The Strategy Unit.

Scoping a Health Needs Assessment for Adults on Probation in England

May 2025

Prepared by:
Sam Callanan, Katie Spanjers, Richard Ward,
Freddie Finlay

NHS
Midlands and Lancashire
Commissioning Support Unit

Document control

Document Title	Scoping a Health Needs Assessment for Adults on Probation in England
Job No	SU1205 (project 4)
Prepared by	Sam Callanan, Katie Spanjers, Richard Ward, Freddie Finlay
Checked by	Abeda Mulla
Date	Version 1 April 2025, version 2 and final version May 2025

Contents

Glossary **1**

Executive summary **3**

Introduction 3

Methodology 3

Key findings 3

Recommendations 5

1. Introduction **6**

1.1 Context 6

1.2 Aims and scope of this study 9

1.3 Approach 9

1.4 Structure of this report 9

2. Methodology **11**

2.1 Interviews with key respondents 11

2.2 Data mapping 11

2.3 Literature mapping 12

3. Findings **13**

3.1 Key respondent interviews 14

3.2 Data mapping 21

3.3 Literature mapping 23

3.4 Recent and ongoing work to address evidence gaps 29

4. Conclusions and recommendations **33**

4.1 Conclusions 33

4.2 Recommendations 33

Appendix 1: Guidance and suggested structure for probation HNAs **38**

Appendix 2: Mapping review stages and guidance **41**

Appendix 3: Definitions for clinical groups from Core20PLUS5 approach **43**

Appendix 4: Data extraction categories **44**

Appendix 5: Summary of literature mapping evidence **45**

Introduction 45
Need or demand outcomes 45
Access outcomes 52
Experience or satisfaction outcomes 58
Appendix 6: Liverpool HNA Questionnaire 62
Reference list 74

Glossary

Term	Description
Approved premises	Approved premises are residential units in the community that provide temporary accommodation and enhanced supervision for offenders released from prison. They provide intensive supervision for those who present a high or very high risk of serious harm.
Community orders	A community order is given by a judge or a magistrate to someone who is found guilty of a crime that does not meet the threshold for a custodial sentence. These orders have the effect of restricting their liberty while providing punishment in the community, rehabilitation and/or ensuring that they engage in reparative activities.
Criminal Justice System (CJS)	The criminal justice system is the collective term for public bodies that work to enforce the law, take action against people who commit crimes and protect the innocent. Key components include: • The Police • The Crown Prosecution Service (CPS) • The Courts • His Majesty's Prison and Probation Service
Criminogenic needs	Criminogenic needs are factors that have been identified as contributing to an individual's likelihood of committing crimes. MoJ use the Offender Assessment System (OASys) to evaluate these needs and help reduce reoffending and improve rehabilitation efforts. OASys measures eight criminogenic needs: • Thinking and behaviour • Attitudes • Lifestyle and associates • Relationships • Alcohol misuse • Drug misuse • Accommodation • Employment
Health Needs Assessment (HNA)	A recommended public health tool for identifying and addressing the health needs of a specific population or population group. It includes determining whether groups have different health needs and pinpointing any inequalities in terms of service provision. It helps organisations, policymakers, and other stakeholders make informed decisions about resource allocation and interventions. A HNA may also assess the social care needs of a population in which case it may be referred to as a health and social care needs assessment (HSNA).
Joint Strategic Needs Assessment (JSNA)	Joint Strategic Needs Assessments are conducted by local authorities and local health organisations. They investigate the current and future health and care needs of a local population to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area. They are broader than a HNA in that they provide a strategic overview of health and social care needs at a community level. As such they may draw on HNAs of specific population groups.

Probation Service	The Probation Service is a statutory criminal justice service that supervises offenders serving community sentences or released into the community from prison.
Suspended sentences	A suspended sentence is a custodial sentence where someone does not go to prison immediately but is given the chance to stay out of trouble and comply with various requirements set by the court. These could include doing unpaid work, being subject to a curfew, undertaking a treatment programme for alcohol or drugs, and being subject to a rehabilitation activity requirement. I have highlighted them where I have found.

Executive summary

Introduction

People under supervision of the probation service experience health inequalities linked to complex and inter-related socio-economic disadvantage. They have significant health and social care needs compared to the general public, face significant barriers to access and yet compared to those in prison there is comparatively little available data on their healthcare needs.

The probation population is approximately three times the size of the prison population, and can be divided into three groups: pre-release supervision, post-release supervision, and those on court orders. Those on court orders may never be held in prison and because of this very little is known about their health.

People on probation are identified as a priority health inclusion ('PLUS') group in the NHS England Core20PLUS5 approach and Inclusion Health Framework. The NHS England Health Inequalities Improvement Programme (HiQiP) team commissioned the Strategy Unit to undertake this scoping study to inform the production of a national Health Needs Assessment (HNA) for adults under probation services supervision in England because of their high health need and relative invisibility to the NHS.

A focus on improving the health of people on probation is expected to increase economic activity in this population group and reduce re-offending. Unmet health and social care needs prevent this group from engaging effectively with probation services and this impedes their rehabilitation.

Methodology

The study consisted of three complementary workstreams which were undertaken in parallel:

- **Interviews with key respondents** to explore expert's views on undertaking the national HNA and identify and discuss available data and relevant literature
- **Data mapping** to identify potential data for informing a HNA, including exploring the possibility of producing population projections
- **Literature mapping** to understand the existing evidence base.

Key findings

Key respondents supported the future production of a national HNA. They believed it would benefit local work to reduce the health inequalities experienced by people on probation by:

- Acting as a template for local HNAs
- Working through some of the challenges around accessing or generating data

- Engaging local stakeholders and setting expectations around their role in delivering local HNAs.

There was consensus that having reliable data on the incidence and prevalence of health conditions in the probation population was necessary to engage local stakeholders in planning effective support for people on probation's health.

Key respondents said that a national HNA should have a wider focus than the five clinical areas in the Core20PLUS5. At a minimum, they suggested including alcohol and drug misuse; other conditions they deemed relevant to the probation population included: oral health, communicable diseases, sexually transmitted diseases and blood-borne viruses.

Respondents requested that a future national HNA determines the intersectionality with other inclusion health groups, stating that this would build health profiles of probation population groups.

Key respondents also stated that a national HNA should explore people on probation's access to, and experience of, healthcare, and to illustrate the links between health conditions and social determinants of health, including people on probation's support networks.

Three groups of stakeholders were identified as necessary co-producers of national and local HNAs, to enable effective actions:

- People with lived experience of probation
- People with experience of working with people on probation, including people working in the probation service
- People who will act on the findings of the HNA, including those with responsibility for commissioning or delivering actions to improve the health of people on probation.

The data and literature mapping workstreams found that there is no reliable data on the prevalence and incidence of health conditions in the probation population, and very limited research on people on probation's access to healthcare and experience of healthcare.

HMPPS and MoJ hold demographic data on the probation population which could support production of prevalence estimates, in conjunction with new data on health conditions in the probation population.

Through scoping activities, four relevant recent or current pieces of work were identified which aim to reduce evidence and data gaps for the health of people on probation. A starting point for a national HNA would be to build on this work and complement it with qualitative data of the lived experience of accessing and using health services of people on probation.

Recommendations

The recommendations below focus on the delivery of a national HNA and how that can support the production of local HNAs for people under supervision of the probation service.

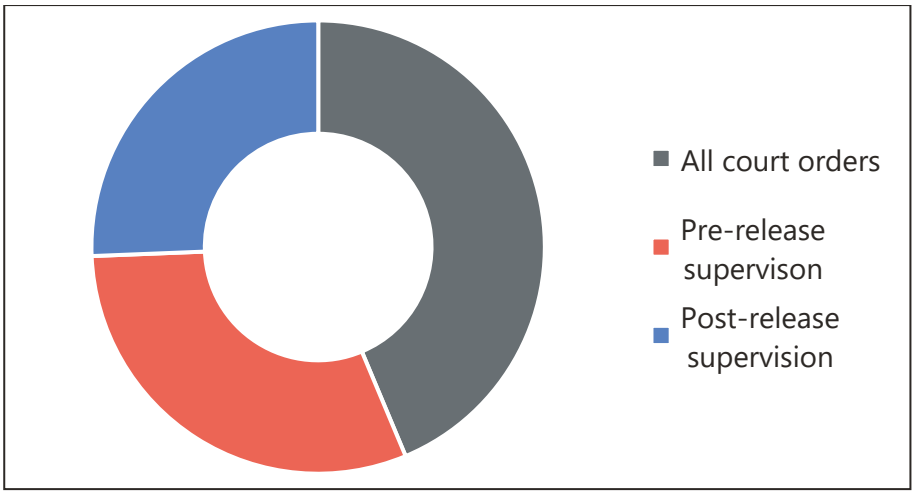
Content for local and national probation HNAs	
1	Identify the demographic and health profiles of the three groups in the probation population and how the population intersects with other vulnerable populations
2	Expand beyond the five Core20PLUS5 clinical conditions to investigate the prevalence and incidence of other health conditions relevant to the probation population
3	Determine and illustrate the links between health conditions, lifestyle and social determinants of health
4	Explore the use of healthcare services by people on probation and their experience of accessing and engaging with healthcare services
5	Explore how support networks and social isolation affect the health of people on probation and their engagement with healthcare services
Reducing data gaps for probation HNAs	
6	Commission or undertake qualitative work into people on probation's experience of accessing healthcare and satisfaction with healthcare
7	Ensure that data collection, analysis and data presentation for a national HNA supports local HNAs and local actions
8	Build on current epidemiological work to understand the prevalence of health conditions and health behaviours of the probation population
9	Gather NHS numbers from people on probation and use them to explore healthcare need and utilisation
Overseeing and co-producing probation HNAs	
10	Explore options for linking to and accessing mortality data to provide deeper insights into the causes of death in the probation population
11	Include people with lived experience in steering a national HNA, and as respondents
12	Include people with professional experience in steering a national HNA, and as respondents
13	Identify and involve those with responsibility for commissioning and delivery of healthcare improvements, and determine how these key stakeholders should be involved in local HNAs

1. Introduction

1.1 Context

People under the probation service account for over two thirds of those in contact with the Criminal Justice System (239,015 people in England and Wales as of March 2024[1]). The probation population can be divided into three groups: pre-release supervision, post-release supervision, and those on court orders (community orders or suspended sentence orders). Those on community orders or suspended sentences may never be held in prison. Figure 1.1 below shows that each group makes up approximately a third of the probation population.

Figure 1.1 Proportions of groups under probation supervision[2]



People under supervision of the probation service face stark health inequalities linked to complex and inter-related socio-economic disadvantage. They have significant health and social care needs compared to the general public, face significant barriers to access and yet compared to those in prison, there is comparatively little openly available data on their healthcare needs. The NHS England Health Inequalities Improvement Programme (HiQiP) team have classified people under the probation service as a priority health inclusion ('PLUS') group because they are a hard-to-reach group with multiple disadvantages currently invisible to the NHS, and have called on leaders at the national and system level to prioritise efforts to better understand and meet their health needs[3].

[1] Gov.uk (2024) Probation data. Available at: https://data.justice.gov.uk/
[2] Chart created from data published in Gov.UK (2024) 'Offender management statistics quarterly: July to September 2024' available at: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2024/offender-management-statistics-quarterly-july-to-september-2024#probation
[3] Owolabi, Lad and Bhattacharya (2023) 'Core20PLUS5: His Majesty's Prison and Probation Service – an approach to address inequities in healthcare for people in contact with the criminal justice system' *BMJ Leader*. Available at: https://bmjleader.bmj.com/content/7/Suppl_2/1.10

There is a need to focus is on those on community orders and suspended sentences in particular because they do not have access to specialised commissioned healthcare and therefore their health needs are less visible to the NHS, and local authority public health.

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. The 'Core20' is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The PLUS population groups should be identified at a local level and include groups experiencing social exclusion (known as inclusion health groups[4]), such as people in contact with the criminal justice system. For adults the five clinical areas of focus which require accelerated improvement are: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding.

The NHS England HiQiP team commissioned the Strategy Unit to undertake a scoping study to inform the production of a national Health Needs Assessment (HNA) for adults under probation services supervision in England. A HNA is a recommended public health tool for identifying and addressing the health needs of a specific population. It helps organisations, policymakers, and other stakeholders make informed decisions about resource allocation and interventions.

The rationale for focusing on improving the health of people on probation is to increase economic activity in this population group and reduce re-offending. The relationship between health and (re)-offending behaviour is complex. Unmet health and social care needs prevent this population group from engaging effectively with probation services and this impedes their rehabilitation. With intersectional needs related to homelessness, rough-sleeping, migration, sex-trafficking, drug and alcohol misuse etc, people on probation are often members of the same communities and social networks who are disproportionately affected by health inequalities. Public Health England argued that addressing this group's health and social care needs would support reduction of reoffending[5], and lead to benefits for the whole society 'a community dividend'[6].

[4] NHS England (2023) 'A national framework for NHS – action on inclusion health' available at: https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/
[5] Public Health England (2019) 'Health and Justice Annual Review 2018 to 2019' available at: https://www.gov.uk/government/publications/prison-health-health-and-justice-annual-report
[6] UK Health Security Agency (2015) 'The community dividend: why improving prisoner health is essential for public health' available at: https://ukhsa.blog.gov.uk/2015/07/06/the-community-dividend-why-improving-prisoner-health-is-essential-for-public-health/

The Chief Medical Officer for England (CMO) is preparing a report on the health of prisoners and those under probation services and the secure NHS estate's supervision, due for publication in summer 2025. We hope that this scoping study will support any actions that the CMO chooses to recommend to address the health inequalities experienced by people on probation.

1.1.2 The probation population

On 30 September 2024, there were 240,497 offenders supervised by the Probation Service in England and Wales[7], this is approximately three times the size of the prison population (85,372 on 31 December 2024). The majority of those under probation are male (approximately 85%). Statistics on the ethnicity for the whole probation population are not available in the most recently published data (2024), but data from 2022 states that the proportion of people from ethnic minorities on community orders or suspended sentences was 18% (in line with the general population), but the proportion of people from ethnic minorities on post release licence was 25%[8], higher than the 18.3% in the general population[9].

Unlike those in prison, whose health care is the responsibility of prisons and prison healthcare services, the responsibility for the health and care of the probation population sits with local systems (ICBs and Local Authorities). However, His Majesty's Prison and Probation Service (HMPPS) is structured into areas and probation regions which may not map directly to health or local authority geographies (see Box 1).

Box 1: HMPPS Areas and probation regions

HMPPS is organised into six areas in England, plus Wales. Each Area has either one or two probation regions, so there are 11 regions across England and Wales.

HMPPS Area	Probation region
North-West	North-West
	Greater Manchester
North-East	Yorkshire & Humber
	North-East
London	London
Midlands	West Midlands
	East Midlands
South-East & East	East of England
	Kent, Surrey & Sussex
South-West & South Central	South-West
	South Central
Wales	Wales

[7] Gov.UK (2024) 'Offender management statistics quarterly: July to September 2024' available at: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2024/offender-management-statistics-quarterly-july-to-september-2024#probation

[8] Gov.UK (2022) 'Statistics on Ethnicity and the Criminal Justice System, 2022' available at: https://www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-2022/statistics-on-ethnicity-and-the-criminal-justice-system-2022-html

[9] Gov.UK (2022) 'Population of England and Wales' available at https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest/

1.2 Aims and scope of this study

The aim of this scoping study is to understand the feasibility of undertaking a national HNA for the probation population, and to determine the appropriate focus and methodology for a national HNA.

Aligned to these aims, the scoping study set out to address the following questions:

- Do key stakeholders believe there is value in conducting a national HNA for the probation population?
- How could or should a national probation HNA support or inform the production of regional and/or local HNAs?
- What data exists on the health of the probation population, and could this be used to produce a national health needs assessment?
- What health conditions and issues of access to and engagement with the healthcare system should be the focus of a national health needs assessment?
- How should a national HNA be undertaken and who should be involved in delivering and steering it?

1.3 Approach

The scoping study consisted of three complementary workstreams which were undertaken in parallel:

- **Interviews with key respondents** to explore expert's views on undertaking the national HNA and identify and discuss available data and relevant literature
- **Data mapping** to identify potential data for informing a HNA, including exploring the possibility of producing population projections
- **Literature mapping** to understand the existing evidence base.

