In a health needs assessment of 183 people on probation in Nottinghamshire and Derbyshire, nearly half were found to be at risk of alcohol abuse or dependence (p49) (Brooker et al., 2009)

29%

In a study of residents in an Approved premises for men with mental illness, 29% received a diagnosis of alcohol abuse or dependence (Geelan et al., 2000)

In a study of alcohol use amongst people in prison and on probation, AUDIT scores showed that of the 266 people on probation

- 25.6% were drinking at 'hazardous levels',
- 7.9% were drinking at 'harmful' levels, and
- 32.7% were 'possibly dependent' (Newbury-Birch et al., 2009)

In this study, "seventy-three per cent of hazardous drinkers, half of the harmful drinkers and 14% of possibly dependant drinkers, identified via AUDIT were deemed not to need an alcohol intervention using OASys" (Newbury-Birch et al., 2009: 207), so a screening tool like AUDIT should be used instead

There are also high rates of poly substance misuse amongst people on probation in the UK:

42%

Findings from the Probation Service's Drugs and Alcohol Survey 2011 completed by Probation Officers in Ireland showed that 42% had misused both drugs and alcohol, and 20% had misused only alcohol (Martyn, 2012) Similarly, a study of Approved Premises residents found that 35% had a history of both alcohol and drug misuse (Geelan et al., 2000)

Mental Health

Very little research has been conducted into mental illness amongst people in contact with probation in the UK overall.

Of the research that does exist, some of it focuses on rates of mental illness amongst people housed in probation Approved Premises in the UK, including specialist Approved Premises for men with mental health disorders (Geelan, Griffin et al. 1998, Geelan, Griffin et al. 2000), and Approved Premises that work in partnership with psychiatric services (Nadkarni, Chipchase et al. 2000). In their study of 533 residents of seven probation Approved Premises in Greater Manchester, Hatfield et al., (2004) report the following rates of 'known' psychiatric diagnoses: depression, 14%; anxiety disorder, 6.9%; schizophrenia, 3%; personality disorder, 3%; affective psychosis/bipolar disorder, 0.4%; other psychoses, 2.1%; and dementia, 0.4%. However, people living in probation Approved Premises are not representative of the wider population of people in contact with probation.

Pritchard et al, report findings from two similar studies of broader probation populations aged 18-35 years. Here findings were based on questionnaires completed by staff. In the first study, they report that 25% of the sample of 261 people had a mental health disorder. In the second study 21% were reported as having a mental illness (Pritchard, Cox et al. 1990, Pritchard, Cotton et al. 1991). In a study of 183 people in contact with probation in two English counties, Brooker et al., (2009) report that 17% of participants listed 'mental health' as their greatest health problem (Brooker, Syson-Nibbs et al. 2009).

The only formally funded study of a stratified random sample of offenders in contact with probation in the UK found that 39% of people in contact with probation in one county had a current mental illness. The rate of psychotic illness was over ten times the average for the general population in the UK. This study also pointed to a high 'likely prevalence rate' of personality disorder, with 47% of the sample screening positive for this. In addition, this study showed that 72% of those with a mental illness also had a substance misuse problem (dual diagnosis) and 27% were experiencing more than one form of mental illness (co-morbidity) (Brooker, Sirdifield et al. 2011, Brooker, Sirdifield et al. 2012).

Research also suggests that some of those with personality disorder that are in contact with criminal justice services are at increased risk of having experienced childhood neglect, domestic violence, or physical, sexual or emotional maltreatment (Minoudis, Shaw et al. 2011). Consequently, they may benefit from access to psychological therapies.

Research points to difficulties in accessing care for those with a mental illness. For example, dual diagnosis and co-morbidity can form a barrier to service access (Melnick, Coen et al. 2008). There can

also be problems with continuity of care when people leave prison (Pomerantz 2003), particularly if information isn't transferred from prison healthcare to probation services in a timely fashion, and if people encounter problems with registering with GPs prior to or upon release from prison.

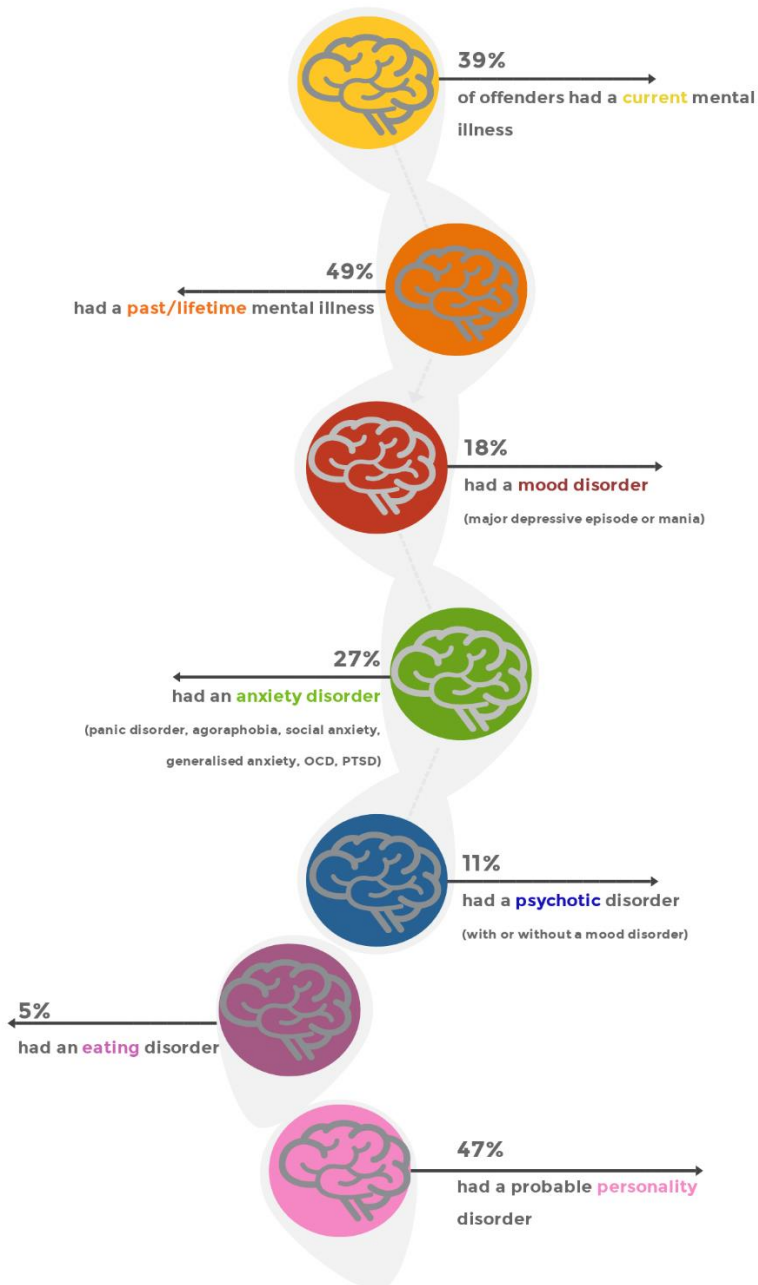
Addressing mental health problems has been identified as a way of reducing reoffending and Mental Health Treatment Requirements are available as an option for people on community orders or suspended sentence orders with a mental illness that do not require immediate compulsory hospital treatment under then Mental Health Act (Khanom, Samele et al. 2009: 5). Guidance states that "CCGs and Local Health Boards are encouraged to engage with local criminal justice agencies to ensure that their commissioning activities and service design facilitate treatment access by offenders to enable the courts to consider an MHTR" (NOMS undated: 12). However, these requirements are currently under-used (Khanom, Samele et al. 2009).

