Speech

Dame Glenys Stacey, HM Chief Inspector of Probation

Inside Government, Offender Management 2019

London, 19 March 2019

Re-imagining probation services to face the challenges of the future

Good afternoon, and thank you for inviting me back (I was here last year). And thank you so much for asking me to speak on the theme of re-imagining probation services. Who can resist the opportunity to flex the imagination!

Let me start by reminding you that many members of the public are but vaguely aware of probation, and what it does, but good quality probation services matter. More than a quarter of a million people are under probation supervision each year. If all these services were delivered well, there would be less reoffending and fewer people being returned repeatedly to prison. The prison population would reduce, and there would also be fewer people living on the streets, fewer people begging, and fewer confused and lonely children, with a smaller number taken into care. Men, women and children currently afraid of assault could lead happier, safer lives. These things matter to us all.

But probation is not working as it should. Overall, it is not delivering well enough for some of the most troubled and troublesome people in society today, when they and the wider public deserve better.

Both the National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) are failing to meet some of their performance targets, although the NPS is doing better. These targets are generally task-based, however – a sentence plan must be drawn up within fifteen days of first meeting, in each case, for example. What is much more concerning, to my mind, is that although there will be exceptions, the probation work of CRCs is generally not good enough. It is not of the right **quality** overall.

As we at HMI Probation inspect, we rate divisions of the NPS and each CRC on a four-point rating scale: Outstanding, Good, Requiring Improvement, Inadequate. In the ten CRCs inspected over the last year, we have rated the *implementation and delivery of core probation supervision* as Requiring Improvement in two CRCs and Inadequate (the lowest possible rating) in the remaining eight.

Now, here we are at the Royal College of Physicians. It seems to me that we may need their help.

I have been asked to reimagine probation services. Last summer, the Justice Secretary made the bold decision to terminate contracts with CRCs two years earlier than planned. They will now come to an end in December 2020. The question on all our minds is this: what comes next?

Let me put myself in the role of probation's physician. Let me poke, and test, and identify some its most worrying symptoms - some immediately visible and some not - and then prescribe some medicine, or even surgery.

First, it is as plain as the nose on the patient's face that the patient is not a strong as it should be. It is under-nourished. It has a shortage of qualified probation professionals. There is now a national shortage, particularly in the ranks of those doing much of the more complex casework (Probation Officers).

This ailment will take time to sort I am afraid. There is no instant tonic. We need a national workforce strategy to make things better, over time. The Ministry of Justice has made a similar diagnosis and intends to develop the strategy, but it will not be straightforward, with the number of different employers and models across probation. This medicine will come at a cost, and might be difficult to administer.

And I suggest there is an underlying weakness in the patient here as well. The profession is not protected by the usual bulwarks of other established professions (such as the profession of physicians).

Established professions generally require individuals who are in practice to be registered as members of the profession – in effect, certifying that they meet entry requirements for the profession. Almost all professions require members to undertake ongoing training (continual professional development) and that members are subject to self-regulation. Under those self-regulation arrangements, members can face Fitness to Practice proceedings if they have acted unethically or incompetently, with debarment for the most serious negligence or misconduct.

The probation profession and the general public are not protected by these specific requirements.

Probation professionals are not obliged to register with anyone, and are not under any profession-wide requirement to keep their knowledge and skills up to date. In recent months we have reported on notable shortcomings in the skills and knowledge of professionals supervising sexual offenders, and perpetrators of domestic abuse, both sizeable areas of work for probation services. We know from our inspections that probation professionals struggle to carve out time for training and development.

Probation professionals are not subject to a common *code of ethics.* Such a code would be an important protection for all people under probation supervision, but codes of ethics also protect members of professions from commercial or other pressures in their employment, as immutable lines are drawn.

I have to advise the patient that the impacts of commerce, and contracts that treat probation as a transactional business can mean that professional ethics can buckle under such pressures, and the evidence we have is that this has happened to some extent.

In our inspection of Dorset, Devon and Cornwall CRC we found cases with no sentence plan at all, or where sentence plans had been prepared without meeting with the individual. We also found the assessment of the risk of serious harm to the public seriously compromised, because of commercial pressures.

A remedy is certainly needed, and here the Ministry of Justice prescription is slightly different to mine. It has proposed the development of a national professional register, with plans to house it under the auspices of the NPS. I think it inappropriate for a major employer of the profession, or a government agency to be responsible for certification and registration of the profession. Instead, such responsibilities generally lie with an independent body.

The Ministry of Justice has also proposed to more clearly specify the training, skills and competencies that staff will require for different roles. While welcome, this does not provide the assurance inherent in other professions' requirements for Continuing Professional Development. Like other professionals, probation staff need to keep up to date with developments.

And I prescribe more medicine: a meaningful code of ethics, and an effective professional body for the profession. It could make such a difference for the profession and for the wider public.

We have diagnosed that immediate issue, but what else is plain to the physician, in studying this patient? What is plain is that it is not getting enough exercise. There will be exceptions, but in general, not enough meaningful activity is taking place in cases supervised by CRCs. The patient is not doing what we know to be good for it! It is not working in accordance with the evidence base for rehabilitation anywhere near enough.

In the day to day work of probation professionals, there has been a notable and extremely regrettable drift away from the evidence base for effective probation services. So why has the patient become so lazy, seemingly, when it knows this is not healthy?