1.4 Structure of this report

The remainder of this report is structured as follows:

Section 2 – Methodology: summarises the methods used for each of the three workstreams.

Section 3 – Findings: summarises the key findings from the three workstreams.

Section 4 – Conclusions and recommendations: summarises the conclusions and recommendations for the design and delivery of a future national HNA based on the findings from the three workstreams.

2. Methodology

2.1 Interviews with key respondents

Key respondent interviews were undertaken to elicit expert opinion on conducting a national probation HNA. A topic guide was agreed with NHS England and the interviews explored the purpose and value of a national HNA, the content and focus of a national HNA, the feasibility and potential methods for conducting a HNA (including exploring issues around data as outlined below) and the involvement of stakeholders in the production of HNAs for the probation population. Key respondents were also asked for information on any current or recent health needs assessments of the probation population, for potential sources of health data for the probation population, and for pointers to relevant literature.

Key respondents were agreed with NHS England, and NHS England introduced the Strategy Unit to interviewees. Most key respondent interviews were one-to-one, but to accommodate interest in the project we conducted some group interviews. In total we conducted 15 interviews with 24 individuals.

Interviews were conducted on the understanding that findings would be reported anonymously, key respondents included: senior staff within the Ministry of Justice (MoJ) and HMPPS with responsibility for the health of people on probation, a Regional Director of Public Health, Directors and Assistant Directors of Public Health from four ICBs, Public Health and Justice Leads for NHS England, Heads of Community Integration for HMPPS, academics, third sector organisations with expertise in conducting HNAs of the criminal justice population, and GPs and other health colleagues with experience of working with this population.

2.2 Data mapping

The data mapping exercise sought to answer the question: '*What data exists on the health of the probation population, and could this be used to produce a national health needs assessment?*' The sub-questions addressed by the data mapping exercise are as follows:

- What service data is available on the prevalence of healthcare conditions in the probation population?
- What service data is available on the prevalence of smoking or vaping in the probation population?
- What service data is available on the need for maternity care in the probation population?
- What service data is available on healthcare utilisation in in the probation population?
- What data is available on the causes of premature mortality in the probation population?

- Is there demographic data for the probation population to support prevalence modelling of healthcare need?
- Is there population projection data for the probation population to support prevalence modelling (of future healthcare need)?

The data mapping workstream explored the validity, reliability and completeness of pre-existing service data on prevalence, healthcare utilisation and outcomes in the Core20PLUS5 five priority clinical areas maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding) and smoking and vaping. We assessed the suitability of this data for use in a national health needs assessment through conversations with staff in NHS England and HMPPS, and by reviewing relevant documents. Some conversations formed part of the interviews with key respondents, other conversations were with new stakeholders such as analytical staff within the MoJ.

2.3 Literature mapping

This workstream adapted scoping and literature mapping review methods (Arksey & O'malley, 2005; Campbell et al., 2023) to identify, catalogue and visually represent gaps in probation population evidence on three broad questions:

1. What do we know about the health needs of people in the probation population?
2. What do we know about access or utilisation of health and care services for people under supervision of the probation service?
3. What do we know about the experiences of people under the supervision of the probation service?

The literature mapping took a pragmatic approach to inform the scope of a national population health needs assessment within the project timelines. The mapping is non-systematic and non-exhaustive. Literature sources were identified through an initial long-list provided by NHS England, this was complemented through contacts with key respondents. In keeping with mapping review methods, we took a descriptive approach to understand high-level patterns within this limited evidence base. No critical appraisal or risk of bias assessment was undertaken due to rapid timelines and emergent nature of evidence base. Further detail on the review protocol, inclusion criteria and definitions for clinical groups is provided in appendices two to four.

3. Findings

Summary of findings

Key respondents supported the future production of a national HNA. They believed it would benefit local work to reduce the health inequalities experienced by people on probation by:

- Acting as a template for local HNAs
- Working through some of the challenges around accessing or generating data
- Engaging local stakeholders and setting expectations around their role in delivering local HNAs.

There was consensus that having reliable data on the incidence and prevalence of health conditions in the probation population was necessary to engage local stakeholders in planning effective support for people on probation's health.

Key respondents said that a national HNA should have a wider focus than the five clinical areas in the Core20PLUS5. At a minimum, they suggested including alcohol and drug misuse; other conditions they deemed relevant to the probation population included: oral health, communicable diseases, sexually transmitted diseases and blood-borne viruses.

Interviewees requested that a national HNA determines the intersectionality with other inclusion health groups, stating that this would build health profiles of probation population groups.

Key respondents also stated that a national HNA should explore people on probation's access to, and experience of, healthcare, and to illustrate the links between health conditions and social determinants of health, including people on probation's support networks.

Three groups of stakeholders were identified as necessary co-producers of national and local HNAs, to enable effective actions:

- People with lived experience of probation
- People with experience of working with people on probation, including people working in the probation service
- People who will act on the findings of the HNA, including those with responsibility for commissioning or delivering actions to improve the health of people on probation.

The data and literature mapping workstreams found that there is no reliable data on the prevalence and incidence of health conditions in the probation population, and very limited research on people on probation's access to healthcare and experience of healthcare.

HMPPS and MoJ hold demographic data on the probation population which could support production of prevalence estimates, in conjunction with new data on health conditions in the probation population.

Through scoping activities, four relevant recent or current pieces of work were identified which aim to reduce evidence and data gaps for the health of people on probation. A starting point for a national HNA would be to build on this work and complement it with qualitative data of the lived experience of accessing and using health services of people on probation.

3.1 Key respondent interviews

3.1.1 How could a national HNA support local work to reduce health inequalities experienced by people on probation?

There was a consensus amongst key respondents in favour of the production of a national probation HNA. Key respondents reported that the probation population was often overlooked in comparison to the prison population, despite being almost three times the size. Interviewees believed that a national HNA would be a way of focusing attention on the health of people on probation. They stated that it was often difficult to achieve local engagement in the health of people on probation, and that a national probation HNA would provide an impetus and mechanism for regional and local engagement (see also section 3.1.7).

> *A national joint needs assessment would open the door for local discussions to say, 'nationally there is a concern about health inequalities, about primary and secondary health care in the Criminal Justice System.' … it would definitely facilitate the local drive around joint needs assessments, and without that national piece, you would struggle at the local level to engage NHS and commissioners.*

Key respondents stated that a national HNA would complement the recommendation expected from the CMO review (see section 1.1) to produce local HNAs, further motivating and engaging local stakeholders in the production of local HNAs.

Interviewees identified how a national probation HNA could facilitate local efforts. This included by providing a template for local HNAs; agreement for sources of data; guidance for data collection; and identification of key local stakeholders to work with.

> *I think it's useful to have a template of some sort for people to work to, and also to have worked through things like: Where are we going to access data? Exactly what do we want this health needs assessment to look like? What should be included? How are we going to access demographic data, epidemiological data? Are we going to be doing interviews with people locally or questionnaires with people locally?' What should it look like? What are the policy drivers for it? What levers are we using locally to get organisations to be involved and support it? You know, what organisational objectives are we actually supporting here which will encourage them to take part? And who should take part?*

There was consensus that a future national HNA should determine and test a structure for probation HNAs, which could then be used as a template for local HNAs to follow. However, there are some common elements that most HNAs include, so as a starting point we provide an outline of the possible contents and structure for a probation HNA in Appendix 1.

Some interviewees caveated their enthusiasm for a national probation HNA, highlighting the variation in regional and local health needs of people on probation and local variation in the availability of services. Interviewees stated that a future national probation HNA would have to

consider potential differences between national and regional or local health needs and availability or accessibility of services, hence the importance of following any national HNA with local needs assessments.

Interviewees also pointed to relevant local activities, and were keen to ensure this work was not unnecessarily duplicated but was built on in any future national probation HNA. Four of these activities are summarised below in section 3.4 and learning from them has been used to inform the recommendations of this study.

3.1.2 How important is having reliable data on the health of people on probation?

Key respondents agreed that it was important to have reliable data on the health of the probation population. However, they reported that the data which currently exists is very limited.

> *I think we should be honest about it. There isn't data. And I know we keep saying, 'Oh, the data is not very good', but it really is there isn't any. You can't run an effective report on any of those elements that gives you anything really useful.*

Key respondents stated that without reliable data on the incidence and prevalence of health conditions in the probation population it was difficult to plan support for people's health, and critically, that it was very difficult to engage local systems in in work to address the inequalities experienced by the probation population.

> *… we have no evidence base on which to support local areas, particularly local ICS systems, to plan for, and respond to probation placements in their jurisdiction. So, we're flying blind, and we're extrapolating from prison health, which is not the same.*

One interviewee described getting stuck in a catch 22 situation where in order to unlock funding to fully investigate the health needs of the of the probation population they needed to be able to show that there was some need there, but were unable to demonstrate this because of a lack of relevant data.

> *…to know the health needs of the patient population, you have to assess them in some way or form or be able to identify them in existing health data sets. And you can't identify them and there isn't a standardised way of assessing their needs. So, you can't find out what their needs are, but to get the money to do the work to find out their needs, you need to be able to demonstrate those needs.*

Although interviewees were clear on the importance of quantitative data, they noted that having evidence of need alone would not necessarily lead to effective action. They emphasised the need to gather qualitative data on the experiences of the probation population accessing health services to identify improvements to access. This is explored further in section 3.1.5 below.

> *[The] quantitative will allow you to describe the size of the problem, the consequences. What it's not so good at is describing the solution, and that's where, I think, you will need*

to switch more to qualitative data. Which is interviews with both people on probation, the families, and those that work with them. … The quantitative can tell you the what but the qualitative will give you the how and the why.

3.1.3 What health conditions are most important to the probation population and those working with them?

Generally, key respondents were supportive of a focus on the Core20PLUS5 clinical areas as a starting point for the probation population.

They've been chosen as the five because they are the biggest drivers of early mortality. So I'm not going to disagree with that. Is there potential to expand? I think yes, absolutely.

They saw a benefit to alignment with the national Core20PLUS5 approach, and as discussed in section 3.1.6 below, observed that there is a significant overlap between the probation population and other populations that are a priority in the Core20PLUS5.

However, there was consensus across interviewees that focusing only on the five clinical areas (plus smoking cessation) alone would be problematic. Key respondents believed that this would lead to limited engagement with the national HNA, and any local work that developed from it.

…part of the reason we've got you in this room right now talking about this is because the Core20PLUS5 exists as a framework and its focused minds and its given us tangible things to think about. So, that in itself means that [it] becomes the framework by which you're operating, which makes sense. I think the challenge that … we've got is that Core20PLUS5 clinical areas are built on the lens of a whole population, but if you were to look at criminal justice populations, you'd probably have a different five.

Most critically, key respondents recommended that a future probation HNA should consider alcohol and drug misuse in addition to the Core20PLUS5 clinical areas. This was seen as necessary due to high rates of alcohol and drug misuse within the probation population, and the strong links between misuse and adverse health, and to reoffending behaviour. Respondents working in the criminal justice system were clear that excluding alcohol and drug misuse in a future HNA would reflect negatively on the credibility and take up of the HNA, by stakeholders.

if that national report was going to be, and I mean this in the nicest possible way, any use to the criminal justice system. If it didn't reference drugs, alcohol, mental health, it would just be seen as a social report around wider social health. And, people if you're lucky would flick through it, and sit and think, 'Oh yes, this is really interesting about smoking and cancer and heart related drugs.' But, how does that really equate to probation?

As well as alcohol and substance misuse, key respondents identified other clinical areas that were of particular importance in this population. These included: oral health; communicable diseases; Sexually Transmitted Diseases (STDs) and Blood-borne viruses (BBVs); healthy living and diet; sleeping; and pain management.

Key respondents also wanted a national HNA to take a broad approach to the health conditions included. For example, they suggested focusing on respiratory conditions in general not just COPD.

> *I think there are other respiratory conditions that drive some of that frequent attendances or barriers to accessing wider healthcare services that I think the probation population face. So, I would want to see it move more broadly outside of that respiratory focus.*

Interviewees also agreed that maternity should be a focus, but some suggested that this should be widened to include parenting generally, particularly given the high ratio of men to women in the probation population. Respondents also noted the very high level of mental health conditions in the probation population, and felt that any work on mental health need to include all mental health conditions, not just severe mental illness. Respondents suggested that widening the focus in this way would support development of appropriate interventions for the population.

3.1.4 Links between health conditions, and the role of social determinants of health

Interviewees wanted a national HNA to explore and evidence the relationships between different health conditions in the population. They said that while they can make assumptions about links between health conditions and lifestyle or substance misuse, without data to back that up it is harder to engage others in actions to address the health conditions or their underlying causes.

> *I could make an assumption to say someone who has been using heroin for 40 years probably has wider problems internally, liver, respiratory functions and stuff like that. But, we can't, you know, give data on those things.*

There are well known links between alcohol and drug misuse, and other conditions such as mental health issues, poor oral health, hypertension and so on. Respondents stated that it would be important for a probation HNA to highlight and summarise evidence of these links in the probation population because that would help identify and motivate appropriate actions to improve these health conditions and their causes.

Relatedly, key respondents wanted a national HNA to explore the role of social factors such as social isolation and social connections in the health inequalities experienced by this population group (see section 3.1.5).

3.1.5 Access to, and engagement with, health services

Key respondents stated that as well as identifying the prevalence and incidence of health conditions in the probation population, it would be important for the HNA to gather and report information on access to and engagement with health services by this population, in order to develop appropriate ways of meeting people's health needs.

> *It's okay to collect the epidemiological data to say, 'What level of need is there?' But then the next piece of the puzzle is, are people accessing care to meet those needs, and does it meet those needs? So, do people feel that their health improves as a result of accessing a service? Do they complete their treatment plan or are there barriers to them accessing care, do they drop out of care? Are they having a poor experience? Are they dissatisfied?*

Key respondents reported that in their experience, people on probation are less likely to engage with primary health care services and may ignore symptoms and health conditions for longer than average or until they have progressed to a point where they are harder to treat. They reported a widely held view that people on probation are more likely to be frequent users of accident and emergency than the population average. As such the probation population may disproportionately burden health services, and having good data on that would be a motivator for engaging local systems in planning health care for the population.

One key respondent noted that people on probation are sometimes referred to as a 'hard to help' group, rather than a hard to access group. Access is possible through the probation service, but there are a range of challenges to this group engaging with healthcare, particularly timely primary healthcare. Some of these challenges may be to do with individual lifestyles and behaviours, but key respondents identified additional barriers such as low levels of literacy, homelessness and/or living in temporary accommodation.

> *We know that in trying to register with a GP there's a prejudice often about appearance and... if you then go, 'can you just fill out these twenty forms? You know, go away and here's a pen, fill out these twenty forms,' you're not going to register properly. In which case, if you're not registered with your GP, you don't access things in primary care, you wait till you're in crisis and you rock up at an A&E.*

Key respondents stated that a better understanding of these issues would support local systems to ensure their services were accessible to people on probation, and could help to reduce barriers to people on probation accessing timely health care. There was a shared view amongst key respondents that there may not be a need for services specifically for people on probation, a better focus would be to ensure that existing services are accessible to people on probation.

Key respondents also wanted the national HNA to explore the support around people on probation, their support networks and how those can be positive or potentially negative, and how the nature of prison and probation may disrupt these.

> *I think we talk about individual's access, experience, outcomes, through a health inequalities lens and then what we often then then forget is actually, around that individual, that person, there's a whole network of people that are also there to support that individual to either navigate the health system or wider system.*

More specifically, there were calls for the national probation HNA to define the extent to which people on probation are either socially isolated or 'in with the wrong crowd' and explore how the work done to improve the health of people with few social contacts, could be applied to those where their social contacts may have a negative influence on their lifestyle and health.

3.1.6 Overlaps between the probation population and other Core20PLUS5 inclusion groups

Many key respondents noted that as well as being one of the inclusion health groups identified in the Core20PLUS5 (people in contact with the criminal justice system), the probation population overlaps with other target groups in the Core20PLUS5 approach. The probation population contains high proportions of people from the most deprived 20% of the national population; from plus groups such as ethnic minority communities and people with a learning disability and autistic people; and from other inclusion health groups such as:

- People experiencing homelessness and rough sleeping
- People with drug and/or alcohol dependence
- Sex workers.

