



Out of Sight, Out of Mind

The state of mental healthcare in prison



Professor Charlie Brooker and Ben Ullmann
Edited by Gavin Lockhart

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Expert panel

This report would not have been possible without the generous assistance of our panel of eight experts who agreed to be interviewed. Their inclusion here does not necessarily indicate an endorsement of the report's contents but quotations are included with their agreement.

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Juliet Lyon is the director of the Prison Reform Trust. She has worked in mental health and in education as head of a psychiatric unit school.

Executive Summary

Our prison population is at its highest ever. Of the 82,000 prisoners in England and Wales it is estimated that nine out of ten have one or more mental health disorders. Although treatment of mental illness in prison has improved over the past decade, mental healthcare is not given the attention it deserves. The rates of mental illness among prisoners suggest that the Prison Service has become a catch-all social and mental healthcare service, as well as a breeding ground for poor mental health.

The general public are largely unaware of the amount of mental illness in prison, although data on the subject has been available for some time. When asked to estimate the proportion of people in prisons in the UK with a mental health problem only 1% answered correctly; the vast majority underestimated the figure. Nearly half (45%) thought that it was 30% or less.

There is significantly less public sympathy for prisoners with mental illness than for those in the community. While 90% of people believe that we have a responsibility to provide the best possible care for those with mental illness, rather less, 64%, thought this applied to offenders. This sits awkwardly with the fact that 60% believe that anyone can have a mental illness and commit a crime.

The current assessment of prison mental healthcare by those who deal with it every day is bleak. In our surveys of prison healthcare professionals, who included mental health in-reach leaders and PCT prison health leads, more than half said that prison mental healthcare was average or poor – surprisingly low for a self-assessment. Our panel of experts also acknowledged that prison mental healthcare is still not working properly despite some improvements.

Spending on mental health services in prison is currently £20.4 million (it will

rise to £24 million in 2008-09). Our research found that over a third, £8.6 million, is not being spent efficiently. This is due to shortfalls in staff recruitment – just over 10% of the total budget is not being spent – and confusion over the role of mental health in-reach teams. These teams, which were originally supposed to deal exclusively with cases of severe mental illness, are working in practice with a much broader caseload: 30% of cases have neither a severe mental illness nor a personality disorder.

Spending is not only inefficient but also insufficient. The proportion of the total health budget spent on mental healthcare in the community is 15%. The proportion of the total prison healthcare budget spent on mental healthcare is only 11%, even though mental illness is much more common in the prison system than the community at large.

Primary care trusts (PCTs) are responsible for the healthcare budgets of prisons in their area. As far as we know no rational basis has been established for the allocation of monies to PCTs for prison health. The current funding reflects a negotiated settlement with the Prison Service based on what it was receiving from the Home Office before prison health services became the responsibility of the Department of Health. In other words, budgets are based on past practice rather than any definition of current need. A sophisticated needs assessment should be undertaken in order to find how much is really required to provide for the prison community.

One consequence of underfunding is chronic understaffing. Mental health in-reach teams, on average, consist of just four clinical staff; they are intended to be multidisciplinary but usually have no psychiatrist, psychologist or social worker. We also know that staffing of in-reach teams varies

across prisons, with some consisting of ten or more staff while others have only two clinical nurses.

If Department of Health (DoH) guidance for community mental health teams was applied to prisons and took into account the much greater prevalence of mental illness there, in-reach teams would have the equivalent of three to four community psychiatric nurses; two to three social workers; a minimum of one full-time clinical psychologist; a support worker and administrator; and two full-time psychiatrists: in total between 12 and 14 professionals. This suggests that the average in-reach team is only a third of the size it should be and does not contain the correct range of skills.

The co-ordination of mental healthcare also leaves much to be desired. In-reach, primary care, drug services and other teams work separately. The line between what is primary and secondary care is blurred and prisoners are passed between the two or even lost completely. A single mental healthcare delivery team, with the same range of skills and practitioners as in the community mental health teams, would go a long way to improving the quality of care. In fact, some teams structured in this way already exist and are proving to be effective.