Things are not what they seem. The patient is active, is busy, but driven to focus on the wrong things sometimes.

The physician might reflect that Rehabilitation Activity Requirements are ordered largely by default and can be largely ineffective, in practice, and also that recognised cognitive-behavioural programmes (Accredited Programmes) and treatment orders are not being ordered or delivered enough.

What is more, in the current model for probation services, the critical relationship between the individual under probation supervision and the probation worker is not sufficiently protected and as a result, core probation supervision itself has been allowed to coast. This has undermined the place of evidence-based and evidence-led practice.

And CRCs are understandably focused on meeting those transaction-based targets I mentioned earlier. They are kept very busy, doing that. Many are running to keep still. Running on the treadmill.

Refreshingly, some CRCs are self-medicating. They are developing evidence-led approaches, and some are taking a further step and evaluating those new approaches. The established national mechanism for evaluation of new approaches – Accreditation – is not being used, however, and promising developments are not being promulgated across the service as a whole. The way the service is now configured inhibits that to a large extent.

It is so important that probation work is evidence-based and evidence-led, and that the evidence base grows over time, and yet we have seen a move away from it in recent years.

To cure this ailment, surgery will be required, I fear. The Ministry of Justice must make sure that in the future arrangements for the provision of probation services, there are enough probation professionals able to have sufficient regard to the evidence base for effective rehabilitative probation services, and able to deliver in accordance with the evidence base.

As the physician of course, I only have a limited time with this patient. Our appointment is coming to an end shortly, but I just have time to consider one more problem. This patient cannot live better, probation cannot deliver well enough without the help of others in the community.

Our aggregated data shows for example that for individuals leaving prison, accommodation is the most pressing issue, followed by the need for help with finance, benefits and debt, with similar issues prevalent for individuals under probation supervision in the community.

We expect every effort in individual cases of course, but national, strategic solutions are needed. Those without a place to live are notably more likely to reoffend and to be sentenced to custodial sentences. Speedier payment of benefits when an individual leaves prison would be more likely to sustain an individual's motivation to turn away from crime, and reduce the prospect of individuals stealing, to sustain themselves.

The patient cannot resolve these issues alone. Instead, the prescription is for the government. Its national *Reducing Reoffending Board* should consider how sufficient accommodation can be provided for those without a home, and how to speed up initial benefits payments (without clawback) for those released from custody and without a means to live.

Accommodation and a means to live are so important, but the patient needs other services to be available locally as well. Under the government's 2014 Transforming Rehabilitation initiative, CRCs became responsible for contracting *specialist* services (such as advice on managing debt) for individuals under probation supervision from those able to provide them, so that they are available for individuals CRCs supervise and for the NPS as well. Our inspection evidence shows there is an insufficient range of these specialist services overall.

CRCs contracts allow CRCs to decide what to offer by way of specialist services. We have found staff in NPS divisions (and even CRC staff themselves) are often unaware of the services on offer. More commonly however, we have found NPS staff and leaders reluctant to purchase services from CRCs, because of concerns about the quality of services to be provided, or whether they represent value for money, or because of an instinctive reluctance to pay for services. In addition, there is an enduring cultural dimension: professional probation staff do not see themselves as purchasers, and most do not want to be.

Surgery is needed here. In designing the future arrangements for probation services, government should make sure that a good range of specialist services are available to meet need, and that the specialist service sector is nurtured and maintained.

It is time for our appointment to end, but I do offer the patient a bit of philosophical advice, to conclude our consultation. Like so many of us, this patient wants things beyond its grasp, and not in its gift. It has been encouraged to aim for greatness rather than focus on the day to day.

Let me explain. All probation professionals aspire to reduce reoffending, and quite right too. But CRCs are rewarded for statistically significant reductions in the reoffending of individuals they have supervised.

Reoffending has reduced slightly in recent years, but the number of offences committed by those who do reoffend has increased. Some CRCs have received extra money as a result, others not.

While changes in the rate of proven reoffending have been used as a strategic measure of the success of individual probation providers, I argue that changes in reoffending rates are not sufficiently and directly attributable to their work. Although evidence-based and evidence-led probation work can reduce reoffending, factors such as an individual's maturity, or police priorities influence the reoffending rate as well. We know for example that in recent years, the criminal justice focus has moved more towards serious crime, crimes that attract long prison sentences.

I think the patient needs to think again about its goals, and focus on living better day to day. The Ministry of Justice needs to encourage the patient in that way. More immediate measures of the quality of probation services (for example, our inspection findings and ratings) are more telling of the health of the patient – and the patient is more likely to play its part in reducing reoffending if it delivers good quality work, day in day out.

In conclusion, I have singled out some of the most distressing symptoms for the patient, and suggested remedies, but in many ways I have looked at individual symptoms rather than their cause, and of course the focus on individual symptoms may be at a cost to the overall health of the patient.

Let us not forget: this patient has so many attractive features. It has a strong ethos, with good leaders and committed staff capable of delivering first class probation service that can make a real difference to the most troubled in society, and to society as a whole. It has a reason to live! But is has been so ground down in recent years, and its future health remains at risk.

The physician can prescribe some immediate medication to alleviate some of the obvious symptoms of ill-heath, but he should also take several steps back, look at the patient in the round, and consider whether a more radical treatment programme is needed. I think it is, don't you?

Thank you. Thank you for listening.

ENDS