Link: Mental health info-graphic: <https://my.visme.co/projects/w4yzw1gr-owplnmnw0gd32zd6>

Prevalence of Mental Illness

Very little research has been done on rates of mental illness amongst people on probation.^(Sirdifield, 2012)

The only formally funded study of a stratified random sample of offenders in probation in the UK showed that:^{(Brooker et al., 2012):}



72% of those with a current mental illness also had a substance misuse problem



*N.B. Figures have been rounded up or down for simplicity

Suicide and Self-Harm

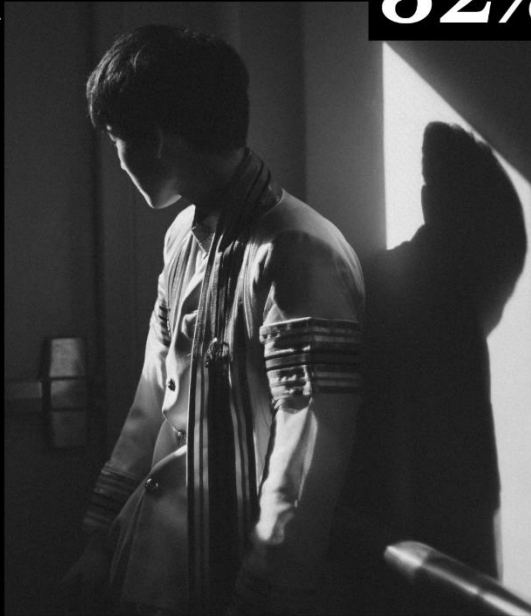
- A small body of research suggests that rates of suicide and self-harm are higher amongst people in contact with probation than amongst the general population in the UK and suicide rates are also higher in this population than amongst prisoners (Phillips, Padfield et al. 2018)
- Moreover, data suggest that the rate of suicides in the criminal justice system in the UK has been increasing (Phillips, Padfield et al. 2018), including amongst those in the community. Recent figures on deaths of offenders in the community in England and Wales show that “there were 285 self-inflicted deaths in 2017/18, an increase of 14% from 2016/17, and this accounted for 30% of all deaths” (Ministry of Justice 2018: 5)
- Individuals are particularly at risk during the first few weeks following release from prison (Binswanger, Stern et al. 2007, Phillips, Padfield et al. 2018)
- There are differences in suicide rates by gender (Corston 2007, Phillips, Padfield et al. 2018). For example, government statistics suggest that in 2017/18 from a total of 836 male deaths amongst offenders in the community 31% were self-inflicted. This compares to 25% of a total of 119 female deaths (Ministry of Justice 2018: 5)

Link: Suicide and self-harm info-graphic: <https://my.visme.co/projects/mxnyg70d-g1d5koqen43326m7>

Suicide and Self-Harm

There is a paucity of research on the rates of suicide and self-harm amongst people in contact with probation

A study of deaths amongst people on probation found that in 1996 they were over 9 times more likely to die than the general population; and in 1997 they were 13 times more likely to die than the general population (Sattar, 2003)



32%

A study of a random sample of 173 offenders on probation in one county in England, found that nearly a third of those interviewed had a lifetime history of suicide attempts (Pluck and Brooker, 2014)

5%

had self-harmed in the month prior to interview (Pluck and Brooker, 2014)

A study of deaths amongst ex-prisoners from the Washington State Department of Corrections concluded that:

- In the first two weeks after release, the risk of death for ex-prisoners was 12 times that of other state residents
- The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide, and suicide" (Binswanger et al., 2007: 157)

General Health

- The results of our systematic review showed that there is very little research about the general health of people in contact with probation. Whilst the general health needs of people in prison could be used as a proxy measure (see for example the *Health and Justice Annual Review 2017/18* by Public Health England for some useful summaries), this an area where more research is needed
- Mair and May (1997) conducted a study with 1213 offenders on probation in the UK, and found that 49% stated that they “currently had or expected to have certain long-term health problems or disabilities listed on a show card (long-term was defined as for at least six months)” (Mair and May 1997: 17). When looking at health problems or disabilities lasting longer than six months, reported rates were often higher than in comparable data from the general population. 18% mentioned musculoskeletal problems, 15% mentioned respiratory system problems, and 14% mentioned mental disorders
- In a health needs assessment of people in contact with probation in two areas of England, Brooker et al., (2009) state that “SF36 scores revealed that offenders’ subjective mental and physical health and functioning was significantly poorer than that of both the general population and manual social classes using comparative standardized data derived from the Third Oxford Healthy Life Survey” (Brooker, Syson-Nibbs et al. 2009: 49). This study also found that 83% of the sample reported smoking tobacco, and 13% had been treated for a sexually transmitted infection
- Similarly, Pari et al., (2012) report that people in their study of 132 people in contact with probation in Reading and Newbury “had significantly lower SF-36 scores on all eight subscales than the general UK population” (Pari, Plugge et al. 2012: 21)
- Prison statistics indicate that a growing proportion of prisoners are aged 50+, suggesting that the probation population is also likely to include increasing numbers of older adults. The needs and costs of providing care for these individuals, some of whom may need specialist care arrangements as they pose a risk of harm to the public, needs to be considered by commissioners

What services are available, what should be available and how can these services best be provided?