A small number of key respondents suggested that given the significant overlaps between groups, rather than conducting health needs assessments of just the probation population a better approach might be to conduct a health needs assessment for all inclusion health groups. However, other interviewees raised concerns that the probation population might get 'lost' amongst the other groups, particularly given the lack of data on the health needs of those on probation.

All respondents who discussed this issue agreed that it would be important for a national HNA, and any local HNAs, to consider these overlaps and provide as clear a picture as possible of how the probation population overlaps with other groups that experience health inequalities.

3.1.7 Who should be part of steering and feeding into HNAs?

Key respondents identified three groups who need to be involved in steering, delivering, and feeding into national and local HNAs for the probation population:

- People with lived experience of probation
- People with experience of working with people on probation, including people working in the probation service
- People who will act on the findings of the HNA, including those with responsibility for commissioning or delivering actions to improve the health of people on probation.

3.1.7.1 Involvement of people with lived experience of probation

All key respondents strongly supported the involvement of people with lived experience of probation in the oversight and production of national and local probation HNAs. This involvement was seen as an important ethical principle, but key respondents focused more on the practical and operational benefits of involving people with lived experience of probation in the HNA.

As discussed in section 3.1.5 above key respondents stated that as well as data on the prevalence and incidence of health conditions it would be important that the HNA explored issues of access to health care and barriers to engagement with health services. They stated that people with lived experience could inform the design of the HNA to ensure these issues were considered, feed in their own experiences, and inform discussions of solutions to address access barriers or challenges.

Key respondents also noted that high proportions of people with neurodiversity, ADHD, learning disability/difficulty and mental health issues in the probation population, and stated that involving people with these conditions is important for increasing understanding and creating appropriate solutions.

> *…lived experience is really important given you've got 30% of people who are in probation [that] will have some kind of learning disability or ADHD or [some form of neurodiversity], and I think there is a very poor recognition of neurodiverse conditions. So, I think it's really important that you get that experience, both from people who are using the service and people who are working within the service.*

Interviewees noted that there are existing lived experience groups which could be accessed, but that some new qualitative work would be required as well. They suggested that people with lived experience could be used to support or conduct primary qualitative research with the probation population.

> *…we use a lot of people with lived experience to do that work [qualitative research with people in contact with the criminal justice system]. As much as I might be quite nice, I might not be the person to sit on the park bench and speak to a homeless person. It might be somebody who has experienced homelessness who'd be better placed to do that. And I think it's about not expecting people to come to you, it's about you go to them. Make it as easy as possible. Hang around in probation, you know? Talk to people. Be present.*

3.1.7.2 Involvement of people with professional experience of probation

Key respondents emphasised the importance of involving probation service staff who have worked in operational roles in a national HNA and in local HNAs, both in steering or overseeing HNAs, and as a source of evidence for a HNA.

Interviewees suggested that those with experience of working in probation and managing people on probation would be able to provide an important perspective on how and when people on

probation engage with health services. And that this perspective would be important to include alongside perspective gathered from speaking to those with lived experience of probation.

Key respondents also stated that it was important for those with experience of working in probation to be part of designing actions to address inequalities because they are best placed to know what will work in the real world.

3.1.7.3 Involvement of roles and organisations responsible for acting on the HNA

A number of key respondents reported the challenges they had experienced in engaging the necessary local stakeholders to work on the health of people on probation. Particularly with identifying and engaging those with responsibility for commissioning and delivering services which could help improve the health of people on probation.

> *It's incredibly hard to try and get local health and social care organisations working together with probation and particularly the ICS world. Who in that world is actually responsible for working with this group? We don't tend to have somebody with that label and you can make the argument, 'This is a marginalised vulnerable group. It's a health inclusion group. But which role is actually responsible?' Or is it a bunch of roles in which case potentially nothing happens?*

Key respondents also emphasised the importance of having the local knowledge and responsibility for delivery around the table to design solutions that would work in the local context.

> *We need to be able to look at the needs of people on that local level with all the local partners around the table together. It can't be just an exercise that probation do on their own, they have to have those partnerships in place. Both to actually undertake the exercise but also to ensure that some action happens as a result of it. And obviously all the local geographies in terms of commissioning boundaries and so on will play into that.*

The direct actions to improve the health of people on probation need to be undertaken locally, but key respondents said that a national HNA could and should consider this issue and identify the roles or responsibilities needed to be present in the production of local HNAs and set this out as part of the template for conducting local HNAs.

> *I think having that national template perhaps, some guidance in terms of expectations of specific roles and how they should be involved in it. … would be really helpful because then local level has got all of that guidance to work from.*

3.2 Data mapping

This section provides a summary of the findings from the data mapping exercise. As described in section 2.2 above, the data mapping exercise sought to identify data that exists on healthcare need and utilisation in the probation population, and ask whether it could be used for prevalence modelling as part of a HNA.

3.2.1 Data on healthcare need and utilisation

HMPPS collect and record limited data on the health needs and utilisation of the probation population.

While HMPPS capture some information about health and wellbeing in their risk and needs assessment tool - Offender Assessment System (OASys), people under supervision of the Probation Service are not subject to health assessments and the data in these records are largely self-reported. Limited data is collected on health behaviours; there are data fields that capture drug and alcohol use but not smoking or vaping. Recording of health conditions is uncommon and where available, the information provided is not comprehensive and does not capture specific health conditions. Data specific to maternity needs is not recorded. Key respondents advised that the sections about drug and alcohol use and mental health conditions were the most likely to be completed by probation officers but may not be up to date or verified for example through medical records or a drug and alcohol sample.

Clinical records held by the NHS (such as primary care records) contain data about diagnosed health conditions (health needs) and healthcare contacts (utilisation). However, being under supervision of HMPPS is not a piece of information that is captured in NHS records and there is currently no mechanism to link HMPPS probation records and NHS health records nationally. However, as described in section 3.4.3 below, an ongoing project in West Mercia has started to record NHS numbers in OASys during routine contact with probation officers and this data is being shared with and processed by local authority public health teams to better understand health needs.

3.2.2 Mortality data

The HMPPS holds data on cause of death for people who died while under the supervision of the Probation Service. Cause of death data is categorised as: natural causes; self-inflicted; drug poisoning (intent undetermined/unintentional); homicide; and other.

Deaths coded as *'natural causes'* will include deaths caused by chronic health conditions such as those related to the five Core20PLUS5 clinical priority areas and smoking and vaping. Available data is not granular enough to provide insights into the causes of death (health needs) among people under supervision of the probation service.

Professor Karen Slade and colleagues are completing a series of studies exploring the patterns and characteristics of people who die under probation supervision. These studies link datasets from the Office for National Statistics and the Ministry of Justice to provide deeper insights into mortality

patterns in the population. The first study has been published, which explores post-prison releases with a study on community/court-ordered sentences expected within 2-3 months[10].

3.2.3 Demographic data

While national probation population figures broken down by: age; sex; and some ethnicity data are openly available[11,12], figures broken down by age and sex (the data required to calculate age and sex standardised prevalence estimates) and ethnicity (required to calculate ethnicity specific prevalence) at the national and sub-national level are not. More granular data can be secured through liaison with the Probation Statistics Team[13].

HMPPS does not produce population projection for the probation population; therefore, prevalence estimates cannot be used to estimate future healthcare need.

3.3 Literature mapping

This section reports literature mapping review findings. Each of the three sub-sections provides count data on the number of sources identified for the broad outcome category (need, access, and experience), broken down by clinical group. This is illustrated via waffle charts and followed by a descriptive summary of the strength of the evidence for each group and outcome, and of gaps in the evidence.

This section does not summarise key findings from the literature, because the aim of the literature mapping was to identify areas of strength and weakness in the evidence. However, in appendix 5 we provide a descriptive synthesis of the evidence for each clinical group under each outcome area. In that appendix summaries of individual sources are provided to understand key findings where synthesis could not be undertaken due to the low volume of sources.

[10] Slade et al. (2025) Mortality after prison release in England and Wales, 2019–2021: A comparative analysis of cause-specific death rates and risk profiles. Available at: https://doi.org/10.1016/j.socscimed.2025.117821

[11] Gov.uk (2025) Statistics on Ethnicity and the Criminal Justice System, 2022 (HTML). Available at: https:/www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-2022/statistics-on-ethnicity-and-the-criminal-justice-system-2022-html

[12] Gov.uk (2025) Offender management statistics quarterly: April to June 2024. Available at: https:/www.gov.uk/government/statistics/offender-management-statistics-quarterly-april-to-june-2024

[13] Information governance requirements will need to be satisfied and may be more stringent if the data requested has the potential to be personal identifiable information.

3.3.1 Need or demand outcomes

The literature mapping review identified 19 sources which described information on the health needs of the probation population. The waffle chart in Figure 3.1 represents the breakdown of sources by key clinical groups.

Figure 3.1 Waffle chart showing the total number of sources which captured demand outcomes, broken down by clinical group.

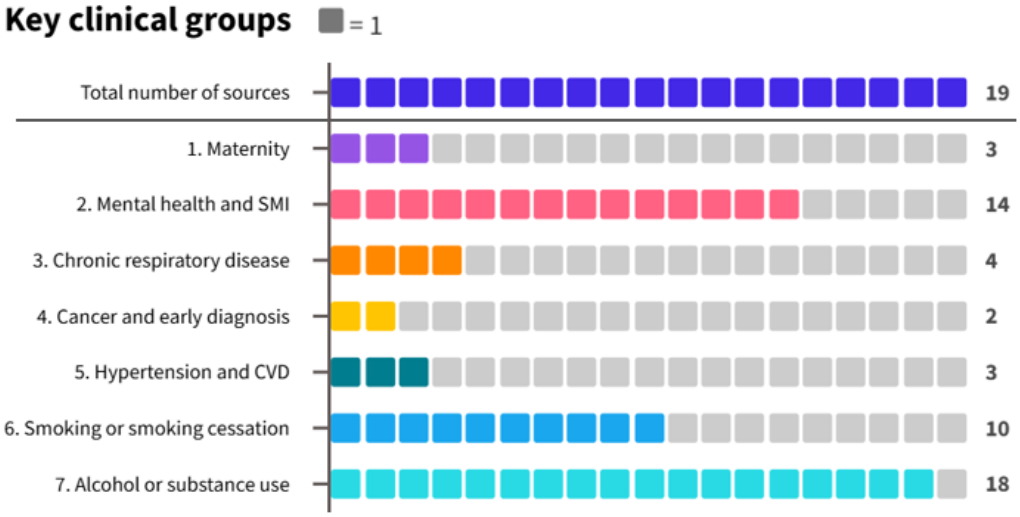


Table 3.1 provides a short summary of the need or demand evidence strength in the literature for each clinical group.

Table 3.1 Summary of need or demand literature

Clinical Group	Summary
1. Maternity	Three sources described information on needs or demand for pregnant women on probation or those who had given birth within the last two years. However, the evidence in the three sources is based on small-scale surveys and qualitative research which limits the generalisability of this evidence for understanding the scope of maternity needs in the national probation population.
2. Mental health and SMI	There is a comparatively high quantity of research on mental health in the probation population. Some sources report condition-level prevalence estimates, or prevalence for broader constructs such as "current mental illness". However, others reported subjective measures of mental health need, self-reported diagnoses or free-text survey responses from service users. The differences in methodology and scope between studies limit objective comparison of information on mental health needs across sources.

Clinical Group	Summary
3. Chronic respiratory disease	Four sources described information on demand or needs in relation to chronic respiratory disease, but there was overlap or redundancy between two sources. Evidence of prevalence of respiratory conditions in these sources was based self-reported data.
4. Cancer and early diagnosis	There was very little work on cancer prevalence in the probation population. No information was found on the prevalence of cancer diagnoses, staging or severity in people on probation compared to the general population. One source did report the rate of cancer frequency amongst community offenders based on survey responses.
5. Hypertension and CVD	Three sources described information on demand or needs related to CVD. None provided information on people on probation in terms of hypertension prevalence, severity or blood pressure readings for hypertension monitoring.
6. Smoking or smoking cessation	Ten sources described information on demand or need related to smoking or smoking cessation. Sources primarily reported the proportion of respondents who were currently smokers, though some broke down rates of smoking by demographic variables. A smaller number of sources provided insights on the use of vapes and e-cigarettes.
7. Alcohol or substance use	There is a comparatively high volume of research on alcohol and substance misuse in the probation population. Eighteen sources described demand or need related to alcohol or substance use, with two of those sources reporting findings from validated measures. However, there is variation in the reported rates across and sources reviewed identified a need for further research to provide up-to-date information on the prevalence of substance misuse in the probation population.

A summary of key findings for each clinical group and further details of the sources are provided in appendix 5.

As Figure 3.1 and Table 3.1 show, there was a high volume of sources on need or demand outcomes for SMI, Smoking, and Alcohol or substance use, whereas there were gaps for: Maternity, Chronic respiratory disease, Cancer, and Hypertension or CVD.

These gaps may reflect the focus of existing research, policy and healthcare provision on probation, and people in contact with the criminal justice system more widely. Gaps in this area suggest that existing research provides limited scope to understand the scale or extent of the health needs of the probation population in terms of: maternity, chronic respiratory disease, cancer, and hypertension and CVD.

There is limited understanding (and no known government published data) on the physical health needs of people on probation, and the health of prisoners is often used as a proxy to understand health needs of this population group. (Rabaiotti, 2024)

3.3.2 Access outcomes

The literature mapping review identified 21 sources which described information on access to care, uptake or service use in the probation population. The waffle chart in Figure 3.2 represents the breakdown of sources by key clinical groups.

Figure 3.2 Waffle chart showing the total number of sources which captured access outcomes, broken down by clinical group.

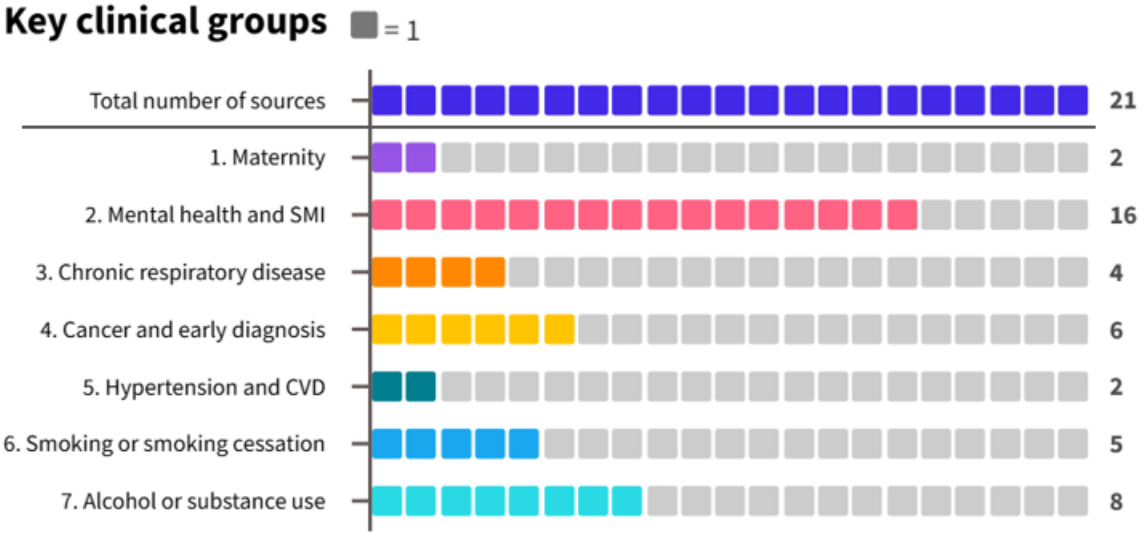


Table 3.2 provides a short summary of the access evidence strength in the literature for each clinical group.

Table 3.2 Summary of access literature

Clinical Group	Summary
1. Maternity	Two sources described information on access to care for women on probation who were pregnant, had been pregnant while in prison, or were new mothers. One sources was based on a small-scale survey (n=44) of women, the other was based on qualitative work with professionals and people with lived experience.
2. Mental health and SMI	Sixteen sources described findings on access to support for mental health or SMI. This includes two systematic reviews which synthesise evidence from a range of sources.
3. Chronic respiratory disease	Four sources described information on access to care or treatment for chronic respiratory disease. This is a notable gap, available information provides little insight into whether access and uptake of support for chronic respiratory diseases is commensurate to need in this population.