Whatever improved level of funding for prison mental healthcare was decided on, we believe the extra cost would be offset by a reduction in reoffending. Former prisoners who suffer social exclusion, which includes factors such as homelessness, unemployment and family breakdown, are more likely to reoffend. Mental illness increases the risk of social exclusion and therefore of reoffending. Recent studies estimate that the £20.4 million currently spent on prison mental healthcare would need to be tripled in order to reach service levels equivalent to that of the wider community. If we accept this figure as a sensible estimate, rates of reoffending would

have to fall by only 0.3% to make the improvement cost effective. A relatively small increase in spending might result in a much larger reduction than this and, subsequently, in the costs of reoffending.

The second report in this series will contain lessons from abroad and detailed recommendations. However, there are four areas that the Government must look at urgently: prison overcrowding; resettlement plans; improved awareness training for prison officers and prison governors; and integrated policymaking.

“ Ensuring that everyone with a mental health problem who is released from prison has a proper care plan is crucial in decreasing reoffending rates ”

A key element of the Bradley Review into court diversion schemes due later this year must be to implement a robust and properly funded system for diverting offenders with mental illness away from prison. Not only would this ease the crisis of overcrowding, but also ensure that offenders with mental illness were provided care and treatment in an appropriate setting, whether in the community or a secure health facility.

If reoffending and mental illness are to be properly addressed, they must be seen in the wider context. The biggest drivers of reoffending – lack of employment, suitable accommodation and access to healthcare – need to be carefully considered in an offender’s resettlement plan. Ensuring that everyone with a mental health problem who is released from prison has a proper care plan is crucial in decreasing reoffending rates. This should already happen for prisoners with a severe mental illness through the care management approach (CPA) but our survey of in-reach teams suggests that it is not always the case.

Although the clinical staff are vital in

delivering effective mental healthcare, prison officers will have the most contact with prisoners day-to-day. It is essential that they have the skills to identify and deal with mental illness. Current training is not sufficient and in some cases is not compulsory. In surveys conducted for this report in-reach team leaders and PCT prison health leads said that one of the biggest improvements that could be made would be to increase mental health awareness training for prison officers. Prison governors play the most important role of all in determining the atmosphere of a prison and their training too should include mandatory mental health awareness training.

The structure of policymaking makes it hard to introduce mainstream health developments, such as the programme for increasing access to psychological therapies, into prisons. Responsibility for prison healthcare was transferred fully from the Prison Service to the Department of

Health in 2006 but offender health is managed by a separate directorate of the DoH. Primary care trusts, which are responsible for prison healthcare budgets, would be more likely to consider prison populations as part of their local communities if a more integrated approach to policymaking was evident from the top.

In 1996, Lord Ramsbotham, then Chief Inspector of Prisons, wrote a report that was heavily critical of prison healthcare services – their lack of suitable training for medical and nursing staff; isolation from new clinical developments; inadequate care for the mentally disordered in prison; failure of continuity of care between prison and community; and a lack of consideration of the care needs of specific groups of prisoners such as women and young people. And although matters have improved since then, progress is slow. This report argues that Lord Ramsbotham's findings are as relevant today as they were 12 years ago.

1

Introduction

Summary

However else the people who populate our jails may differ from the community at large, there is one distinguishing characteristic of which we can be certain: prisoners are far more likely to suffer from mental ill-health than the general population. Nearly half have at least three co-existing mental health problems compared to less than 1% in the community.¹ Some 70% of sentenced prisoners suffer from two mental conditions, of which the most common are personality disorders, neurotic disorders, drug dependency and alcohol dependency.² Between 6% and 13% have a severe schizophrenic or delusional disorder and 1% to 2% psychosis.³

Faced with such figures the obvious question is whether the prisoner has a mental disorder from the outset or whether prison life leads to its development. Much of the available research measures the proportion of people in a population who have a disease or condition at a particular time – it is a snap shot or what epidemiologists term “point-prevalence” – so it is not possible to be sure. However, we know that the prison experience itself does have an

effect on mental health. In a 2003 study prisoners reported that long periods of isolation with little mental stimulus led to intense feelings of anger, frustration and anxiety; they used drugs to relieve the long hours of tedium.⁴

Black and minority ethnic communities People from black and minority ethnic (BME) communities make up about 10% of the UK population⁵ but about 20% of the prison population.⁶ The rate of diagnosed mental health problems is lower in BME communities than among white prisoners, perhaps because of lower rates of referral and recognition.⁷ The Chief Inspector of Prisons, Anne Owers, recognised this inequality in her 2007 report on mental health:

“In general, we found that services were insufficiently responsive to diverse needs. Neither substance use nor mental health services were sufficiently alert to the different needs of BME prisoners; nor were they monitoring access effectively.”⁸