We wanted to:

- Find out what healthcare services are currently commissioned for people in contact with probation across England
- Identify examples of good practice in delivering healthcare to people in contact with probation in a way that improves their health or access to healthcare
- Identify barriers to service access that people in contact with probation or probation staff may encounter when trying to access or facilitate access to healthcare services
- Find out what measures may ensure accessibility of healthcare for people in contact with probation

To do this, we conducted a review of the international literature from the year 2000 to May 2017. We also used a combination of surveys and freedom of information requests to Clinical Commissioning Groups, Mental Health Trusts, Public Health Departments, Community Rehabilitation Companies, the National Probation Service and probation Approved Premises to find out about what healthcare services they commission, provide or receive. Additionally, we conducted interviews with people from these organisations in six areas of England to find out about the services and/or barriers to service access in their area of the country in more detail.

Findings from the systematic review, survey work and interviews are summarised below to highlight gaps in current service provision, and recommendations for optimal commissioning strategies and potential models of good practice to improve health and access to healthcare.

Suicide

In our literature review, we identified that very little research in the UK has studied suicide and self-harm amongst people in contact with probation. However, the research that has been conducted shows that rates of suicide are higher amongst people in contact with probation than amongst the general population, and people are at particularly high risk during the weeks following release from prison.

In our case study work we identified that some areas have suicide prevention partnerships and suicide audit processes. Our review of the literature identified one study of a small sample of cases in one UK probation area which suggested that management of suicide risk could potentially be improved through:

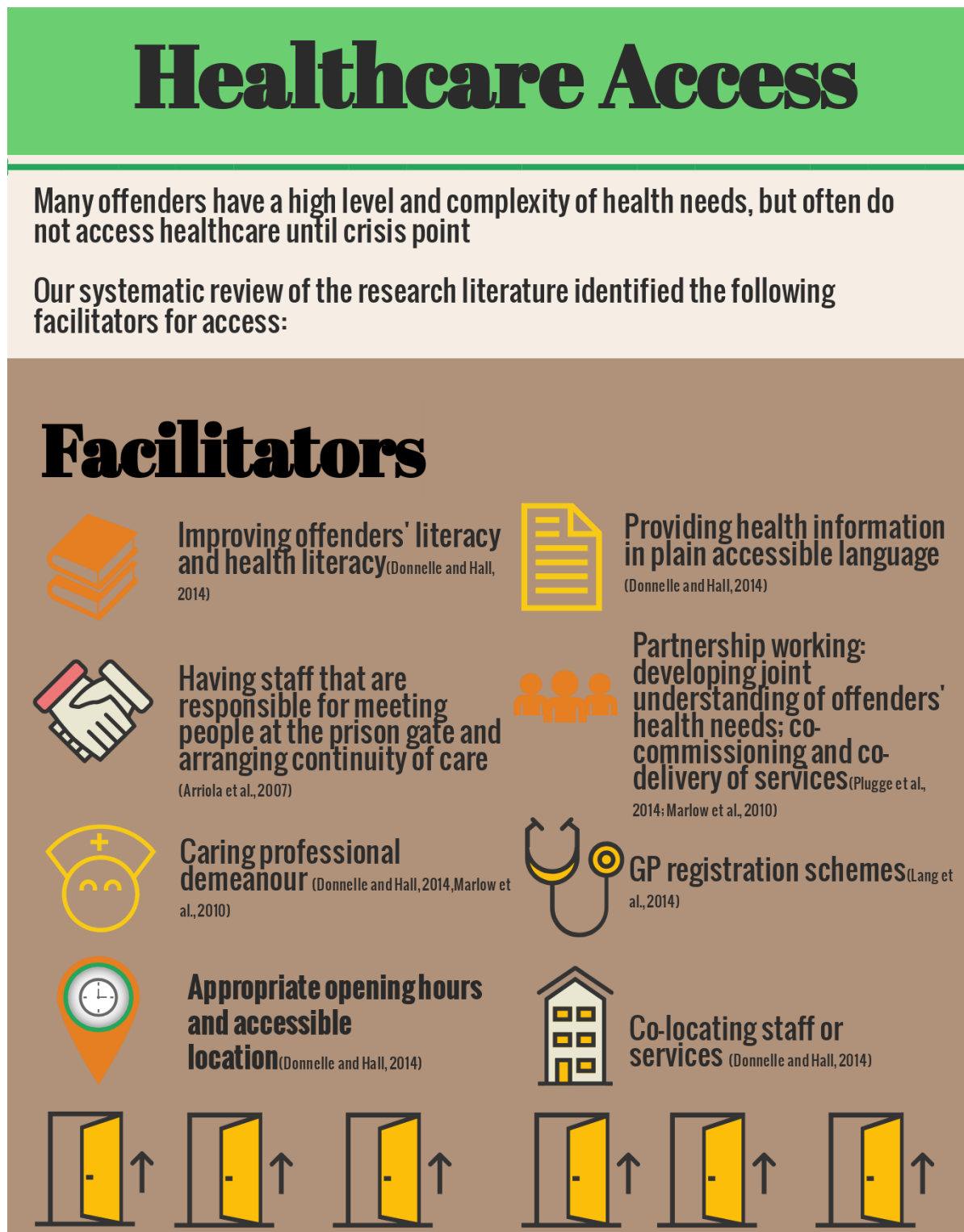
- Targeted suicide prevention training
- Staff recognising that missed appointments could be a sign of increased risk of suicide
- Staff reviewing suicide risk when instigating breach, legal proceedings or enforcement action
- Consistent supervision by the same staff
- Using the Delius system (a system that probation staff use to record contacts with their clients) to alert others about an individual's perceived risk of suicide (Borrill, Cook et al. 2017)

Improving access to services and continuity of care

Papers included in our systematic review pointed to a number of barriers that people in contact with probation may encounter when trying to access healthcare. These are summarised in the info-graphic below.



The literature also pointed to potential ways of improving access to services to maximise good health. These are summarised in the info-graphic below.