Clinical Group	Summary
4. Cancer and early diagnosis	Six sources described information on access to or uptake of cancer screening for people on probation. However, no evidence was identified on the access to treatment or impacts of late cancer diagnoses for probation population groups in England or internationally.
5. Hypertension and CVD	Two sources described information related to access to treatment or care for hypertension or cardiovascular disease. Although, neither source described the extent to which people on probation with high blood pressure or other risk factors are able to access hypertension monitoring within primary care.
6. Smoking or smoking cessation	Five sources described access information on support for smoking or smoking cessation interventions. These sources tended to report rates of those wanting to stop smoking or who have tried to quit smoking, there was less evidence on uptake of smoking advice, or access to smoking cessation support such as medication.
7. Alcohol or substance use	Eight sources described information on access to treatment or support for alcohol or substance use for people on probation. Despite the prominent focus of drug and alcohol needs in the wider literature, we know relatively little about whether drug and alcohol treatment needs are adequately met for people on probation. With gaps in the wider evidence base on devising effective approaches to drug and alcohol support and measuring their impact on access to adequate support and reducing unmet needs.

A summary of key findings for each clinical group and further details of the sources are provided in appendix 5.

There was a higher volume of sources on access outcomes or information for SMI, and alcohol or substance use, and fewer, but still a reasonable number for cancer and smoking cessation. Key gaps included maternity, chronic respiratory disease, hypertension or cardiovascular disease.

This suggests that more is known more about access to support for mental health, smoking, alcohol and substance use than for physical health conditions such as cancer. With limited research to build a detailed picture of probation population service access, utilisation, and availability for maternity, respiratory disease, cancer, hypertension and CVD. There are substantial knowledge gaps even for areas with a high volume of research such as: mental health and SMI; and drug or alcohol use. As despite the more prominent focus on SMI and drug or alcohol use in the literature, we lack the comprehensive picture of service provision, availability and uptake necessary to understand the true extent of unmet needs in the probation population.

3.3.3 Experience or satisfaction outcomes

The literature mapping review identified four sources which described information on experience or satisfaction outcomes for people on probation. Due to the low volume of sources, count data is presented in tabular format to show where information on experience or satisfaction is reported against a particular clinical group. Table 3.2 also contains a short summary of the experience or satisfaction evidence in the literature for each clinical group.

Table 3.3 Number of sources and summary of experience or satisfaction literature

Clinical Group	Number of sources	Summary
1. Maternity	2	There is limited evidence on experiences relating to maternity. Two sources were identified, which used small-scale surveys and qualitative methods.
2. Mental health and SMI	4	Four sources described information on the experiences or satisfaction of people with SMI or people with a mental health condition who were on probation. Information related to experiences of mental health support generally, rather than taking a specific focus on SMI. No source described the experiences or satisfaction of people on probation accessing or receiving support for SMI.
3. Chronic respiratory disease	0	N/A
4. Cancer and early diagnosis	0	N/A
5. Hypertension and CVD	0	N/A
6. Smoking or smoking cessation	0	N/A
7. Alcohol or substance use	2	Two sources described rates of satisfaction, patient experience or other formal measures of quality of care to understand how people on probation had experienced support for alcohol and substance use. This is a notable gap given alcohol and substance use are more prominent topics in the literature compared to other health issues.

A summary of key findings for each clinical group and further details of the sources are provided in appendix 5.

This is a substantial gap compared to the volume of sources which reported information on demand or access. With the review identifying no sources which described experience or satisfaction with care for chronic respiratory disease, cancer, hypertension and CVD, and smoking cessation. There was comparatively more information on experiences of accessing support for maternity, mental health and SMI, and alcohol or substance use. Despite this, insight into the quality of support available for people on probation is limited. This constitutes a stark gap in the evidence which limits our ability to understand whether the support provided to people on probation reflects what matters most to them.

3.4 Recent and ongoing work to address evidence gaps

From interviews with key respondents and through other contacts with stakeholders we identified four recent or current pieces of work on the health of people on probation which aimed to fill the gaps in health data for this population through new primary research or data linkage, and so had the potential to inform or be used for a national HNA. Discussions with stakeholders and review of documents relating to these projects have informed our key findings and recommendations. A brief summary of each of these projects is provided here.

Respondents identified other examples of ongoing and recent work on the health of people on probation, including a needs analysis for the South Central probation region, a HNA of people on probation within the Swansea Neath Port Talbot Probation Delivery Unit, a HNA of offenders in the community in Derbyshire and Derby City, and work for the Chief Medical Officers review. These are important pieces of work but they do not contain new research or data linkage to address the gaps in quantifiable data on health need and utilisation in the wider probation population, and so they are not described here.

3.4.1 Wales Health and Social Care Needs Assessment for Residents in Approved Premises

In 2023 Betsi Cadwaladr University Health Board in partnership with HMPPS Wales undertook a Health and Social Care Needs Assessment (HSCNA) for people in approved premises. The needs assessment covered physical and mental health as well as lifestyle factors and health related behaviours including smoking, drug and alcohol use, gambling, diet and exercise. There are four approved premises in Wales with approximately 100 residents across the four sites, all of whom are male. There were 76 residents at the time of the HSCNA[14].

The HSCNA used a mix of qualitative and quantitative methods, it undertook questionnaires, focus groups and interviews with service users, staff and wider stakeholders. Data on health conditions

[14] York (2023) A Health and Social Care Needs Assessment for Residents in Approved Premises in Wales

was collected via the self-reported questionnaire which was completed by 53 residents (this represented 70% of the AP population in Wales)[15].

While important as evidence to support the health needs of those in approved premises in Wales, this data is self-reported, and from a relatively small number of people who were in approved premises. Those in approved premises are usually higher risk prisoners, and so this group may not be representative of the larger probation population. Therefore, the findings from this report could not be generalised to the wider probation population in England and Wales.

3.4.2 Liverpool HNA for the probation population

NHS England (North West) are currently undertaking a HNA for the probation population in Liverpool, in partnership with North West Probation Services. As part of this they have commissioned a survey of the health of people under the supervision of the probation service in Liverpool. The survey is being undertaken by a private organisation with experience of engaging individuals in the North West criminal justice system, who work with people with lived experience. They attend probation offices and recruit people on probation who are there to attend their probation service meetings. The survey used the questionnaire developed for the HSCNA of residents in approved premises in Wales (above) as a starting point. It is completed outside of the probation meeting and is self-reported. The survey has been designed to capture prevalence data (including prevalence of conditions in the Core20PLUS5 five clinical areas), it asks respondents to rate their physical and mental health and the impact of this on their day-to-day activities; to report any conditions they have been diagnosed with or that they think they may have; about health-related behaviours such as drinking alcohol, smoking and taking drugs; and about their engagement with health services. A copy of the questionnaire is included as appendix 6.

At the time of producing this report the survey was in its early implementation stages. Initial indications were that they were receiving a good response rate with over 100 people completing the survey so far. The work is due to complete and report in 2025/26.

3.4.3 West Mercia collecting NHS numbers from people on probation for data linking

An ongoing West Mercia-wide project involves the routine collection of NHS numbers. During routine meetings with offender managers, staff are asking people under probation supervision for consent to look-up and record their NHS numbers in nDelius. The initiative was devised to addresses the gap in data about health need and utilisation among those under probation.

[15] York (2023) A Health and Social Care Needs Assessment for Residents in Approved Premises in Wales

Newly developed nDelius reports extract NHS numbers from the records management system. Two extracts are produced, based on individuals' residence in the two West Mercia Integrated Care Boards (ICBs) (Herefordshire & Worcestershire ICB and Shropshire, Telford & Wrekin ICB). The extracts are shared with the corresponding local authority public health teams who are analysing the NHS data for people living in their area to understand their health needs. This data will be presented in aggregate and shared with stakeholders across West Mercia. Outputs from these analyses are excepted in quarter one of 2025.

Engagement from the probation population has been good, with 80-90% of those who have an NHS number consenting to have it recorded in their records. However, approximately 20% of people do not have an NHS number. Working with local primary care networks (PCNs) the project has been able to support people to get an NHS number and register with a GP. Further collaborative working between HMPPS and local PCNs has led to mobile health vans (that offer free NHS Health Checks) being promoted by probation staff and located at probation offices to improve access. By increasing GP registration and access to health checks this approach has the potential to improve some of the health and social care quality indicators for people on probation identified in the recent "Measuring and improving the health and quality of healthcare for people on probation: Developing data collection and quality indicators" study[16].

As of late-March 2025, 260 NHS Numbers had been recorded, 10% of the West Mercia probation population. Processes are being developed to make requesting NHS Number a business-as-usual activity during offender manger contacts; ideally this information would be requested at the pre-sentence report interview or sentence meeting plan (a person's early contacts with the probation service).

3.4.4 Birmingham Justice Health Needs Assessment

Birmingham City Council have commissioned a Justice Health Needs Assessment (JHNA) for people who are in contact with the criminal justice system or who are at risk of being in contact with the criminal justice system. It Is being undertaken by a voluntary sector organisation and has a wide scope on health and wellbeing themes for the population. The project consists of a literature review, quantitative data analysis, qualitative data collection, service mapping and rapid ethnography. This may help improve understanding around access and engagement with health services and people on probation's experience of health care. However, there is no scope to collect

[16] 'Health and Social Care Needs and Quality Indicators in Probation' Available at: https://probationhealth.blogs.lincoln.ac.uk/

primary quantitative data, so it is not expected this project could help address the healthcare need and utilisation data gaps identified above.

At the time of producing this scoping report the draft JHNA report was being finalised.

4. Conclusions and recommendations

4.1 Conclusions

As reported in the findings section above, key respondents support the production of a national HNA for the probation population and think it would be an important and potentially necessary step to producing local health needs assessments. There was also consensus amongst key respondents on the content of that national HNA, and on what groups were important to steer and inform the national HNA, and subsequent local HNAs.

However, the workstreams identified a significant gap in the available data and literature on the health of people in the probation population, and the importance of addressing this gap to engage stakeholders to produce HNAs, and to identify effective actions to reduce healthcare inequalities in the probation population.

The next section sets out recommendations for commissioning and delivering a national HNA for the probation population, including ways of addressing the data gap. Where appropriate the recommendations specify how these actions could be applied or adapted for local HNAs.

4.2 Recommendations

Recommendation 1: Identify the demographic and health profiles of the three groups in the probation population and how the population intersects with other vulnerable populations

As described in section 1.1 the probation population is usually divided into three groups and these groups may have distinct demographic and health profiles. Therefore, the national HNA should investigate the profile of each group, and identify any relevant differences between them in their health and health related behaviours. This should include understanding lifestyle factors such as diet, exercise, drug and alcohol misuse and smoking. Particular attention should be paid to those on community orders or suspended sentences who will have had no contact with prison health services, and their contact with probation services and/or the criminal justice system more widely may be invisible to the NHS.

Key respondents reported a significant overlap between people on probation and other target groups in the Core20PLUS5 such as people from ethnic minorities, people with learning disabilities or other neurodiversities including autism and ADHD, people living in poverty, people in temporary or insecure accommodation, sex workers and any other groups that experience health inequalities. The national HNA should determine the extent and nature of these overlapping groups. Having this evidence at a national level will support local areas to develop local health profiles and plan appropriate local actions to address health inequalities.

Recommendation 2: Expand beyond the five Core20PLUS5 clinical conditions to investigate the prevalence and incidence of other health conditions relevant to the probation population

The scoping study findings suggest a national probation HNA should not be limited to the clinical areas of the adult Core20PLUS5 approach as the health needs of the probation population are different to the general population.

At a minimum a future probation HNA should cover wider mental issues (not limited to SMI) and physical health issues (such as oral health, communicable diseases, and STDS) and the health and social determinants of these conditions (such as substance and alcohol misuse, as well as alcohol and vaping).

Recommendation 3: Determine and illustrate the links between health conditions, lifestyle and social determinants of health

The national HNA should explore and explain how health conditions which are prevalent in the probation population are linked, particularly where there are links between health behaviours such as alcohol and substance misuse and other health conditions, and links with social determinants of health. This should include gathering data on co-morbidities in the probation population.

This will support local HNAs and local actions to address health inequalities by providing a reference document outlining these links.

Recommendation 4: Explore the use of healthcare services by people on probation and their experience of accessing and engaging with healthcare services

There is a view that people on probation are high users of urgent and emergency care, and less likely to access primary care than the average in the population. Initial findings from the data linkage project in West Mercia were that approximately 20% of people on probation do not have an NHS number.

A national HNA should gather evidence of people on probation's experience of accessing and engaging with health care services to determine whether people on probation are high users of urgent and emergency care and if so why that is, and to explore how timely access to primary care could be improved. There may be opportunities to learn from the High Intensity Use programme and associated resources[17].

[17] Such as the HIU Support Pack (this resource is hosted on FutureNHS and requires a login)

Recommendation 5: Explore how support networks and social isolation affect the health of people on probation and their engagement with healthcare services

Support networks, or the lack of positive support networks, were identified as a factor that can impact on people's health, and engagement with health services. The national HNA should explore the support networks that people on probation have, and how those affect their health behaviours and access to and engagement with health care services. This exploration could be undertaken in parallel with recommendation 4.

Recommendation 6: Commission or undertake qualitative work into people on probation's experience of accessing healthcare and satisfaction with healthcare

Findings showed that for many of the Core20PLUS5 clinical areas there is relatively little research on access to health care for people on probation, and even less on their experience of, and satisfaction with, healthcare. A future national HNA should commission or undertake qualitative research with people with lived experience to address these gaps. This research would also present an opportunity to explore lifestyle factors and the support networks and social isolation of people with lived experience of probation (linking in with recommendations 4 and 5).

When designing this qualitative research consider how the method could be adapted and used in future local HNAs.

Recommendation 7: Ensure that data collection, analysis and data presentation for a national HNA supports local HNAs and local actions

When planning and commissioning the quantitative epidemiological elements of a national HNA (for example: an epidemiological survey, prevalence modelling, and analysis of the causes of death) consider how the data can be collected, analysed and presented to support local action to address local healthcare inequalities.

If the necessary data is gathered for sub-national geographies at the outset of planning, analyses and outputs can be developed at administrative geographies of relevance to key stakeholders with responsibility and accountability for the health and wellbeing of this population. For example: if geographies are considered and specified when preparing the dataset, it may be possible for data on prevalence estimates for health conditions can be presented at integrated care board geography.

To reduce duplication and maximise the actionable insight from a national HNA the coding and methods for the quantitative analyses should be published and made openly available on a platform such as GitHub, supporting local systems to replicate outputs.

Recommendation 8: Build on current epidemiological work to understand prevalence of health conditions and health behaviours of the probation population

The ongoing epidemiological survey being conducted as part of the Liverpool HNA (section 3.4.2) should produce age and sex standardised prevalence estimates for a variety of health conditions and health behaviours. Once data is available, consider the survey's sample (its size and the extent to which it is representative of the wider probation population) and other factors to make a judgment about the appropriateness of using the data to undertake prevalence modelling. A judgement should be reached with reference to best practice guidance[18].

Depending on the data generated by the Liverpool HNA, and resource available to undertake a national HNA, it may be appropriate to conduct a national epidemiological survey. A survey should consider geography, age, sex and ethnicity in its sampling method, as well as methods for administering the survey that maximise participation (such as being scheduled to coincide with attendance at probation meetings).

To apply prevalence estimates from proposed epidemiological survey to probation population, work with the Probation Statistics Team to gain access to necessary probation population demographic data (for example: demographic data broken down by age and sex and ethnicity by small geographies – both HMPPS and healthcare administrative geographies).

Recommendation 9: Gather NHS numbers from people on probation and use them to explore healthcare need and utilisation

Once available, review the analyses from the ongoing West Mercia project (section 3.4.3) – these outputs are expected in quarter one of 2025. If appropriate, extrapolate these findings to gain improved insight into the healthcare needs and utilisation of the probation population in England.

Take steps to make collecting and recording NHS numbers in nDelius a business-as-usual practice nationally. If this is widespread and sustained, it will enable trends in healthcare need and utilisation to be analysed and reviewed, informing action from stakeholders to implement and monitor interventions.