Table 1: % Rates of mental illness among prisoners and the general population

	% Prisoners ⁹	% General population (adults of working age) ¹⁰
Psychosis	6-13	0.4
Personality disorder	50-78	3.4-5.4
Neurotic disorder	40-76	17.3
Drug dependency	34-52	4.2
Alcohol dependency	19-30	8.1

1 Corner J, Jones E, Honeyman R, Prisons: Britain's 'Social Dustbins', Revolving Doors Agency, 2007

2 Prison Factfile, Bromley Briefing May 2007, Prison Reform Trust

3 Ibid

4 Nurse J, Woodcock P, Ormsby J, "Influence of environmental factors on mental health within prisons: focus group study", *British Medical Journal* 327 480, 2003

5 Office for National Statistics, 2001 Census. See www.statistics.gov.uk/cci/nugget.asp?id=263

6 Rickford D and Edgar K, *Troubled Inside: Responding to the Mental Health Needs of Men in Prison*, Prison Reform Trust, 2005

7 Durcan G, Knowles K, *London's Prison Mental Health Services: A review*, Policy Paper 5, The Sainsbury Centre for Mental Health, 2005

8 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

9 Singleton N et al, *Psychiatric morbidity among prisoners in England and Wales*, Office for National Statistics, 2007

10 Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H, "Psychiatric morbidity among adults living in private households, 2000", *International Review of Psychiatry*, 15 (1), 65-73, 2003

Women

Women make up approximately 5% of the prison population.¹¹ They serve shorter sentences, but during that time their children may be taken into local authority care and they may lose both their job and their home. There are relatively few women's prisons, so family visits often involve a long journey and may be very difficult to arrange for any children involved. All these factors increase the likelihood of mental stress.

In fact, women prisoners are twice as likely as their male counterparts to have received help for a mental or emotional problem in the 12 months before their imprisonment.¹² It is estimated that 14% suffer from psychosis; the equivalent figure for the community is less than 1%.¹³ Antisocial personality disorder is estimated at 31% among women prisoners. They are also more likely than male prisoners to suffer from common mental health problems. It has been estimated that 66% exhibit neurotic disorders such as depression and anxiety compared to 16% of women in the general population.¹⁴

Of all groups, women in prison have the highest levels of emotional and psychological distress, often related to past abuse and exacerbated by distance from home and children. Primary mental healthcare, relationship support and survival counselling are particularly important to meet their needs.¹⁵

The Corston Report for the Home Office recently recommended completely replacing the women's prison estate with local, smaller-scale alternatives.¹⁶ (Policy Exchange has made a similar recommendation for the whole prison estate.¹⁷) Research by SmartJustice, an advocacy group that campaigns for alternatives to custody, shows that there is broad public support for this measure. Given a choice between prison and various alternatives, its survey found overwhelming support (86%) for the idea of local community

centres where women would be sent to address the root causes of their crimes in addition to doing compulsory work to recompense the community.¹⁸

Young People

Almost 14% of the prison population is under 21 years, a fifth of who are only 15-17 years.¹⁹ Young people in prison are even more likely to suffer poor mental health than adults; 95% have at least one mental health problem and 80% more than one – disturbed sleep, anxiety and depression being the most common.²⁰

Older People

There are more than 1,765 prisoners aged 60 and over, 2% of the total prison population.²¹ Fazel and Danesh reviewed the treatment needs of older prisoners and found that, although mental health conditions were recognised and recorded in the clinical record of half of older prisoners, only 18% of those who needed medication received any.²²

Suicide and self-harm

Rates of self-harm and attempted suicide in prison are high. Although suicide and self-harm is not necessarily associated with mental illness, both are highly correlated with clinical depression, psychosis and personality disorder. There were 67 prison suicides in 2006 and 22,324 incidents of self-harm were recorded during 2005-06.²³ Attempted suicide over a 12-month period ranged from 7% (in male sentenced prisoners) to 27% (in female remand prisoners).²⁴ The greatest risk of suicide or self-harm is among newly arrived prisoners in their first seven days in prison.²⁵

According to figures for England and Wales released by the Ministry of Justice, there were 92 suicides last year, among them a boy of only 15 years. Before 2007 suicide rates in prison appeared to be declin-

11 Ministry of Justice, *Population in Custody, Monthly Tables, March 2008, England and Wales*. See www.justice.gov.uk/docs/population-in-custody-mar08.pdf