Link to barriers info-graphic: <https://my.visme.co/projects/mxnkkvy8-pmjli0qx44qg2z39>

Link to facilitators info-graphic: <https://my.visme.co/projects/q6r811zr-3ezl33p8drjr10q1>

The following were also identified as barriers to service access in the interviews that we conducted in six case study areas in England:

- **Behaviour difficulties:** People in contact with probation displaying or being perceived as likely to display disruptive behaviour
- **Complexity:** People in contact with probation often have complex health problems and in addition, the healthcare system is complex to navigate
- **GPs:** Getting people in contact with probation registered with a GP can be problematic, particularly for people that are homeless. This in turn can cause difficulties for gaining access to other services
- **Problematic referral processes:** The National Probation Service and Community Rehabilitation Companies do not always have straightforward referral routes that they can use to facilitate access to healthcare for their clients. Sometimes people in contact with probation do not meet the referral criteria for services, for example, because their problems are not deemed to be severe enough, they are not resident within the correct geographical boundary to access a service, or they have a dual diagnosis
- **Motivation:** People in contact with probation are not always motivated to attend appointments with healthcare
- **Under-use of requirements:** People not having mental health, drug or alcohol treatment or rehabilitation requirements as part of their probation could also form a barrier to service access
- **Risk over health:** The primary focus of criminal justice staff has to be on risk management rather than assessing or addressing their clients' health issues, so when resources are scarce, health may not be seen as a priority
- **Opening hours:** Services are often only open 9-5
- **Difficult for some services to engage in partnership working:** This was particularly apparent in relation to CCGs

So the accessibility of healthcare could be improved by increasing literacy and health literacy levels amongst people in contact with probation; providing health information in plain language to make it more accessible; having case managers meet individuals at the prison gate and monitor their access to services; criminal justice and health organisations working together to understand offenders' health needs and provide appropriate service provision; the introduction of GP registration schemes; co-location of services or staff, and healthcare staff having a caring professional demeanour.

The government has recognised the importance of improving continuity of care, and many organisations have committed to working towards this (see for example HM Government and NHS England 2018).

The NHS Long Term Plan published in 2019 highlights that RECONNECT will be helping people to transition from prison to community based services. Similarly, work published by Public Health England highlights the value of community workers reaching into prisons and visiting prisoners prior to release in order to improve engagement with substance misuse treatment services post-release (Public Health England 2018).

Mental health

Our review of the literature suggested that having **probation Approved Premises that specialise in working with people with mental illness** is beneficial.

The review also identified an article about approaches to tackling the problem that people with mental illness are more likely to fail on probation supervision (defined in the literature as having an order revoked for a technical violation or a new offence (Skeem and Eno Louden 2006)). This pointed to **‘specialty probation agencies’** as a potential solution to this problem and stated that they “hold promise for improving clinical and criminal outcomes for probationers and parolees with mental illness” (Skeem and Eno Louden 2006: 333). Key findings from the research about the main features of these agencies and their effectiveness are summarised below.

SPECIALTY PROBATION

Research suggests that 'specialty probation' agencies have the following characteristics:

PEOPLE WITH MENTAL ILLNESS ARE ASSIGNED TO STAFF WITH TRAINING IN MENTAL HEALTH



STAFF HAVE RELATIVELY SMALL, EXCLUSIVELY MENTAL HEALTH CASELOADS



STAFF RECEIVE ONGOING TRAINING, 20-40 HOURS A YEAR



PROBATION STAFF WORK IN TEAMS WITH TREATMENT PROVIDERS, ATTENDING THEIR TEAM MEETINGS AND ACTIVELY ACCESSING CARE FOR PEOPLE ON THEIR CASELOADS



NON-COMPLIANCE WITH TREATMENT IS APPROACHED USING PROBLEM-SOLVING STRATEGIES RATHER THAN THREATS OF REINCARCERATION



Early research also suggests the following potential benefits from this approach:

- Improved access to treatment
- "Two studies—one focus group study and one national survey—suggest that probationers with mental illness, probation officers, and probation supervisors perceive specialty caseloads as more effective than traditional caseloads" (Skeem and Eno Louden, 2006: 339)
- "Three additional studies—two randomized controlled trials and one uncontrolled cohort study—suggest that specialty agencies are more effective than traditional agencies in linking probationers with treatment services, improving their well-being, and reducing their risk of probation violation. Evidence is mixed on whether specialty agencies reduce probationers' longer term risk of rearrest" (Skeem and Eno Louden, 2006: 339-340)

We also identified some other innovative practice through our case study work, and have produced info-graphics in collaboration with participants in our research and individuals involved with these services or ways of working. **It is important to note that not all of these initiatives have been formally evaluated.** Thus we cannot conclusively recommend them as ‘good practice’, merely as services or ways of working that were considered to be working well by participants. In some cases they are currently undergoing evaluation. Those looking to improve practice may wish to learn from these examples when considering new ways of working, but should also commission evaluation work alongside this to improve our understanding of the effectiveness of these approaches.

The first of these is the Offender Personality Disorder Pathway, which is jointly funded by HMPPS and NHS England and operates nationally. The info-graphic below provides an overview of the core aims and elements within this initiative. The info-graphic can also be viewed here: <https://my.visme.co/projects/ep83k9vy-4qk5y7oz88kr5r1v>. Those wishing to learn more about personality disorder may also wish to refer to *Working with offenders with personality disorder. A practitioner’s guide*, particularly appendix B: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/work-offndrs-persnlty-disorder-oct15.pdf>.





Our second example here is the service provided by Clear Counselling for Warwickshire CRC.

Offender Personality Disorder Pathway





The OPD pathway programme is jointly commissioned by Her Majesty's Prison and Probation Service (HMPPS) and NHS England Specialised Commissioning. It is jointly delivered by the National Probation Service, HMPS, Mental Health and third sector providers and was established in 2011

It aims to provide a pathway of psychologically informed services for a highly complex and challenging group who are likely to satisfy a diagnosis of personality disorder (significant psychological and social difficulties usually originating in deprived, abusive, neglectful or difficult childhoods); and who pose a high risk of harm to others (men), or are managed by the National Probation Service (women)

Core aims of the pathway ⁽¹⁾:

 <p>1 Reduce repeat serious sexual and/or violent offending</p>	 <p>2 Improve psychological health, wellbeing and pro-social behaviour</p>
 <p>3 Improve confidence, competence and attitudes of staff working with complex cases who are likely to satisfy a diagnosis of "personality disorder"</p>	 <p>4 Increase efficiency, cost-effectiveness and quality of OPD pathway services</p>