Recommendation 10: Explore options for linking to and accessing mortality data to provide deeper insights into the causes of death in the probation population

Take forward the learning from the West Mercia pilot (section 3.4.3), and the current work by Professor Karen Slade's team, to explore the possibility of working collaboratively with the Department for Health and Social Care (DHSC) and or the Office for National Statistics (ONS) to

[18] https://fingertips.phe.org.uk/documents/APHO%20Tech%20Briefing%208%20Prevalence%20Modelling.pdf

undertake national data linkage between probation caseload records (nDelius) and ONS death registrations records.

Once linked and analysed, this data would provide insight into the causes of death in the probation population and help to inform the development of appropriate interventions (for example targeted and tailored healthcare offers) to improve access, experience and health outcomes.

Recommendation 11: Include people with lived experience in steering a national HNA, and as respondents

People with lived experience of probation should have a role in steering and overseeing the production of a national HNA and any local HNAs. At a minimum this would be by having people with lived experience as members of the HNA steering group. To expand inclusion and ensure broad representation the HNA should also engage with lived experience groups and organisations.

This would complement evidence gathered directly from people with lived experience under recommendation 6 above.

Recommendation 12: Include people with professional experience in steering a national HNA, and as respondents

As well as people with lived experience it is important that the national HNA (and local HNAs) include the voice of professionals who work with people on probation. This should be both in steering or overseeing the undertaking of the HNA, and as respondents into that HNA.

Recommendation 13: Identify and involve those with responsibility for commissioning and delivery of healthcare improvements, and determine how these key stakeholders should be involved in local HNAs

Key respondents emphasised the importance of involving and engaging those stakeholders and organisations that would be responsible for taking forward any actions to address health inequalities in the production of local HNAs. They suggested it would be important to identify the roles and responsibilities that need to be involved in producing local HNAs, rather than specific organisations, because local structures and the responsibilities of organisations and will differ from place to place.

The national HNA should determine the roles of local stakeholders that need to be involved in producing local HNAs, and the ways they should be involved.

Appendix 1: Guidance and suggested structure for probation HNAs

There isn't a set structure that all HNAs follow. They are usually tailored to their purpose and population. The expectation is that the national HNA would determine and test a structure for probation HNAs, which could be used as a template for local HNAs to follow. However, there are some common elements that most HNAs include, and below we provide an outline of the possible contents and structure for a probation HNA.

When producing a HNA it may also be helpful to review the PHE guidance for undertaking health and social care needs assessments for adults under the probation service[19], and to look at existing published examples such as the Swansea HNA of people on probation[20], the HSCNA of residents in approved premises in Wales[21], the HNA of offenders in the community in Derbyshire and Derby City[22], or any other recent probation HNAs held internally by the MoJ and HMPPS.

The process of producing HNAs for people on probation will bring together experts in probation and the probation services (including experts by experience) with experts in public health. The audience for the HNA will also be both people with a CJS or probation background, and those with a public health background and interest. To support mutual understanding it will be important for the HNA to describe key aspects of the probation service and how it works, and explain key concepts from probation and the CJS, and public health.

Outline structure and contents for a probation HNA

This is intended as a starting point for national or local HNAs. It may need to be adapted or expanded.

Executive summary

A short summary of key findings and recommendations.

[19] Available at: https://www.gov.uk/government/publications/adults-on-probation-health-and-social-care-needs-assessment
[20] Available at: https://primarycareone.nhs.wales/tools/healthcare-public-health-framework-toolkit/population-healthcare-framework-toolkit-resource/hna-swansea-pdf/
[21] Available at: https://primarycareone.nhs.wales/tools/healthcare-public-health-framework-toolkit/population-healthcare-framework-toolkit-resource/ap-hsna-residents-final-pdf/
[22] Available at: https://observatory.derbyshire.gov.uk/wp-content/uploads/reports/documents/health/specialist_reports_and_assessments/2018/Derbyshire_and_Derby_City_Offenders_HNA_2018_Full_report.pdf

Introduction

Sets out the rationale for conducting the HNA and its aims and objectives. Likely to include a definition of HNAs and a description of why they are undertaken for those less familiar with them.

Background

This section should provide important background information for the reader. It is likely to include an overview of the CJS, probation services and how they are organised as important context for non-probation specialists. It would also outline the size of the probation population and summarize what is known about the links between health and re-offending behaviour. This section could also define any key concepts which may be unfamiliar to readers, though short definitions of key terms could be included as a sperate glossary.

Methodology

This section should provide an overview of the methods used to gather data for the HNA. This would include listing any secondary data sources used and how they were analysed, and outlining any primary research such as surveys, interviews and/or focus groups.

This section should also briefly describe the governance and steering arrangements for the HNA, including how the voices of people with lived experience and professional experience of probation have been part of steering and delivering the HNA.

Any detailed technical discussion of methods might fit better in an appendix. Any materials used for gathering data, such as questionnaires, could also be included as an appendix.

Findings

The structure will depend on the aims and scope of the HNA, but we would expect the findings to discuss the following areas for the probation population. And as much as possible to separate findings between the three probation groups.

Demographics, including age, gender and ethnicity.

Wider determinants of health and criminogenic needs

This section will explore the general socioeconomic, cultural and environmental conditions relevant to people in the probation service, covering topics such as: educational attainment, employment and training, finance, level of deprivation, housing relationships (social and community networks), and substance use.

Health related behaviours, such as smoking, exercise and diet.

Access to and engagement with healthcare services

This section would explore demand and use of healthcare services and contain data on people in the probation services' health seeking behaviours and their experiences of accessing and receiving healthcare. A particular focus may be access to primary care and substance use services. This section may be broadened to cover access and experiences of accessing other services which are not directly related to addressing the sider determinants of health – for example: employment, social care, and housing support services. It may also contain the views and experiences of staff.

Life expectancy

Mortality

Disability and neurodiversity, including autism and learning disabilities.

Physical health needs

This section would include sub-sections focussing on the priority physical health conditions agreed by the HNA steering group. For each physical health condition, there would be data on prevalence, outcomes (where available) and if appropriate, an overview of the models of care service offers available.

Mental health needs and personality disorders

This section would include sub-sections focussing on the priority mental health conditions agreed by the HNA steering group. For each condition, there would be data on prevalence, outcomes (where available), and if appropriate, an overview of the models of care service offers available**.**

Discussion

The discussion section would summarise and discuss key findings and highlight links and relationships between health conditions (mental and physical), wider determinants of health, criminogenic needs, health related behaviours and access to and engagement with health services. This section would highlighting unmet needs and priority areas for action. This section would typically cover any limitations of the HNA and the consequences of these.

Recommendations

This section should set out recommendations for service provision and service improvement, and any recommendations for further research or other work.

Recommendations should be clear and targeted. It may be helpful to group recommendations by who will act on them.

Appendix 2: Mapping review stages and guidance

This annex shares the stages followed for the literature mapping, and guidelines which were drawn up based on initial internal and client discussion.

The seven stages below were followed to develop and apply review methods for the literature mapping workstream.

1. **Scope**. Define scope, protocol and review questions with a descriptive focus and draft data extraction prototype sheet.

1. **Identify**. Expert interviewees shared key sources, with citation pearl growing to develop a longlist of key sources.

2. **Screen and familiarise**. Papers included/ excluded via single reviewer screening with checks: included papers sifted by outcome area + clinical groups. Reading key papers and becoming familiar with findings.

3. **Data extraction**. Finalise data extraction template, extract key source details and map sources to relevant worksheets for three outcome areas via a combination of categorical and free-text data extraction.

4. **Data charting**. Mapping the presence or absence of information in sources based on review criteria.

5. **Visualisation**. Using pivot tables to visualise categorical data initially.

6. **Synthesis, summary and reporting**.

As part of stage two we developed the guidelines below which specify the broad criteria for the mapping review, including limits, population and outcomes of interest and key clinical groups.

Mapping review protocol		
Broad review limits	Annex 1: Annex 2: Annex 3:	Date of publication: last 10 years (2014/15 – 2025). Geography: UK focused: sources from England, Scotland, Wales and NI. Exclude commentaries, books and conference abstracts.
Population (definition taken from Richards, 2020 [pp.11] which cites MOJ consultation)	Adults under probation service supervision in the community, including those on: • community order, • suspended sentence order, or • post-release supervision under National probation service or a community rehabilitation company.	
Outcomes of interest (sub-domains are indicators of what evidence base may describe, but not an exhaustive list)	Demand • Prevalence • Incidence • Morbidity / mortality (all-cause and cause-specific) Access/service utilisation • Uptake • Utilisation rate • Referral rate • Waiting times • Self-reported access Experience • Acceptability (of an intervention or service) • Patient satisfaction or experience • Patient reported experience measures	
Key clinical groups from: NHS England, Core20PLUS5 approach + Alcohol or substance use	Annex 1: Annex 2: Annex 3: Annex 4: Annex 5: Annex 6: Annex 7:	Maternity Hypertension Severe mental illness Chronic respiratory Cancer Smoking Alcohol or substance use

Appendix 3: Definitions for clinical groups from Core20PLUS5 approach

This appendix describes guidance for the review which was produced to help reviewers conceptualise key clinical groups from the five clinical groups plus smoking cessation. Outlining key definitions for the broad clinical group and any intervention focus which sources mentioned.

Clinical groups	
1. Maternity	Women who are pregnant or in the perinatal period – focus on maternity care, perinatal mental health. Flag if any evidence on continuity of care and minority ethnic groups
2. Hypertension	People who have high blood pressure. May broaden this to CVD or general information about heart health. Flag if any evidence of case finding or hypertension management (lipid monitoring)
3. Severe mental illness	People who have at least one of the following diagnoses. • Schizophrenia spectrum disorders • Psychosis • Mood disorders (depression) with psychosis symptoms, and • Bipolar disorder. May include anxiety disorders, eating disorders, and personality disorders, if the degree of functional impairment is severe. Flag if any evidence on physical health checks for SMI (e.g. may overlap with hypertension due to physical health monitoring focus: blood pressure)
4. Chronic respiratory disease	Conditions which alter the structure and function of the respiratory system (COPD and asthma most commonly). Flag if any evidence on driving up vaccinations (COVID, Flu, pneumonia)
5. Cancer	People who have diagnosed cancer or cancer symptoms. Focus on common forms of cancer which form basis for screening programmes: bowel cancer, skin cancer, lung cancer, breast and cervical cancer, prostate cancer. Flag if any evidence of early cancer screening access
6. Smoking	Describes specific health-risk behaviour in the form of smoking. Includes tobacco consumption through cigarette smoking, but may also include the use of vaporisation-based delivery systems (vaping) Flag if any evidence of smoking cessation interventions/ support to quit smoking
7. Alcohol or substance use	Describes alcohol and substance use as health-risk behaviours, as well as diagnosed cases of alcohol use disorder or substance misuse or dependence.

Appendix 4: Data extraction categories

This appendix describes key categories for data extraction the review.

Data extraction categories	
Reference information	Annex 4: Reference information Annex 5: Year of publication Annex 6: Abstract or source summary Annex 7: URL
Source properties	• Type of source (original peer-reviewed research; grey literature) • Source format (e.g. report; health needs assessment) • Country • Care setting/ population described
Outcomes of interest	• High level outcome category • Granular outcome category
Key clinical groups from: NHS England: Core20PLUS5 approach	• Dichotomous categories for 1-7 clinical groups specified in appendix three (Yes or blank) • Free-text information extraction to indicate the presence or absence of evidence on the group.
Recommendations or key policy actions	• Recording whether the source reported information on recommendations (e.g. 'No recommendations'; 'some recommendations')

Appendix 5: Summary of literature mapping evidence

Introduction

This appendix briefly summarises key findings from the sources identified in the literature mapping workstream. There is a section on each of the three outcome areas in the mapping exercise: need or demand, access, and experience or satisfaction. Within each outcome area there are sub-sections which provide a descriptive synthesis of the evidence for each clinical group. Summaries of individual sources are provided to understand key findings where synthesis could not be undertaken due to the low volume of sources. Key information on sample size or geographic scope of sources is presented alongside findings to provide the reader with necessary context and as a foundation for any future work.

Need or demand outcomes

Maternity

Three sources described information on needs or demand for pregnant women on probation or those who had given birth within the last two years. The limited information reported via small-scale surveys (Gipson & Wainwright, 2023a; 2023b) and qualitative research (Clinks & Birth Companions, 2021) is summarised in greater detail below. Little is known about the national scope of maternity needs in the probation population in England.

Engagement surveys with people on probation provided some information to understand maternity needs in this population (Gipson & Wainwright, 2023a; 2023b). Surveys described the percentage of respondents for prison leavers and those on community orders who were: pregnant at the time; in the first 20 weeks of pregnancy; pregnant in the last two years but did not have a baby; and those with older children (Gipson & Wainwright, 2023b). Several quotes and survey responses from different sections noted:

- Four percent indicated a need for maternity care (accessing scans, antenatal checks; Gipson & Wainwright, 2023a)
- Ninety-one percent reported mental health needs or the need for support, with *"consistent worries [...] around mental health"*; Gipson & Wainwright, 2023b).

Voluntary sector, midwifery professional, and lived-experience engagement surveys and focus group highlighted several findings on maternity needs (Clinks & Birth Companions, 2021). Although findings do not describe the prevalence of common conditions during pregnancy, perinatal mental health issues, or the frequency of different treatment and support needs. Key quotes and findings from this Clinks and Birth Companions (2021) are highlighted below.

- The report draws on previous UK evidence (MBRACE) noting high rates of maternal and neonatal morality for marginalised groups – *"all of whom are over-represented in the CJS"*.
- A gap in data to understand demand is described where *"There is as yet no specific data on the numbers of pregnant women or women who have given birth in the last two years under supervision in the community"*
- Further quotes highlight: *"[a] level of complexity […] linked to the overlap of CJS procedures, child protection procedures, housing, mental and physical ill-health, and high levels of isolation. Alongside […] needs in relation to domestic violence or abuse, financial hardship, risk of self-harm or suicide, substance misuse, and employment and training."*

Mental health and SMI

Fourteen sources reported information on SMI or other mental health condition need or demand for people on probation (Bissell, 2024; Brooker & Sirdifield, 2013; Brooker et al., 2008; Brooker et al., 2020; Brooker et al., 2022; Brooker et al., 2023; Clinks & Birth Companions, 2021; Cooper 2018; Cooper 2019; Rabaiotti 2024; Richards 2020; Sirdifield & Brooker, 2020; Sirdifield et al., 2024; Williams et al., 2024).

Some sources reported condition-level prevalence estimates, or those for broader constructs such as "current mental illness" or mood disorders (Brooker et al., 2023; Williams, Gray & Perrett, 2024; Brooker & Sirdifield, 2013; Brooker et al., 2020). Others shared subjective measures of mental health need or diagnoses such as free-text survey responses from service users or self-reported survey responses (Rabaiotti, 2024; Cooper 2018; 2019). Differences between existing studies in this area preclude objective comparison of information on the mental health needs across sources (Brooker et al., 2020; Sirdifield & Brooker, 2020).

Key insights are summarized below. General prevalence information from sources is broken down, followed by condition-level information. This snapshot of prevalence information is descriptive, rather than a substantive and exhaustive comparison, given variation in sample size, data collection methods, design and granularity of diagnostic categories reported.

Reviews described that people on probation have high rates of mental health conditions (Bissell, 2024; Brooker et al., 2020; Brooker et al., 2022; Brooker et al., 2023). With high complexity alongside other mental health conditions, alcohol and substance use, and unrecognised health or social needs (such as homelessness, debt, unemployment, housing or other wider determinants of health; Bissell, 2024; Brooker et al., 2023; Cooper, 2018; Richards, 2020). One source noted high complexity and mental health needs in relation to women on probation with maternity needs (Clinks & Birth Companion, 2021).

Several reviews cited research mentioning higher mortality rates or premature mortality in people on probation (Bissell, 2024; Brooker et al., 2023); one described international research linking co-occurring substance use and mental health issues to mortality (Bissell, 2024).

Breakdowns of general information on mental health needs and condition-prevalence are provided below, accompanied by information on sample size where available.

- Recent research from Wales reported that people on probation had eight-fold higher odds of having a mental health condition than those in the general population odds; this was reported by (n= 257; Williams et al., 2024). With around 40-50% reporting any current mental illness or diagnosis across different studies (39%: n=173; Brooker & Sirdifield, 2013; 49%: n=257; Williams et al., 2024).
- Previous needs assessments noted 60% reported mental health problems (n= 153; Cooper, 2018; 2019); with 27% having reported being *"seen formally by a mental health service"* previously (n= 183; Brooker et al., 2008).