12 *Justice for Women: The need for reform*, Prison Reform Trust, 2000

13 O'Brien M, Mortimer L, Singleton N, Meltzer H, "Psychiatric morbidity among women prisoners in England and Wales", *International Review of Psychiatry*, 15 (1) 153-157, 2003

14 *Ibid*

15 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

16 *The Corston Report: A review of women with particular vulnerabilities in the criminal justice system*, Home Office, 2007

17 Lockhart G, McClory J, Ullmann B, *Unlocking the Prison Estate*, Policy Exchange, 2007

18 "Public say: Stop locking up so many women", SmartJustice, 2007

19 *Population in Custody, Monthly Tables, March 2008, England and Wales*, Ministry of Justice, 2008

20 Lader D, Singleton N, Meltzer H, *Psychiatric morbidity amongst young offenders in England and Wales*, Office for National Statistics, 2000

21 *Statistical Bulletin: Offender Management Caseload Statistics 2006*, Home Office Dec 2007

22 Fazel S and Danesh J, "Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys", *The Lancet*, 359 (9306) 545-50, 2002

23 Prison Factfile, Bromley Briefing May 2007, Prison Reform Trust

24 Brooker C, Sirdifield C, Gojkovic D, *Mental Health Services and Prisoners: An updated review*. University of Lincoln, 2007

25 Shaw J, Baker D, Hunt I, Moloney A, Appleby L, "Suicide by Prisoners: National Clinical Survey", *British Journal of Psychiatry*, 184: 263-7, March 2004

ing, so the sudden increase last year gives cause for concern.

One possible explanation is that the Home Office safer custody initiative, together with the introduction of the assessment, care in custody and teamwork approach – a case management system that aims to identify individual need and offer individualised care and support to prisoners in advance of, during and after a crisis – and the mental health awareness training initiative for prison officers, all helped to reduce the rate of suicide. The 2007 increase is likely to be a function of greater overcrowding. Juliet Lyon, director of the Prison Reform Trust, commented:

“This massive increase in prison suicides of almost 40% on 2006 figures is a result of the pressures of chronic overcrowding across the prison estate. Far too many people with serious and enduring mental health problems are held in custody, which despite the best efforts of prison staff can only make their illness worse.”

History of policy development

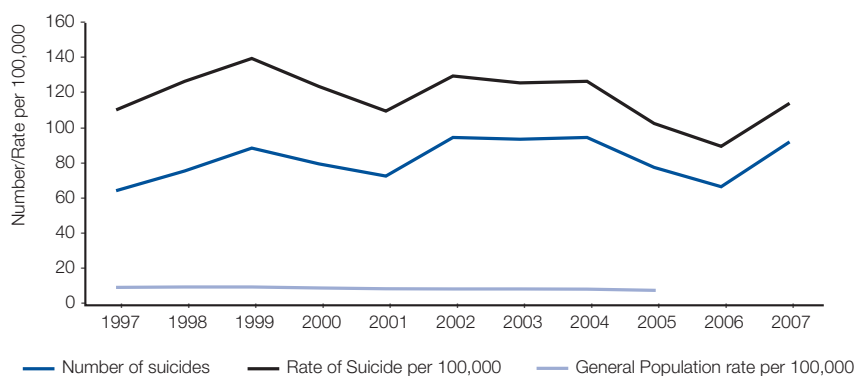
In 1996 the responsibility for all healthcare rested with the Home Office and the Prison Service not the Department of Health and NHS as one might have expected. In that year, David Ramsbotham, then Chief

Inspector of Prisons, published a highly critical report, *Patient or Prisoner?* which drew attention to the inadequate care for the mentally disordered in prison; the lack of suitable training for medical and nursing staff and isolation from new clinical developments; the lack of continuity of care between prison and community; and ignorance of the needs of specific groups of prisoners such as women and young people.²⁶ Despite these unsatisfactory standards, his report pointed out that mental healthcare in prison was more than twice as expensive per person than that provided by the National Health Service for the general population. He noted that prison could exacerbate mental health problems with long-term impact on the individual concerned and the community into which he or she was released.²⁷ *Patient or Prisoner?* declared:

“Prisoners are entitled to the same level of healthcare as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated...to the same standards demanded within the National Health Service.”²⁸