The pathway involves the following core elements:

 <p>People who may benefit from being on the pathway are identified through completion of a case ID screening tool by offender managers with or without support from specialist practitioners</p>	 <p>Probation staff can request a case consultation with a psychologist or PD Probation Officer. This will be recorded on probation systems and uses a bio-psychosocial approach</p>
 <p>Joint meetings between an individual, their Offender Manager, and OPD pathway practitioners to resolve specific issues or observe relational dynamics in order to improve understanding of risk</p> <p>Intensive Intervention and Risk Management Services (IIRMs) where probation and mental health staff jointly deliver interventions and support. The pathway may also provide a gateway into other mental health services</p>	 <p>Some probation Approved Premises now operate a Psychologically Informed Planned Environment (PIPE) model</p> <p>This offers an environment intended to support pro-social development</p> <p>All Approved Premises are also working towards the Enabling Environments award (Royal College of Psychiatrists)</p>

The structure of this model offers opportunities to improve partnership working and information sharing between health and justice staff. It recognises that neither criminal justice nor health staff can manage such complex cases alone. Therefore, a partnership approach is essential

The pathway is commissioned as a whole - extending from the community into prison and back out with treatment and PIPEs also being offered in prisons as well as in the community

Various evaluations of the pathway are currently underway

1. HM Prison and Probation Service and NHS England. (2018) Principles and Practice. Guidance for implementing the community specification. The offender personality disorder pathway 2018

Clear Counselling

Warwickshire CRC

1

A need for mental health support

Using Offender Assessment System (OASys) data and thinking about Maslow's hierarchy of needs, probation staff identify the following as problem areas for many of their clients:

- Lifestyle, thinking and behaviour
- Drug and alcohol misuse
- Relationships
- Emotional wellbeing
- Environment
- Attachment issues
- Health
- Domestic violence
- Social Service intervention i.e. children being removed
- Bereavement
- Low self esteem
- Depression
- Anxiety



2

Rationale for providing an intervention

Staff believe that:

- Access to a counsellor would help offenders to address the above problem areas
- Counselling would compliment the work already being undertaken by offender managers and substance misuse services - by grounding, supporting and working in a 'joined up' way the overall experience can have wholly positive effect on the client
- Counselling may improve offenders' mental well-being, and may also assist them with being able to reframe issues and find alternative coping strategies to drugs, alcohol or violence
- Providing a counselling service will contribute to reducing re-offending and improving compliance with probation
- Access to face to face counselling can be fundamental to moving forward. Working in a trusting relationship and problem solving alongside 'hearing' a client as a non-authoritative person can be beneficial at whatever stage the service user is at



3

The Intervention

- Clear Counselling are funded by the Community Rehabilitation Company (CRC) to provide 1:1 therapy to their low/medium risk clients
- The service can then be purchased by the National Probation Service (NPS), via the CRC contract, where Clear Counselling will also provide 1:1 therapy to medium/high risk offenders



The service:

- Service users are invited to attend an assessment session to meet the counsellor and discuss what they would benefit from working on. This is also an opportunity to begin building the therapeutic relationship
- Is accessed by a simple referral form that is completed by an Offender Manager
- Clear Counselling's main criteria for entry to the service is that individuals are motivated to change
- The initial therapy contract is for six sessions, which can be extended if appropriate
- Is provided on probation premises
- Has an average waiting time of 6 weeks to access at the time of writing
- Is well attended
- Was featured as a model of good practice in a report produced by HM Inspectorate of Probation in September 2017



The aims and potential benefits of attending counselling:

- To promote self awareness
- Learn life skills
- Build a positive relationship with 'another'
- Be able to recognise trigger points
- Build curiosity within self to understand the impact other people can have on mental well-being
- Encouraging clients to recognise when they have taken on feelings from others and incorporated them as their own - exploring how and why this takes place in order to promote self-awareness and consider how to strengthen personal boundaries and own responsibility for what is ours, and what is not
- To have respect for self and not dismiss how they feel

4

Evaluation

- To date, the intervention has received positive feedback from service users
- Data are shared with the CRC to show progress made between the first and last sessions on the problem areas identified by the offenders
- Further work may be undertaken in the future to investigate the impact on reducing reoffending and compliance



FOR FURTHER INFORMATION PLEASE CONTACT:

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Warwickshire and West Mercia CRC
Andrew.Bourne@wwmcr-probation.co.uk

The Clear Counselling info-graphic can also be viewed here: <https://my.visme.co/projects/kkzyk163-ok32rznzm1vn5w8d>

Some of our participants, also rated the services offered by 'Inclusions Visions' (<https://www.inclusion.org/services/inclusion-visions-thurrock/>) and 'Change, Grow, Live' (<https://www.changegrowlive.org/>) highly. We cannot recommend these services above others, but they were valued by our participants.

Substance Misuse

In our literature review, we identified a diverse range of studies on ways of addressing substance misuse problems for those in contact with probation or on parole. Much of this research consists of small-scale studies of short-term projects or initiatives and has limited generalisability. Therefore, it is difficult to draw firm conclusions in terms of what the most effective ways of providing substance misuse services to people in contact with probation are in order to improve their health and/or access to treatment.

Many substance misuse services are provided by third sector organisations. In several areas of the country substance misuse services are provided by a charity called Addaction, a service which was highlighted in our interviews. An info-graphic on this service is included below, and can also be accessed here: <https://my.visme.co/projects/ep8ye6ry-z4p5zzd7qq6957n1>

Similarly, Change, Grow, Live also provide services for people with substance misuse problems and were referred to by several of our interviewees. Again, it is important to note that we are not recommending these services above others, we are simply attempting to provide an overview of them that includes the positive features that were noted by participants in our case study work.