Several sources reported prevalence information across different diagnostic categories. A summary of key findings is provided below.

- **Anxiety prevalence rates** across sources ranged from 27% (n= 173; Brooker & Sirdifield, 2013) to 52% (n=41; Rabaiotti, 2024). One source noted a rate of 39.5% (n=153; Cooper, 2018). This compares to 4.4% in general population (Adult Psychiatric Morbidity Survey [APMS]; McManus et al., 2009).
- **Depression prevalence rates** across individual sources ranged from 52% (n=153; Cooper, 2018) to 75% (n=41; Rabaiotti, 2024). Two reviews described findings from Brooker et al. (2012) where *"17.3% [screened] positive for a current major depressive episode"* (Brooker et al., 2020) and around 14% had experienced a major depressive illness (Brooker et al 2022). APMS shows a rate of around two percent for mood disorders or depressive disorders (McManus et al., 2009).
- **SMI condition prevalence** was reported through a variety of categories including psychosis schizophrenia and bipolar (21%: n=41; Rabaiotti, 2024), psychotic disorders (11%: n=173; Brooker & Sirdifield, 2013).
    - Brooker et al. (2022) concluded *"Varying estimates of the frequency of serious mental illnesses […]"* obtained through studies in their review. Further review evidence noted that *"[…] in both probation and prison the estimates for psychosis are much higher than in the general population (0.7% vs 10%)"* (Brooker et a., 2023). While a breakdown is given by Brooker et al. (2015) (n=183) low numbers of respondents provided this information.
- **Prevalence rates for other conditions** included eating disorders (5%, Brooker and Sirdifield, 2013); and personality disorders (6.6%, Cooper, 2018; 19% Rabaiotti).
    - Richards (2020) cites Brooker and Sirdifield noting that *"47% had a probable personality disorder"* (n= 173; Brooker & Sirdifield, 2013).

Chronic respiratory disease

Four sources described information on demand or needs in relation to chronic respiratory disease. There was overlap or redundancy between two sources: Cooper (2018) reported findings for a health needs assessment in Derbyshire, whereas Cooper (2019) summarised key findings and learning from this process in a peer reviewed journal article; overlapping findings from Cooper (2019) are omitted.

Across sources, prevalence rates for respiratory conditions included: 15% (Mair & May, 1997- cited by Brooker et al., 2008), and 17% (Rabaiotti, 2024); one source described prevalence for asthma (15.7%) and lung disease (2%) (Cooper, 2018). A breakdown of information on need or demand from these studies is provided below, accompanied by information on study sample size where available.

- One study in Wales found that of 41 probation staff survey respondents, 17% reported respiratory conditions as a common physical health need in the probation population they served (Rabaiotti, 2024).
- A health needs assessment in Derbyshire showed of n=153 respondents, two percent reported lung disease and around 16% reported asthma (Cooper, 2018). Asthma was noted as one of the most frequently reported conditions behind backpain and mental illness (Cooper, 2018). This source also noted the potential link between respiratory conditions and the high prevalence of smoking (as well as younger age profile of smokers) in this population (Cooper, 2018).
- A Nottinghamshire and Derbyshire HNA highlighted earlier evidence (Mair & May, 1997) from comprehensive interviews with a sample of people on probation caseloads (n=1213); respiratory problems were present in 15% of this sample (Brooker et al, 2015).
- The source reported a breakdown of offenders' *"self-perceived greatest health problems"* from respondents in Nottinghamshire (n=37) and Derbyshire (n=23); respiratory system problems were reported by eight and seven respondents respectively (Brooker et al., 2008).

Cancer or early cancer diagnosis

While two sources described information on cancer prevalence in people on probation, they included duplicated information (Cooper, 2018; 2019). There was no information in this or other sources to understand the prevalence of cancer diagnoses, staging or severity in people on probation compared to the general population.

The single source which described information in this area noted that the rate of cancer frequency was two percent amongst community offender survey respondents in Derbyshire and Derby City (n=153; Cooper, 2018).

Given this considerable gap in the evidence, the reader is referred to recent mixed-methods research showing poorer cancer outcomes and access for prisoners or people in custodial settings

in England (Davies et al., 2025). Studies related to this research showed: higher cancer incidence and poorer access to curative treatment compared to the general population (Lüchtenborg et al., 2024; Davies et al., 2025); barriers to diagnosis and complexity of treatment access (Armes et al., 2024; Davies et al., 2025); and lower planned care costs with higher emergency care costs (Hunter et al., 2024). This research also described that *"Little is known about cancer in people in prison or how the cost of their care compares to the general population."* (Hunter et al., 2024).

Hypertension or cardiovascular disease

Three sources described information on demand or needs related to CVD. None provided information on people on probation in terms of hypertension prevalence, severity or blood pressure readings for hypertension monitoring.

Two sources reported on the same HNA activity (Cooper, 2018; Cooper, 2019). Although the latter was a mixed-methods academic paper which shared learning and methods; linking findings to existing evidence (Cooper, 2018; 2019). Key findings on demand or need related to hypertension or CVD are summarised by source below.

- A survey of probation and non-statutory staff in Wales included 41 responses which described common physical health needs encountered when working with service users (Rabaiotti, 2024). Heart conditions were described by a small proportion; although the percentage was not reported as heart conditions formed part of an aggregate category of responses with a low count. Including: diabetes, dental health, sexual health and pain issues (Rabaiotti, 2024).
- HNA in Derbyshire and Derby City found that of 153 local offenders just under four percent (3.9%) reported heart and under three percent (2.6%) reported diabetes (Cooper, 2018). Neither the HNA nor the academic paper compared the frequency of heart conditions or diabetes found to wider evidence; there was also no information on symptoms experienced (Cooper, 2018; 2019).

Smoking or smoking cessation

Ten sources described information on demand or need in terms of smoking or smoking cessation (Brooker et al., 2008; Bissell, 2024; Cooper, 2018; 2019; Gipson & Wainwright, 2023a; 2023b; 2023c; 2023d; Richards, 2020; Williams et al., 2024). Three sources reported on the same data collection activity from Cooper (2018) including: an academic paper (Cooper, 2019), and two summative sources which examined previous evidence (Bissell, 2024; Richards, 2020). Sources tended to report the proportion of respondents who were currently smokers; some broke down rates of smoking use by demographic variables. For example, breaking down smoking status by demographic variables such as age, sex and ethnicity (Gipson & Wainwright, 2023c; 2023d). Others broke down vape use into different categories such as those who smoked or had never smoked before vaping

(Gipson & Wainwright, 2023a; 2023b; 2023c; 2023d). Information on proportions and smoking status is provided alongside information on sample size for each source.

A summary of key information on current smoking status is provided below.

- Current smoking status ranged from 16% to 83% across sources (n=44; Gipson & Wainwright, 2023b; n=183; Brooker et al., 2008).
- Most sources showed that between a third to half of people on probation were smokers (36%; n=135: Gipson & Wainwright, 2023a; n =126: Gipson & Wainwright, 2023d; 49% n=177; Gipson & Wainwright, 2023c; 52%: n=257; Williams et al., 2024).
- Some showed that over half of people on probation were smokers (63%: n=159; Cooper, 2018; 83%: n=183; Brooker et al., 2008). One source shared a general population estimate from the ONS (2021) stating that 13.3% of UK adults were smokers (Gipson & Wainwright, 2023d)

Fewer sources provided information on usage of vapes or e-cigarettes; key insights included are summarised below.

- Current vaping or e-cigarette use ranged from 12% to 71% across sources (n=257: Williams et al., 2024; n=44: Gipson & Wainwright, 2023b). Notably, high rates of vape use were described in women who were pregnant or had a baby in the last two years (71%; n=44; Gipson & Wainwright, 2023b).
- Three sources reported that around 29% of respondents used vapes (n= 135: Gipson & Wainwright 2023a; n=177: Gipson & Wainwright, 2023c; n=126: Gipson & Wainwright, 2023d).

Alcohol or substance use

Eighteen sources described demand or need related to alcohol or substance use (Bissell, 2024; Brooker & Sirdifield, 2013; Brooker et al., 2022; Brooker et al., 2023; Brooker et al., 2008; Clinks & Birth Companions, 2021; Cooper 2018; 2019; Gipson & Wainwright, 2023a; 2023b; 2023c; 2023d; Rabaiotti, 2024; Richards, 2020; Sirdifield & Brooker, 2020; Sirdifield et al., 2020; Sirdifield et al., 2024; Williams et al., 2024).

Due to the considerable volume of sources in this area, a summary of key insights from summative or review sources is provided below, with further detail from individual sources or studies. Proportional data from alcohol or substance use outcomes are presented alongside study sample sizes for illustrative purposes.

Evidence in this area suggests rates of drug and alcohol use are high in this population, although the severity of use and how this translates to the scale of treatment needs nationally was unclear.

Insights from reviews and summative sources

Summative sources or reviews on this topic provide an outline of the research in this area. Namely we know that rates of drug and alcohol misuse are high in this population, alongside co-occurring mental health problems (Sirdifield & Brooker, 2020; Sirdifield et al., 2020); with elevated rates of premature death from drug and alcohol use as a contributory factor. However, there is limited overall or broader insight where *"no single estimate of the level of substance misuse among people under probation service supervision in the community"* (Richards, 2020). With Sirdifield et al. (2020) outlining a need for *"research-informed and up-to-date information about the prevalence of substance misuse"* where existing data provides only a fragment of insight into the wider picture of demand or need in this area for people on probation.

Insights from individual sources

There was considerable variation across sources in how they reported the frequency or level of alcohol and drug use. One source reported no prevalence information but outlined substance misuse as part of a wider pattern of complex needs for pregnant or new mothers on probation (Clinks & Birth Companions, 2021).

Alcohol use

Two sources reported findings using a validated measure for alcohol use disorders (Alcohol Use Disorders Identification Test; AUDIT). Brooker and Sirdifield (2013; n=173) reported that 56% of the sample had a strong likelihood of harmful alcohol consumption; the authors state a general population rate of around 24%. Sirdifield et al. (2024) piloted an approach to assessing needs of those on probation, involving n=57 participants, they noted 35% of respondents had scores indicating alcohol misuse or harmful consumption. Most were classed as low risk (64.9%), although around 29% had high or elevated risk, with 5.3% being classed as having a high likelihood of dependence on alcohol.

- Needs assessments, academic studies and other sources in this area showed around half of respondents were noted as consuming alcohol 'sometimes' (Gipson & Wainwright, 2023a; 2023b; 2023c; 2023d). With under 10% in engagement surveys reporting daily alcohol use (5% n=135; Gipson & Wainwright, 2023a; 7% n=44; Gipson & Wainwright, 2023b; 4% n=177; Gipson & Wainwright, 2023c; 7% n=126; Gipson & Wainwright, 2023d).
- Needs assessments show similar findings around a high rate of consumption generally (around 69%; n= 161; Cooper 2018; 43%; n=257; Williams et al., 2024). Although, one sources noted that this does not automatically indicate problematic or hazardous consumption (Williams et al., 2024).
- Engagement surveys broke-down alcohol consumption measures such as daily consumption by age, sex and ethnicity (Gipson & Wainwright, 2023a; 2023b; 2023c; 2023d).

Substance use

Two sources described rates of substance use using the Drug Abuse Screening Test (DAST-10). Around 12% of those in Brooker and Sirdifield (2013) had substantial or severe levels of drug use (n=173). The authors state general population prevalence at 0.5%. Sirdifield et al. (2024) surveyed n=57 people on probation and found similar results. With 38.6% had scores indicating possible drug misuse; around 25% had low to moderate severity misuse and a slightly lower proportion had either substantial (19.3%) or severe levels of drug misuse (8.8%) (Sirdifield et al., 2024).

- Engagement surveys (Gipson & Wainwright, 2023a; 2023b; 2023c; 2032d) did not report frequency or severity of substance use; although they did report a proxy measure where 60% of respondents disclosed a *"substance misuse [health or care] need"* (Gipson & Wainwright 2023a), with limited further detail.
- Other sources reported varying rates of substance use: ranging from 21% reporting current drug use in one source (n=257; Williams et al., 2024) to 63.5% reporting ever having used illegal drugs (n=156; Cooper, 2018).
- Information on granular patterns of substance use, such as rates of use for specific drugs was generally not provided across sources.

Access outcomes

Maternity

Two sources described information on access to care. Key findings are summarised below by source.

Gipson & Wainwright (2023b) conducted a survey of 44 women who were pregnant, had been pregnant while in prison or were new mothers (under two years). Despite being small-scale, this survey highlighted findings around access to perinatal mental health, uptake of different services around maternity and mental health, and areas of unmet need or difficulty accessing services. A high-level summary is provided below to illustrate some of the key findings.

- **Perinatal mental health and wider mental health.** The survey noted a concerning finding that *"not a single person was referred to perinatal support services in our prison leaver sample (especially since 95% were concerned about their mental health in prison)."* With 32% of the sample not being able to access mental health support during pregnancy or the post-natal period.
- **Difficulty accessing care for maternity needs**. Several figures highlighted difficulty accessing essential maternity and midwifery services and support across a high number of respondents. Over 80% of respondents struggled to access: maternity and breast pads; nutrition support; breastfeeding support; and imaging or scans. All respondents reported difficulty accessing morning sickness support and 54% reported difficulty accessing antenatal groups.

- **Disparity between access to support during pregnancy in prison versus the community.** The survey noted a difference between those leaving prison or in the community and women in prison: *"many more women in prison currently [benefit] from easier access to provisions and services."*. Further describing findings where only one person in the prison leaver group finding it easy to access urgent hospital treatment.

A report by Clinks and Birth Companions (2021) described findings from online surveys and focus groups with voluntary sector professionals (n=46), specialist safeguarding midwives (n=27) and people with lived experience (n=6). Key findings related to access are summarised below.

- Professionals highlighted perceived negative impacts of community sentence or probation license requirements on maternity care. As well as barriers to meeting women's needs around lack of appropriate spaces or services; lack of funding or resources; and lack of established referral routes.
- Further issues included *"A lack of clear and agreed protocols on, for example, organisational responsibility and decision-making, referral routes, and information gathering and sharing"*.
- This report noted key barriers around the fear of separation from children perceived to be a risk or consequence of accessing support, and the stigma and judgement experienced by women in contact with the criminal justice system.
- There is a need for wider support in context to gaps in existing provision outside the criminal justice system, with Clinks and Birth Companions noting the *"[…] lack of appropriate services, beyond the CJS context […] particularly a lack of adequate support; opportunities to improve parenting and life skills; and specialist support for women who have had their children removed."*

Mental health and SMI

Sixteen sources described findings on access to support for mental health or SMI. Many people on probation have limited or no access to mental health services, despite the considerable levels of mental health condition and SMI prevalence (see "Demand: SMI") (Brooker and Sirdifield, 2013; Cooper, 2018; Brooker et al., 2008. In stark contrast to the lack of adequate provision described, we know that people on probation have eight-fold higher odds of having a mental health condition (Williams et al., 2024); with higher rates of SMI, mood disorders and other mental health conditions compared to rates the general population (Brooker et al., 2013; McManus et al., 2009). With other sources noting high levels of unmet needs (Sirdifield et al., 2024). Given the volume of findings, a high-level summary of key themes is provided below:

Barriers and enablers to access for mental health support

The first systematic review on probation and mental health describes patterns of use of mental health support for people on probation (Brooker et al., 2020). This provides several important insights on access and barriers:

- Brooker et al. (2020) outlines that although this population have a high level of mental health need, they face considerable barriers to services. Further noting that while service use is higher than in in the general population, *"it is still low relative to the prevalence of mental illness in this population" (*Brooker et al., 2020).
- The review describes system and personal level barriers impact access to services for people on probation who have a mental health condition (Brooker et al., 2020).
- Highlighting that there is some evidence that improving access to mental health treatment for people with SMI on probation can lead to cost savings, however the research cited on this did not come from the UK or a comparable health or probation system.

Barriers identified across sources included: poor mental health awareness of probation staff (Brooker & Sirdifield, 2013), low health literacy in probationers (Sirdifield and Brooker, 2020), with a lack of skills, confidence and motivation to navigate the system (Cooper, 2019); and poor service availability (Rabaiotti, 2024; Brooker et al., 2020).

Enablers identified across studies included: good communication and relationships between people and services involved in mental health care and probation support (Brooker and Sirdifield, 2013); combining mental health treatment with probation orders (Brooker et al., 2020); use of brief screening tools in probation settings to identify mental health needs (Brooker et al., 2022); provision of probation staff with specialist mental health knowledge (Brooker et al., 2023); and improving commissioning processes (Sirdifield & Brooker, 2020).

A systematic review on access to care for women transitioning from prison to the community noted no UK studies in this area (Agbaria et al., 2024). The review noted barriers to mental health care from international evidence, including perceived stigma and lack of family support (Agbaria et al., 2024). These barriers dovetail with evidence from focus groups and surveys with maternity care and voluntary sector professionals. Which noted that new mothers on probation may fear accessing mental health service due to potential social services involvement, and perceived stigma around being a mother in contact with the criminal justice system (Clinks & Birth Companions, 2021)

Chronic respiratory disease

Four sources described information on access to care or treatment for chronic respiratory disease. This is a notable gap in information. Key insights into access to treatment or support for chronic respiratory disease are summarised below. Available information provides little insight into whether

access and uptake of support for chronic respiratory diseases is commensurate to need in this population.

An engagement survey found that 22% of prison leavers that responded had undergone treatment for lung health (n=135; Gipson and Wainwright, 2023a). Around 13% of respondents had accessed treatment for lung health across two other engagement surveys with people on probation (n=177; Gipson & Wainwright, 2023c) and people in approved premised (n= 126; Gipson & Wainwright, 2023d). For women with maternity needs, the rate of previous treatment was nine percent (n=44; Gibson & Wainwright, 2023b).

These sources provided similar detail as to treatments or support accessed by respondents. Free-text comments shared noted treatment for asthma via ongoing support from asthma nurses; medication (Gipson & Wainwright, 2023c); and *"checks by [the] GP and asthma nurse"* (Gipson &Wainwright, 2023a). Further free-text comments described hospital stays for lung health where individuals had received treatment for cystic fibrosis or COPD (Gipson & Wainwright, 2023a). For those on approved premises *"those who did comment [on what had helped them for lung health treatment or support] all referred to their asthma inhaler as being important to them"* (Gipson & Wainwright, 2023d).

Cancer or early cancer diagnosis

Six sources described information on access to or uptake of cancer screening for people on probation. There was no evidence identified on the access to treatment or impacts of late cancer diagnoses for probation population groups in England or internationally. Given the absence of probation-relevant evidence, the reader is referred to recent NIHR funded research in England (Davies et al., 2025) describing prison population cancer incidence over time, experiences of cancer care and barriers. With the caveat that we do not yet know the extent to which prison and probation populations may differ on cancer epidemiology, outcomes and treatment needs.

Four were reports highlighting variation in uptake of all types of cancer screening amongst different offender and ex offender populations including. This included prison leavers (Gipson and Wainwright, 2023a), women who had been pregnant in prison or on probation (Gipson and Wainwright, 2023b), people serving a community sentence (Gipson and Wainwright, 2023c) and people living in approved premises (Gipson and Wainwright, 2023d).

- Similarly, a health needs assessment of offenders in community settings in Derbyshire and Derby City recorded access to screening for different cancers amongst this population group (Cooper, 2018).
- A study in Canada found that female ex-offenders were more likely than the general population to be overdue on cervical cancer screening (Agbaria et al., 2024). This was also reported to be the case for colorectal and breast cancer screening.

Hypertension or cardiovascular disease

Two sources described information related to access to treatment or care for hypertension or cardiovascular disease (Gipson & Wainwright, 2023a; 2023d). Although, neither source described the extent to which people on probation with high blood pressure or other risk factors are able to access hypertension monitoring within primary care.

Both sources were survey engagement reports which asked prison leavers (Gipson & Wainwright, 2023a) or people in approved premises (Gipson & Wainwright, 2023d) about whether they had previously accessed treatment for heart health. With thirteen percent of prison leavers having undergone previous treatment for heart health (n=135; Gipson and Wainwright, 2023a) and nine percent of those living in approved premises (n=126; Gipson and Wainwright, 2023d).

Smoking or smoking cessation

Five sources described access information on support for smoking or smoking cessation interventions. Sources in this area tended to report rates of those wanting to stop smoking, uptake of smoking advice, or access to smoking cessation support such as medication. A summary of individual sources is provided below given the low volume of studies and variation in the way that findings were reported.

- A systematic review of women transitioning to probation settings identified no UK studies on women's access to primary care (Agbaria et al., 2024). Although the review noted a disparity in access to smoking cessation support. As one study from Australia reported only 9% of women transitioning to community settings were offered subsidised medication to support quitting smoking (Compared to 52% of women in the general population)
- A HNA in Wales (n=257) showed high rates of people wanting to quit smoking (54%) in their sample, but around 3% of those offered advice had refused it or not taken it up (Williams et al., 2024)
- Similar findings are highlighted in terms of the rate of respondents who had ever tried to quit smoking within a community offender population in Derbyshire and Derby City (n=153) (Cooper, 2018). The source showed that more than a third of respondents had never tried to quit smoking (Cooper, 2018). It was unclear whether those who had attempted to quit smoking (61.4%) had access support or treatment for smoking cessation.
- A systematic review highlighted a study in Australia that found that only 9% of female participants that smoked were provided with subsidised smoking cessation pharmacotherapy, compared to 52% of the general population (Agbaria et al., 2024).
- An engagement survey with prison leavers in England reflected on rates of smoking in those released within the previous year (n=135; Gipson & Wainwright, 2023a).

- The source noted smoking cessation services as a health intervention in prison settings. They described that *"despite this health intervention, at least some people began smoking again following the break enforced on them while in prison. Encouragingly, around a third of smokers did show some appetite to reduce their smoking"*. With hopes to re-introduce prison leavers to smoking cessation in the community; though the source did not describe any who had accessed support to stop smoking in the community or while on probation.

Alcohol or substance use

Eight sources described information on access to treatment or support for alcohol or substance use for people on probation (Brooker et al., 2008; Brooker et al., 2020; Brooker et al., 2023; Brooker & Sirdifield, 2013; Cooper 2018; Richards, 2020; Sirdifield et al., 2020; Sirdifield et al., 2024). Despite the prominent focus of drug and alcohol needs in the wider literature, we know relatively little about whether the drug and alcohol treatment needs are adequately met for people on probation. With clear gaps in the wider evidence base on devising effective approaches to drug and alcohol support and measuring their impact on access to adequate support and reducing unmet needs (Sirdifield et al., 2020).

Reviews provide context on compulsory treatment orders, with mixed evidence on their uptake or usage, and wider knowledge gaps in terms of effective treatment for alcohol and substance use problems. Noting considerable gaps in knowledge as to how to develop effective approaches to support people on probation who have a drug or alcohol use-related care needs (Sirdifield et al., 2020). Two sources described contrasting findings: with "*relatively low use of drug rehabilitation requirements (DRRs) and alcohol treatment requirements (ATRs) [despite the high level of substance misuse]"* in Richards (2020) contrasting with *"[…] strong uptake of treatment orders for alcohol and drug misuse [compared to low usage of treatment orders for mental health]"* described by Brooker et al., (2020).

Further evidence from summative sources or reviews noted challenges around successfully engagement in community treatment: "*Across England in 2018 to 2019, 34% of adults with a substance misuse treatment need successfully engaged in community-based structured treatment following release from prison; this figure varies across England from 21% to 47%"*. (Richards, 2020). This source further described access issues for people who have severe levels substance or alcohol misuse: *"The combination of substance misuse and mental health challenges can also make it very difficult for people to access healthcare as they can be "bounced" between mental health and substance misuse service"* (Richards, 2020).

Insights from several individual sources described information on access or uptake of treatment for drug or alcohol problems. These are summarised below. While fragmented across studies and

different ways of measure or examining reported findings around access, findings may indicate unmet needs for treatment or support for substance and alcohol use in the probation population. Sample size information from studies is provided where relevant.

- Cooper (n=153; 2018) report rates of respondents who had received help for drug or alcohol problems. Where Only 24.7% of respondents to a community offender survey in Derbyshire reported receiving current help or previously help for alcohol consumption (n=153). Around 37% of the sample had asked for support around stopping drug use, but only 13% were receiving this support.
- This source shared a quote from an ex-offender who described the nature and consequences of the access gap for those with extreme addictions with co-occurring mental health issues: *"I have been involved with people who have died as a result due to the mental health services saying that they cannot treat until addictions sorted."* (Cooper, 2018)
- Sirdifield et al. (n=67; 2024) reported rates of respondents under compulsory treatment orders: with under four percent of respondents reported having a drug rehabilitation requirement and under two percent having an alcohol treatment order.
- Brooker and Sirdifield (n= 173; 2013) found that that of those with severe drug or alcohol problems identified by screening tools, only 40% of those with high AUDIT scores (indicating harmful alcohol use) were accessing substance misuse services. Whereas 88% of those with high scores for substance use were accessing substance misuse services.
- Brooker et al. (n= 183; 2015) describe potential gaps in meeting needs for the physical impacts of drug and alcohol problems: *"Some offender managers were aware of the physical impact of drug and alcohol problems [...] but presumed that the Drug and Alcohol Service staff were addressing these aspects of care or referring clients to the appropriate services."*

Experience or satisfaction outcomes

Maternity

There were only two sources identified relevant to experiences during maternity. They were both reports which adopted survey-based methods (Clinks & Birth Companions, 2021; Gipson & Wainwright, 2023b). Given the limited focus of research on experiences of maternity support for women on probation key insights are summarised by source below.

An engagement survey described rates of satisfaction or experience of support for those with maternity needs (n=44; Gipson & Wainwright, 2023b). The survey asked respondents on community orders to rate the support they had received from specific services:

- Eighty-nine percent reported that the support provided by probation was *"ok"*, with a minority describing it as *"really supportive"* (11%).

- Seventy percent found community maternity services to be *"really supportive"* with the remainder describing support as "ok" (29%). Breakdowns of the number of respondents for different questions was unclear.
- Those in prison appeared to receive more help for pregnancy than those on probation, with higher proportions of current prisoners rating several sources as "*really supportive"* (e.g. 100% for specialist maternity support in prisons such as mother and baby units; none for prison leavers or those in the community). (Gipson & Wainwright, 2023b).

Stakeholder engagement surveys and focus groups with voluntary sector, midwifery professionals and those with lived experience reported several findings on experiences of support for maternity (Clinks and Birth Companions, 2021). These are summarised below.

- **Negative experiences of initial probation appointments on release**. For pregnant women and new mothers leaving prison *"it was frequently felt that their first appointment with probation on the day of release – when anxiety was uppermost – was a negative experience."*. While these experiences were not universal, appointments focused on ensuring compliance with little empathy for personal or individual circumstances.
- **Continuity of probation support.** Positive support experiences tended to describe continuity in probation officer allowing for strong and supportive relationships to develop.
- **Poor recognition and responsiveness to pregnancy and motherhood.** Fewer than half of voluntary sector survey respondents felt that probation services take sufficient account of maternity and pregnancy needs for people on probation (48%; n= 46).

Mental health and SMI

Four sources described information on the experiences or satisfaction of people with SMI or people with a mental health condition who were on probation. Information related to experiences of mental health support generally, rather than taking a specific focus on SMI. No source described the experiences or satisfaction of people on probation accessing or receiving support for SMI. As there were limited findings insights are summarised by source below.

A systematic review on probation and mental health noted positive impacts on patient experience or satisfaction from different approaches to provision of mental health support in probation settings (Brooker et al., 2020). While providing limited insight into how people on probation in England experience current mental health services, findings described:

- High client or service user satisfaction as a result of partnership working between probation and mental health services in Canada (Mitton et al., 2007- cited by Brooker et al., 2020);

- Better resident experience as a key benefit of adopting a *"Psychologically Informed and Planned Environment (PIPE)"* in an approved premises in England (Castledine, 2015- cited by Brooker et al., 2020).

A report by Healthwatch shared quotations from a sample of 64 offenders using health services in Derbyshire (Morton, 2019). Summary-level insights described dissatisfaction at only being offered medication for mental health support and limited focus on support to alleviate the issues underlying mental health symptoms. Some noted poor experiences of mental health crisis services and community mental health support in general due to: poor availability; limited follow-up; and lack of continuity of care.

Two engagement surveys described the proportion of respondents who found mental health services helpful for access; although exact proportions of those who did not find these services helpful were unclear from the figures reported (Gipson & Wainwright, 2023a; Gipson & Wainwright, 2023c). Findings included that more than half of those who had used mental health services found them helpful when accessing services (n= 177; Gipson & Wainwright, 2023a; n=135; Gipson & Wainwright, 2023c)

Chronic respiratory disease

No source reported information on experience or satisfaction for chronic respiratory disease in people on probation.

Cancer or early cancer diagnosis

No source reported information on experience or satisfaction for cancer in people on probation.

Hypertension or cardiovascular disease

No source reported information on experience or satisfaction with care for hypertension or cardiovascular disease in people on probation.

Smoking or smoking cessation

No source described smoking cessation support in terms of rates of satisfaction, patient experience or other formal measures of quality of care for people on probation. With little insight into whether people on probation are satisfied with smoking cessation support. Although one report by Healthwatch (Morton, 2019) shared a relevant recommendation based on free-text comments from respondents. Morton (2019) reported *"Help to stop smoking and/or more publicity on who to contact"* as a key suggestion to improve health and wellbeing.

Alcohol or substance use

Two sources described rates of satisfaction, patient experience or other formal measures of quality of care to understand how people on probation had experienced support for alcohol and substance use. This is a notable gap given alcohol and substance use are more prominent topics in the literature compared to other health issues. This is also reflected within interactions between healthcare professionals reported by people on probation. For example, Morton (2019) described a quote from an ex-offender who spoke about primary care registration: *" […] They do ask if you have drug and alcohol problems but not about any other sort of health problems"*.

A series of engagement surveys with people on probation and prison leavers described that drug and alcohol services were helpful for 43% of those who used them (n=135; Gipson & Wainwright, 2023a; n=177; Gipson & Wainwright, 2023c). Both sources reported the same information in this area. For those in approved premises, Gipson and Wainwright (2023c) described that *"over two thirds of those engaged in drug and alcohol services found them helpful when accessing healthcare services."*. While figures are provided in each report described those who found drug and alcohol services to be very unhelpful and very helpful, the exact proportions in each category were unclear and were not reported in-text.

Appendix 6: Liverpool HNA Questionnaire

The text from the questionnaire used in the Liverpool HNA is presented below, this questionnaire was a development of the one used in the health and social care needs assessment for residents in approved premises in Wales.

The questionnaire was presented with NHS England branding, and some formatting details may have been lost when copying the survey into this appendix.

Consent

This survey is to gather information about the health of people under the supervision of Probation Services in Liverpool. We want to understand your health needs and experience of accessing NHS services in the community. If you choose to take part please answers as honestly as possible. For any questions you chose not to answer please tick "prefer not to say" or leave blank.

All information is anonymous – you will not be identifiable by taking part

Information gathered will be securely stored by NHS England

Participating is entirely voluntary, and you do not need to give a reason if you choose not to complete this survey.

Are you happy to take part in this survey?