Many people on probation in England have a substance misuse problem - this could be with drugs or alcohol or both, and is often combined with a mental illness (dual diagnosis)



- » In Weston-Super-Mare and other parts of England, substance misuse services are provided by Addaction
- » The service has trained staff that provide assessment, counselling and prescriptions

Referral Routes



- » The service can be accessed by:
 - » Probation staff completing a form supplying basic information about an individual
 - » GPs
 - » Self-referral - here individuals will be assisted by Addaction workers to complete a registration form



Signposting

- » In addition, Addaction workers can also facilitate access to mental health services for service users



Information Sharing

- » People can sign a consent form so that Addaction workers can share information with probation about things like whether they attend appointments and whether they test positive or negative for drugs



- » Problems with motivation and transient lifestyles can often form barriers to service access for people on probation - they miss an appointment and have to start the referral process all over again
- » However, Addaction will continue to work with people that fail to attend appointments



The wait between referral, being assessed and receiving a prescription is relatively short, which helps to keep people motivated to become abstinent



Specialist Housing

- » Addaction also have a small amount of specialist 'dry' housing where those engaging with the service and testing negative to drugs can have temporary residency

Strategic Partnership Working

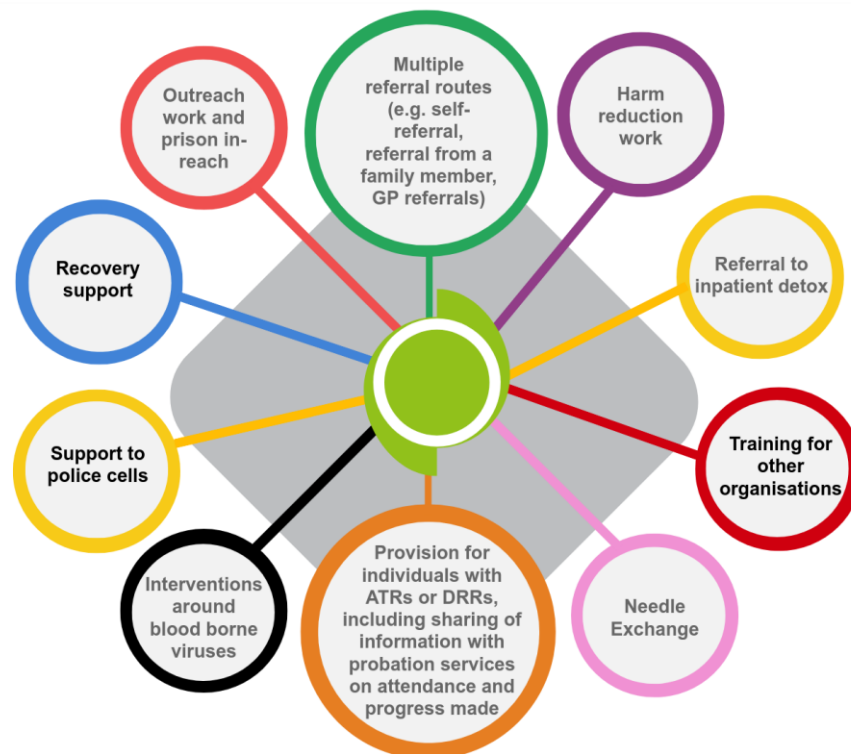
In our case study work participants described robust partnership working as a key to effective service provision. We identified a model of integrated care provision for people with drug and/or alcohol misuse problems. This is described in the info-graphic below.

Integrated Care Provision for Drug and Alcohol Misuse

Within their 'community offer', some Local Authorities are now commissioning integrated care for people with drug and/or alcohol misuse problems

These services are not restricted to any particular type(s) of service user, substance misuse problem, or level of severity of need

An example of integrated care from our case study interviews included the following components:



Services are also starting to look at wider health care, including tobacco and physical activity, and long term conditions

ATR: Alcohol Treatment Requirement
DRR: Drug Rehabilitation Requirement

In our case study work we also identified a useful model of partnership working to address the healthcare needs of Approved Premises residents. This is described in the info graphic below, which can also be accessed here: <https://my.visme.co/projects/dmvy9y07-m3x58kv13zye5krp>

Addressing Residents' Healthcare Needs Through Partnership Working and Co-Production

Example from a Probation Approved Premise in Lancashire

- People housed in probation Approved Premises often have complex health needs
- Sometimes they do not receive much notice that they are going to be released from prison and they may be fearful of what living at an AP will be like
- In some cases, people that have been receiving healthcare in prison are released without a supply of medication or links to appropriate community services

This is an example of a recovery focused Approved Premise (AP) that is trying to address these issues

Model of way of working at the AP



Needs and Strengths Assessment

4-6 weeks prior to release from prison, AP staff talk to a prisoner and their Offender Manager to identify their health needs, any concerns they have about moving to the AP, and what their strengths are. Staff can then begin to prepare for the individual's release

Prisoners are also encouraged to contact healthcare to get a weeks' supply of medication prior to release



Substance Misuse Support

If an individual has a current substance misuse problem or a history of this they will be given details of the Inspire Change Grow Live service, and a worker from this service will meet them on their first or second day at the AP

Details of AA, NA and CA support will also be shared, and in addition are publicised at the AP

Sessions take place at the AP run by AA and also by people who are in recovery



Mental Health Support

There are weekly time to talk events at the AP

Positive Minds run a quarterly sleep workshop

AP staff use Assess Care and Treatment (ACT) procedures for cases of self-harm and suicidality, and also work with the local crisis team when required



Employment Skills

Residents are encouraged to see themselves as an asset, and to think about what skills they have that they can teach to other residents e.g. support with learning to read

The AP work with various local partners to support residents to gain employment skills and qualifications e.g. there are plans to offer residents the chance to train as Health Trainers and some residents are currently working towards qualifications for working on building sites

Job Centre staff also visit the AP



GP

At present, there is no dedicated GP at the AP. This is problematic as it means residents are unable to register with a GP prior to release from prison, which makes it hard to plan ahead to ensure continuity of care

However, there is a dedicated pharmacy service to ensure residents receive their medication and usage is monitored



Monitoring

Staff at the AP will monitor residents' medication use, presentation and behaviour. They will also informally monitor residents' experiences of accessing healthcare services by asking how they have got on at appointments when they come back to the AP

An outcomes star model is used to map residents' journeys



Co-Production

There is a co-produced weekly residents' meeting

Residents and ex-residents actively shape the content of the programme of activities taking place in the AP, personally providing content, making requests for specific content, and feeding back on how residents' experience at the AP could be improved



The AP also work with HealthWatch

AP Team

The AP has a strong staff team who take a recovery focused approach

For further information please contact:

Geri Byrne-Thompson

AP Manager

North West Division AP's, HM Prison and Probation Service

geri.byrne-thompson@justice.gov.uk

Our case study work also included an example of strategic partnership working by Public Health:

Public Health Partnership Working

Drug and Alcohol Services



Public Health teams commission these services and rely on all of their partners to support appropriate access into treatment