- ☐ Yes
- ☐ No

1. About you

1.1 Are you under the supervision of Liverpool North or Liverpool South Probation Delivery Unit?

- ☐ Liverpool North
- ☐ Liverpool South
- ☐ Liverpool Women Unit
- ☐ Prefer not to say

1.2 Are you under supervision following release from prison, or whilst serving a community order/sentence?

- ☐ Under supervision following release from prison

- [ ] Under supervision whilst serving a community order/sentence
- [ ] Other (please specify below)
- [ ] Prefer not to say

1.3 What is your gender?

- [ ] Male
- [ ] Female
- [ ] Non-binary / other
- [ ] Prefer not to say

1.4 How old are you?

- [ ] 20 years old or younger
- [ ] 21-30 years old
- [ ] 31-40 years old
- [ ] 41-50 years old
- [ ] 51-60 years old
- [ ] 61-70 years old
- [ ] 71 years or older
- [ ] Prefer not to say

1.5 What is your ethnic group?

White

- [ ] English, Welsh, Scottish, Northern Irish or British
- [ ] Irish
- [ ] Gypsy or Irish Traveller
- [ ] Roma
- [ ] Any other White background

Mixed or Multiple ethnic groups

- [ ] White and Black Caribbean
- [ ] White and Black African
- [ ] White and Asian
- [ ] Any other Mixed or Multiple background

Asian or Asian British

- [ ] Indian
- [ ] Pakistani
- [ ] Bangladeshi
- [ ] Chinese
- [ ] Any other Asian background

Black, Black British, Caribbean, or African

- [ ] Caribbean
- [ ] African background
- [ ] Any other Black, Black British or Caribbean background

2. About your health

2.1 How would you rate your physical health right now?

- [ ] My physical health is very good / "I feel great"
- [ ] My physical health is good / "I feel well"
- [ ] My physical health is fair / "I feel ok"
- [ ] My physical health is bad / "I don't feel well"
- [ ] My physical health is very bad / "I feel really unwell"

2.2 How would you rate your mental health right now?

- [ ] My mental health is very good / "I feel great"
- [ ] My mental health is good / "I feel well"
- [ ] My mental health is fair / "I feel ok"

- [ ] My mental health is bad / “I don’t feel well”
- [ ] My mental health is very bad / “I feel really unwell”

2.3 Does your physical or mental health reduce your ability to carry out day-to-day activities?

- [ ] Yes, a lot
- [ ] Yes, a little
- [ ] Not at all

2.4 Have you ever been diagnosed with any of the following medical conditions? Please tick all that apply.

- [ ] Cancer
- [ ] Diabetes
- [ ] Hypertension or high blood pressure
- [ ] Cardiovascular disease or heart disease
- [ ] Stroke
- [ ] Chronic lung / respiratory disease
- [ ] Asthma
- [ ] Musculoskeletal conditions, including arthritis
- [ ] Learning disability
- [ ] Prefer not to say
- [ ] Other, please specify in **Box 1** below:

Box 1: ‘Other’

If you have not been medically diagnosed but feel you suffer from any of these conditions, please specify in box 2 below:

Box 2: I have not been medically diagnosed with any of these conditions, but from the list above I feel I suffer with:

2.5 Have you ever been diagnosed with any of the following medical conditions related to your mental health? Please tick all that apply.

- [ ] Anxiety
- [ ] Depression
- [ ] Post-traumatic stress disorder
- [ ] Cardiovascular disease or heart disease
- [ ] Schizophrenia
- [ ] Bipolar disorder
- [ ] Personality disorder
- [ ] Addictions
- [ ] Prefer not to say
- [ ] Other, please specify in **box 1** below:

Box 1: 'Other'

If you have not been medically diagnosed but feel you suffer from any of these conditions, please specify in box 2 below:

Box 2: I have not been medically diagnosed with any of these conditions, but from the list above I feel I suffer with:

2.6 Which best describes your ability to go about your usual activities (considering your mobility and ability to care for yourself)?

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

2.7 Which best describes your current level of pain?

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

2.8 Do you have any tooth / dental problems? (tick all that apply)

- ☐ Tooth decay / holes in your teeth
- ☐ Toothache / pain
- ☐ Mouth ulcers
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Other (please specify in the box below):

2.9 In the last 12 months have any of these problems with your teeth and mouth led to difficulties with:

	None	A little	A lot
Sleeping	☐	☐	☐
Eating	☐	☐	☐
Speaking	☐	☐	☐
Your feelings (for example feeling angry or easily upset)	☐	☐	☐
Smiling or laughing	☐	☐	☐
Mixing with friends and other people	☐	☐	☐

3. Health Behaviours

3.1 Alcohol (tick all those that apply)

- ☐ Drinking alcohol has caused health problems for me in the past
- ☐ Drinking alcohol has caused financial problems for me in the past
- ☐ Drinking alcohol has led or contributing to offending
- ☐ I am worried that drinking alcohol will cause problems for me in the future
- ☐ I am receiving support around alcohol use
- ☐ I am not receiving support around alcohol use but am trying to reduce my use
- ☐ Prefer not to say

3.2 Do you smoke tobacco?

- ☐ Yes, I smoke now
- ☐ I used to smoke but I have given up

- [ ] I have never smoked

3.4 If you smoke, how many cigarettes / roll-ups do you smoke per day?

3.5 Do you chew tobacco?

- [ ] Yes
- [ ] No

3.6 Do you use a vape / e-cigarette?

- [ ] Yes
- [ ] No

3.7 If you smoke, would you like support to stop smoking?

- [ ] Yes
- [ ] No

3.8 Drugs (tick all that apply)

- [ ] Using drugs has caused problems for me in the past
- [ ] Using drugs has led or contributed to offending
- [ ] I am worried that drugs will cause problems for me in the future
- [ ] I am receiving support to avoid or stop using drugs
- [ ] I am not receiving support to avoid or stop using drugs but I am trying to reduce my use
- [ ] Prefer not to say

4. NHS Health Services

4.1 Are you registered with a doctor / GP?

- [ ] Yes

- [ ] No
- [ ] Don't know

4.2 How often do you visit your doctor / GP?

- [ ] More than once a month
- [ ] Every 3-6 months
- [ ] At least once a year
- [ ] Less than once a year
- [ ] Never
- [ ] I don't know

4.3 Have you heard of an NHS Health Check, or a 'Health MOT'? This is a discussion with a health professional, to check your current health and understand your risk of developing a long-term condition?

- [ ] Yes
- [ ] No
- [ ] Don't know

4.4 Have you attended an NHS Health Check or 'Health MOT' in the last 5 years?

- [ ] Yes
- [ ] No
- [ ] Don't know

4.5 If yes, did you find the Health Check or 'Health MOT' helpful?

- [ ] Yes
- [ ] No
- [ ] Don't know

4.6 If no, do you feel you would benefit from a Health Check or 'Health MOT' (A discussion with a health professional, to check your current health and understand your risk of developing a long-term condition?)

- [ ] Yes
- [ ] No
- [ ] Don't know

4.7 What would be the most convenient place for you to attend an appointment for this?

- ☐ GP Practice
- ☐ A local community venue (e.g. a leisure centre, pharmacy or community organisation)
- ☐ Probation office
- ☐ On-line (a virtual appointment with a nurse)
- ☐ Via an App (a digital health check)
- ☐ Don't know/other (if other please provide any suggestions below)

4.8 When did you last visit a dentist?

- ☐ In the last year
- ☐ In the last 2 years
- ☐ In the last 3 years
- ☐ More than 3 years ago
- ☐ I don't know

4.9 In the last year, which of these services have you needed, and have you been able to get an appointment? (tick all that apply and provide any further comments in the box below)

	I have needed, and I had / have an appointment	I have needed, but I couldn't get an appointment
GP	☐	☐
A&E / Emergency department	☐	☐
Hospital appointment	☐	☐
Dentist	☐	☐
Optician	☐	☐
Mental Health Services	☐	☐
Physiotherapist	☐	☐

	I have needed, and I had / have an appointment	I have needed, but I couldn't get an appointment
Speech and language therapist	☐	☐
Substance misuse service	☐	☐
Other service (write below)	☐	☐

Comments:

4.10 How many times in the last year have you been to A&E / the Emergency Department, or needed an ambulance, for yourself?

- ☐ None
- ☐ 1-2 times
- ☐ 3-5 times
- ☐ 5-10 times
- ☐ More than 10 times
- ☐ I don't know

4.11 Is there anything that you feel stops you from using healthcare services? Please tick all that apply and provide any further comments in the box below

- ☐ I'm not being registered (e.g. with a GP / dentist) so can't get support
- ☐ I don't have time to get to any appointments
- ☐ I can't afford to get to any appointments
- ☐ The hours that services are open don't suit my needs
- ☐ I feel judged, or feel worried I will be judged, for being under probation services
- ☐ I don't trust, or don't like, using healthcare services
- ☐ I have previously had bad experiences of healthcare services
- ☐ I don't know

- [ ] Not applicable / I haven't needed any healthcare services
- [ ] Other (please specify):

4.12 Is there anything else you would like to share with us about your experiences of using healthcare services in the community, or what services you would find helpful to improve your physical or mental health?

Reference list

Agbaria, N., Wirth, M., Winkler, V., Moazen, B., Van Hout, M.C. and Stöver, H., 2024. Determinants of access to primary healthcare for formerly incarcerated women transitioning into the community: a systematic review of the literature. *BMJ Public Health*, *2*(2). Available from: https://bmjpublichealth.bmj.com/content/bmjph/2/2/e000735.full.pdf

Arksey, H. and O'malley, L., 2005. Scoping studies: towards a methodological framework. *International journal of social research methodology*, *8*(1), pp.19-32. Available from: https://eprints.whiterose.ac.uk/1618/1/scopingstudies.pdf

Bissell, S., 2024. Literature Review Health Needs Assessment of Individuals within Community Justice Services and Untried in Custody (Remand). Available from: https://www.stor.scot.nhs.uk/bitstreams/0d5cccc8-5fa0-4d4c-877c-75aa8fb258c0/download

Brooker, C. and Sirdifield, C., 2013. An investigation into the prevalence of mental health disorders in an English probation population: an overview. *Eurovista: Probation and Community Justice*, *2*(3), pp.154-160. Available from: https://www.cep-probation.org/wp-content/uploads/2019/01/VOL-2.3-An-Investigation-into-the-Prevalence-of-Mental-Health-Disorders-in-an-English-Probation-Population-An-Overview.pdf

Brooker, C., Sirdifield, C. and Marples, R., 2020. Mental health and probation: A systematic review of the literature. *Forensic science international. Mind and law*, *1*, p.100003. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC7612333/

Brooker, C., Sirdifield, C. and Parkhouse, T., 2022. Identifying mental illness and monitoring mental health in probation service settings. *European journal of probation*, *14*(3), pp.179-203. Available from: https://journals.sagepub.com/doi/pdf/10.1177/20662203221140646

Brooker, C., Sirdifield, C. and van Deinse, T., 2023. Serious mental illness in probation: A review. *European journal of probation*, *15*(1), pp.60-70. Available from: https://journals.sagepub.com/doi/pdf/10.1177/20662203231162739

Brooker, D., Fox, C., Barrett, P., and Syson-Nibbs, L., 2008. A health needs assessment of offenders on probation caseloads in Nottinghamshire and Derbyshire: report of a pilot study. Available from: https://www.researchgate.net/publication/276937756_A_health_needs_assessment_of_offenders_on_probation_caseloads_in_Nottinghamshire_and_Derbyshire_report_of_a_pilot_study

Campbell, F., Tricco, A.C., Munn, Z., Pollock, D., Saran, A., Sutton, A., White, H. and Khalil, H., 2023. Mapping reviews, scoping reviews, and evidence and gap maps (EGMs): the same but different—the "Big Picture" review family. *Systematic reviews*, *12*(1), p.45. Available from: https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-023-02178-5

Clinks and Birth Companions., 2021. A window of opportunity-Understanding the needs and experiences of pregnant women and new mothers in contact with the criminal justice system in the

community in England. Available from: https://www.clinks.org/sites/default/files/2021-05/Understanding%20the%20needs%20and%20experiences%20of%20pregnant%20women%20and%20new%20mothers%20in%20contact%20with%20the%20criminal%20justice%20system%20in%20the%20community%20in%20England_0.pdf

Cooper, R., 2018. A health needs assessment of offenders in the community. Derbyshire and Derby City. Available from: https://observatory.derbyshire.gov.uk/wp-content/uploads/reports/documents/health/specialist_reports_and_assessments/2018/Derbyshire_and_Derby_City_Offenders_HNA_2018_Full_report.pdf

Cooper, R., 2019. Assessing the Health Needs of Offenders Residing in the Community: a mixed-methods approach to reducing criminal behaviour. *Papers from the British Criminology Conference, 1*. Available from: https://www.britsoccrim.org/wp-content/uploads/2019/12/Assessing-the-Health-Needs-of-Offenders-Residing-in-the-Community-PBCC19.pdf

Davies, E.A., Lüchtenborg, M., Maree Hunter, R., Visser, R., Huynh, J., Pow, R., Plugge, E., Taylor, R.M. and Armes, J., 2025. Cancer in English prisons: a mixed-methods study of diagnosis, treatment, care costs and patient and staff experiences. *HSDR*, 13(3). Available from: https://www.journalslibrary.nihr.ac.uk/hsdr/HYRT9622

Gipson, D. & Wainwright, L., 2023a. Patient perspectives: Prison leavers. Core20PLUUS5. *Empowering People: Inspiring Change (EP:IC)*. Available from: https://media.tghn.org/medialibrary/2023/08/Prison_Leaver_Core20PLUS5_report.pdf

Gipson, D. & Wainwright, L., 2023b. Patient perspectives: maternity needs. Core20PLUS5. *Empowering People: Inspiring Change (EP:IC)*. Available from: https://media.tghn.org/medialibrary/2023/08/CORE20PLUS5_Maternity_Patient_Perspectives.pdf

Gipson, D. & Wainwright, L., 2023c. Patient perspectives: people on probation Core20PLUS5. *Empowering People: Inspiring Change (EP:IC).* Available from: https://media.tghn.org/medialibrary/2023/08/People_on_Probation_CORE20PLUS5_4.pdf

Gipson, D. & Wainwright, L., 2023d. Patient perspectives: Approved premises. Core20PLUS5. *Empowering People: Inspiring Change (EP:IC)*. Available from: https://media.tghn.org/medialibrary/2023/08/_Approved_Premises_CORE20PLUS5.pdf

Hunter, R.M., Huynh, J., Lüchtenborg, M., Armes, J., Plugge, E., Taylor, R.M., Visser, R. and Davies, E.A., 2024. Does the cost of cancer care for people in prison differ from those in the general population? Analysis of matched English cancer registry and hospital records. *EClinicalMedicine*, *72*. Available from: https://www.sciencedirect.com/science/article/pii/S2589537024001548

Lüchtenborg, M., Huynh, J., Armes, J., Plugge, E., Hunter, R.M., Visser, R., Taylor, R.M. and Davies, E.A., 2024. Cancer incidence, treatment, and survival in the prison population compared with the

general population in England: a population-based, matched cohort study. *The Lancet Oncology*, *25*(5), pp.553-562. Available from: https://www.thelancet.com/pdfs/journals/lanonc/PIIS1470-2045(24)00035-4.pdf

Morton, H., 2019. Offender Health Report Experiences of offenders using health services in Derbyshire. *Healthwatch Derbyshire*. Available from: https://cdn.prod.website-files.com/6325e07facd3d82fad5f0eee/633763bf289efe4514798310_V2-OFFENDER-HEALTH-REPORT-09122019-HM.pdf

Rabaiotti, E., 2024. People on probation as an inclusion health group: Exploring needs, barriers and service provision in Wales. *Probation Journal*, *71*(4), pp.364-386. Available from: https://journals.sagepub.com/doi/10.1177/02645505241247291

Richards, A., 2020. Health and social care needs assessment of adults under probation service supervision in the community: A guidance document. *London: Public Health England*. Available from: https://assets.publishing.service.gov.uk/media/5e7b2803e90e0706ee64a78e/Probation_HSNA_Guidance.pdf

Sirdifield, C. and Brooker, C., 2020. Maximising positive mental health outcomes for people under probation supervision. *HM Inspectorate of Probation, Academic Insights.* Available from: https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2020/08/Maximising-positive-mental-health-outcomes-for-people-under-probation-supervision.pdf

Sirdifield, C., Brooker, C. and Marples, R., 2020. Substance misuse and community supervision: A systematic review of the literature. *Forensic Science International: Mind and Law*, *1*, p.100031. Available from: https://www.sciencedirect.com/science/article/pii/S2666353820300242

Sirdifield, C., Parkhouse, T., Brooker, C. and Law, G., 2024. Testing and refining an approach to identifying health and social care needs in probation. *Probation journal*, *71*(4), pp.387-406. Available from: https://journals.sagepub.com/doi/10.1177/02645505241232128

Williams, O., Gray, B.J. and Perrett, S.E., 2024. Identifying the public health needs of a UK probation cohort: a cross-sectional analysis. *Journal of Public Health*, *46*(1), pp.12-19. Available from: https://academic.oup.com/jpubhealth/article/46/1/12/7277134

The Strategy Unit
Tel: 0121 612 1538
Email: strategy.unit@nhs.net
Web: www.strategyunitwm.nhs.uk
Twitter: @strategy_unit

Midlands and Lancashire
Commissioning Support Unit