Collaborative partnerships between the Police, National Probation Service (NPS), Community Rehabilitation Companies (CRC) and Community Safety staff are important to ensure pathways and referral mechanisms into treatment are made at the earliest opportunity

For example, the Office of the Police and Crime Commissioner (OPCC) funded arrangements for Alcohol Treatment Requirements (ATRs) and Drug Rehabilitation Requirements (DRRs) supporting NPS and CRCs with court related assessments can aid people getting into treatment

As the prevalence of drug and alcohol related unmet needs increases it becomes more important for agreed pathways to be developed and reviewed across partners

Partnerships between the OPCC, NPS and CRC and integrated offender management leads for the Police work closely together to assess and recommend to the courts those who would benefit from treatment orders

Similarly, drug and alcohol service providers being involved on anti-social behaviour and street dwelling groups is designed to support an integrated approach to community based responses by a range of partners with the intention of reducing acquisitive crime and reducing vulnerable people being exposed to county lines and gang related activities

Work is ongoing to develop stronger connections and continuity of care arrangements for those leaving prison who are in need of treatment for drug or alcohol dependencies. Public Health England in the West Midlands are holding specific events with invites to all relevant partners to shape improvements to this agenda

On average only around 30% of people who need ongoing treatment upon release reach and access community treatment services

Dual Diagnosis and Treatment



Those with drug and alcohol dependencies often suffer from mental health related disorders

Often it is difficult to distinguish cause and effect when substance dependencies limit an effective assessment of mental health needs

NHS and Mental Health Services need to work much more closely together with these potential clients to address needs in tandem rather than treating substance misuse before treating mental health needs

Pilots to understand this agenda better are underway. Similarly, extended support following treatment and rehabilitation includes access to mental health and well being centres that enable people to attend a welcoming environment as part of their continued recovery and re-ablement

Public Health Department

Health Protection and Screening

NHS England accredit providers such as pharmacies and GPs to provide the flu vaccine to a range of vulnerable groups

Currently this does not include those who are homeless and may be street dwellers or sofa surfing

Commissioners worked with the Drug and Alcohol local service provider and a homeless charity to risk assess, co-ordinate and fund a flu immunisation programme specifically for this group in an attempt to reduce hospital admissions and the onset of chronic ill health for this cohort of people as well as prevent unnecessary deaths. Many of this cohort have drug and or alcohol dependencies



Blood Borne Virus Testing and Treatment



Hepatitis C is a treatable condition and nationally there is an attempt to eradicate it by 2025. An increased level of testing and outreach facilities where NHS colleagues and drug and alcohol service providers collaborate to scan, test and treat individuals will help to reduce the impact of liver disease. This is an increasing priority for all commissioners of drug and alcohol services

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Measuring and improving health, and the quality of healthcare that people in contact with probation receive

As part of ensuring that people in contact with probation receive appropriate healthcare, we need to consider how their health and the quality of the healthcare that they receive could be measured, monitored and improved.

Healthcare quality can be defined in terms of the Darzi dimensions of quality, which are commonly used in evaluation of NHS services in the UK:

- **Safety:** prevention of harm caused by healthcare or lack of healthcare
- **Effectiveness:** improvements to or worsening of health status
- **Patient experience:** patients' memory of what they received and which aspects of care they regard positively or negatively

When thinking about how such dimensions of quality can be measured, Donabedian (2005) divides information that can be used to measure the quality of care into three categories – information about:

- **Structure:** infrastructure and resources in the settings within which healthcare is provided e.g. staff training, equipment, buildings, staff to patient ratios, policies and procedures
- **Process:** what actually happens to deliver a desired outcome – includes technical and interpersonal aspects of care delivery e.g. giving vaccinations
- **Outcomes:** the impact on the service user in e.g. changes in health status, improvements in health literacy, or improved service user experience (Donabedian 2005)

Our recommendations here are based on:

- Findings from six national surveys that we conducted asking Clinical Commissioning Groups, Public Health Departments, Mental Health Trusts, the National Probation Service, Community Rehabilitation Companies and probation Approved Premises about what data they already routinely collect that could be used to measure and improve health and healthcare quality
- Data from interviews with key stakeholders in six areas of England,
- Reference to wider literature such as the NICE guidance for physical health of people in prison [NG57] and for mental health of adults in contact with the criminal justice system [NG66], and the National Probation Service Health and Social Care Strategy 2019-2022

Findings from our surveys told us a little about the *outcomes* that some organisations routinely record, but did not tell us much about the processes or structures that lie behind those outcomes. Consequently, we have created a list of possible indicators that organisations could use for monitoring and improvement. These are shown in the table below.

Darzi Dimension of Quality	Donabedian Definition		
	Structure (Present/absent)	Process (Rates)	Outcome (Rates)
Safety	<ul style="list-style-type: none"> • Mortality review process in place • Adverse event monitoring/review process in place 	<ul style="list-style-type: none"> • Mortality review process in place • Adverse event monitoring/review process in place 	<ul style="list-style-type: none"> • Mortality rate • Proportion of people attempting suicide • Proportion of people committing suicide • Proportion of people that self-harm
Effectiveness	<ul style="list-style-type: none"> • Probation involvement in commissioning • Creation of pathways into services for different conditions • Systems for access to health professionals (e.g. GP, dentist) and services 	<ul style="list-style-type: none"> • Proportion of cases where GP registration (or lack of) is recorded • Proportion of non-registered service users that go on to be registered with a GP • Proportion of cases where dentist registration (or lack of) is recorded • Proportion of non-registered service users that go on to be registered with a dentist • Proportion of service users screened for hazardous or dependent drinking [Prison reception screen Q13] • Proportion of hazardous or dependent drinkers a) offered and b) accepting referral to substance misuse services • Proportion of service users screened for drug misuse [Prison reception screen Q14 and 15] • Proportion of those misusing drugs a) offered and b) accepting referral to substance misuse services • Proportion of cases screened for mental illness [Prison reception screen Q16-20] 	<ul style="list-style-type: none"> • Proportion of NPS areas and CRCs reporting involvement in commissioning • Proportion of staff that are aware of and understand these pathways • Proportion of people that are registered with a GP • Proportion of people that are registered with a dentist • Proportion of people drinking at hazardous or dependent levels • Proportion of people misusing drugs • Proportion of people showing a reduction in misuse of drugs • Proportion of people reporting well

	<ul style="list-style-type: none"> Registers of conditions e.g. mental illness (including personality disorder), learning disabilities, disability, substance misuse 	<ul style="list-style-type: none"> Proportion of 'likely' or known cases of mental illness a) offered and b) accepting referral for diagnosis and/or treatment or c) continuing with existing treatment Proportion of cases where smoking status is recorded Proportion of smokers a) offered and b) accepting referral to smoking cessation services Proportion of cases where physical health measures are recorded Proportion of cases where need or absence of need for vaccinations is recorded Proportion of cases established as needing vaccinations that are a) offered onward referral for them and b) accept this referral Proportion of cases screened for communicable diseases Proportion of cases found to have a communicable disease a) offered and b) accepting referral for treatment or support Proportion of people offered safe sex education 	<p>managed mental health</p> <ul style="list-style-type: none"> Proportion of people smoking Proportion of people reporting well managed physical health Proportion of service users identified as in need of vaccinations that receive them Proportion of people with communicable diseases Proportion of people practicing safe sex
Experience	<ul style="list-style-type: none"> Service user experience measure or survey 	<ul style="list-style-type: none"> Proportion of experience surveys returned Proportion of cases where service access is considered to be timely (number of days) 	<ul style="list-style-type: none"> Proportion of service users reporting positive experience of services Proportion of service users reporting encountering barriers to service access

Much of the above could be achieved through National Probation Service and Community Rehabilitation Company staff or a healthcare professional based with probation conducting a health assessment and making onward referrals to healthcare as appropriate for all new cases as set out in the NICE guidance on the physical health of people in prison. This covers aspects of both physical and mental health, and we have included key question numbers from this assessment in the table above.

Our suggestions fit well with the commitments set out in the National Probation Service Health and Social Care Strategy 2019-2022.

Our research showed that currently, very few Local Authorities include the health needs of people in contact with probation in their Joint Strategic Needs Assessments which inform local level healthcare commissioning. Data collected from the above process could be used to inform this type of assessment, providing data to enable comparison between the health needs of individuals in contact with probation, and members of the general population in a geographical area.

In addition, Her Majesty's Prison and Probation Service are in the process of producing datasets from their routinely collected data, which could potentially be used to inform this and other commissioning processes.

Moreover, Public Health England has produced evidence-based guidance on undertaking Health Needs Assessments in prescribed places of detention which is available at:

<https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

Public Health England is also currently developing guidance on undertaking a Health and Social Care Needs Assessment for people in contact with the criminal justice system who are living in the community.

We would also suggest that it would be beneficial for all NPS and CRC areas to have a named Offender Health Lead with responsibility for sharing the above data at aggregate level with healthcare commissioners and providers and establishing inter-agency referral and information exchange procedures for staff to use and disseminating these to staff.

Recommendations

This toolkit is being produced at a time when systems change is either happening or likely to happen in both the health and justice arenas. For example, a number of attempts are underway to integrate health and social care systems. These include

- New care models, which introduced new models of working such as integrated primary and acute care systems (PACS) and multispecialty community providers (MCPs)
- The introduction of Sustainability and Transformation Partnerships (STPs), which bring together a variety of organisations such as CCGs, Mental Health Trusts and Local Authorities; and
- The continued roll out of Integrated Care Systems which evolved from STPs and involve the NHS working with local councils and others to collectively plan and run health and social care provision in their region. Here, budgets are pooled and the emphasis is on preventative work and avoiding hospitalisation. We recognise that in this toolkit we have focused on health needs, but increasingly health and social care are likely to be considered as one in the future

In addition, questions have been raised about the competency of Community Rehabilitation Companies, which were introduced as part of the structural reforms to probation created by *Transforming Rehabilitation*. The Ministry of Justice undertook a consultation called '*Strengthening probation, building evidence*', the results of which are yet to be shared.

Within the context of this changing landscape, it appears that the key to improving healthcare provision for people in contact with probation lies in four main areas:

Commissioning

- a) CCGs need to fundamentally recognise that healthcare commissioning for people in contact with probation is their responsibility not NHS England's
- b) CCGs in association with Public Health departments should be undertaking 'gap' analyses to examine the complex healthcare needs of people in contact with probation in their areas and the extent to which current service provision meets those needs. The new National Probation Service Health and Social Care Strategy 2019-2022 outlines ways in which routinely collected data in probation might be able to enable such gap analyses. Data on health needs from the research literature provided in this toolkit can also be shared with Health and Wellbeing Boards to inform commissioning

- c) Those in contact with probation have high levels of mental health and substance misuse needs, CCGs and Public Health departments should examine the extent to which services are currently configured to meet these needs
- d) Working with criminal justice agencies to address other obstacles to health service access such as GP registration
- e) Including criminal justice agencies in commissioning processes to help improve understanding of the complex needs of people in contact with probation and ensure that services are capable of meeting them

Practice

- a) Provision of cross-agency training, in particular around supporting people with mental health and substance misuse needs
- b) All National Probation Service areas and Community Rehabilitation Companies having named health leads
- c) Improved partnership working between health and justice agencies including
 - Developing mechanisms to support routine sharing of health data at transition points throughout the criminal justice pathway
 - Involvement of criminal justice agencies in Health and Wellbeing boards and other commissioning forums
 - Co-location of criminal justice and health staff
 - Developing clear pathways into services for those in contact with probation including for continuity of care from prison to probation Approved Premises and the community
 - Health agencies proactively sharing details of services available and how to access them with their local National Probation Service and Community Rehabilitation Company to support service access and use of community sentences with treatment requirements

Policy

- a) Extension of current policy to create a national strategy for joint working between health and criminal justice agencies including co-commissioning of services
- b) Development of shared cross-agency targets around the monitoring and improvement of health and access to healthcare

Research

- a) Provision of up to date information on the prevalence of different health problems amongst people in contact with probation
- b) Further development and evaluation of quality indicators for the health of people in contact with probation and the quality of the healthcare that they receive
- c) Formally piloting, evaluating, and/or scaling up potential models of good practice identified in the literature and case studies
- d) Extending the work undertaken to produce this toolkit to cover other areas of the country and/or social care needs

Contact us

If you would like to contact us to learn more about our research project or about any of the information within this toolkit, provide feedback on the toolkit or how you are using it, or share examples of good practice that could be added to the toolkit if we update it then please contact us by writing to:

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