It recommended that the NHS should take over responsibility for prison healthcare and outlined several ways of doing so. Looking back recently on what prompted him to write the report, Lord Ramsbotham said:

Figure 1: Number and rate per 100,000 of suicides in prisons 1997-2007 compared to the rate per 100,000 in the general population, 1997-2005



²⁶ HM Chief Inspector of Prisons, *Patient or Prisoner?* HM Inspectorate of Prisons, 1996

²⁷ *Ibid*

²⁸ *Ibid*

“How could the prison service have a health system which was not part of the NHS? They were missing an opportunity, when people were in prison, to identify their physical and mental health problems and do something about them. So I made it my business to get prison healthcare into the NHS as quickly as I could.” (Lord Ramsbotham)

The principle of equivalence

The following year, the Health Advisory Committee for the Prison Service published its report, *The Provision of Mental Healthcare in Prisons*.²⁹ This also drew attention to the poorly co-ordinated delivery of healthcare in prisons and the need for more effective through-care and aftercare arrangements.³⁰ Prisons, it said, should “give prisoners access to the same quality and range of healthcare services as the general public receives from the NHS.”

These two documents paved the way for the transfer of responsibility for healthcare in prisons from the Prison Service to the National Health Service. The desire was to provide services to prisoners that would match those received by the general population. In Chapter 4 we assess to what extent this has been achieved.

The transfer of prison healthcare to the NHS

To address the issues raised by *Patient or Prisoner?*, a joint Prison Service and NHS executive working group was established to develop practical proposals for change. The resulting report, *The Future Organisation of Prison Healthcare*, conceded that prison healthcare varied considerably in terms of organisation, delivery, quality, effectiveness and links with the NHS.³¹ It acknowledged that an extensive programme of change was required but rejected calls that the NHS should assume sole responsibility for all prison healthcare on the ground that differences in workplace culture might lead to

healthcare staff working in prisons being marginalised. It therefore recommended that the two organisations should be jointly responsible for identifying the health needs of prisoners in their area and, thereafter, for the planning and commissioning of appropriate services.

The working group was clear that systems for dealing with the high incidence of mental health problems in prisoners were underdeveloped. Two major deficits were screening arrangements to identify the need for mental healthcare at reception and the inadequate level of care-planning that takes place generally within prisons.³² Its report recommended that to improve this situation the care of mentally ill prisoners should develop in the following manner:³³

- In general all future improvements should be in line with NHS mental health policy, in particular the National Service Framework (NSF) for mental health (see Box 1);
- Special attention should be paid to the better identification of mental health needs at reception screening;
- Mechanisms should be put in place to ensure the satisfactory functioning of the care programme approach (CPA)³⁴ to develop mental health outreach work on prison wings;
- Prisoners should receive the same level of community care within prison that they would receive in the wider community;
- Policies should be put in place to ensure adequate and effective communication between NHS mental health services and prisons.

The advent of mental health in-reach

Two years later, *Changing the Outlook* developed a more specific policy for modernising mental health services in prisons.³⁵ The foreword reaffirmed the principle of the National Service Framework underpinning the strategic direction of service development and set out a vision for the next three

29 Health Advisory Committee for the Prison Service, *The Provision of Mental Healthcare in Prisons*, Home Office, 1997

30 Birmingham L, “The mental health of prisoners”, *Advances in Psychiatric Treatment*, 9, 191-201, 2003

31 Joint Prison Service and National Health Service Executive Working Group, *The Future Organisation of Prison Healthcare*, Department of Health, 1999

32 Ricketts T, Brooker C, Dent-Brown K, “Mental health in-reach teams in English prisons: Aims, processes and impacts”, *International Journal of Prisoner Health* 3(4) 234-247, 2007

33 Brooker C, Sirdifield C, Belshaw L, *A Review of Mental Health Service Provision in the Lincolnshire Prisons*, University of Lincoln, 2008

34 CPA is an approach to case management adopted by all secondary care mental health services in the community (ie outside prison) in England. A care co-ordinator is appointed to co-ordinate various elements of care and to organise multidisciplinary reviews of care. CPA should involve both users and carers in planning and reviewing care

35 *Changing the Outlook: A strategy for developing and modernising mental health services in prisons*, Department of Health, 2001

Box 1: A National Service Framework for Mental Health

National Service Frameworks are policies set by the Department of Health to define standards of care in the NHS for serious conditions such as cancer, coronary heart disease, diabetes and mental illness. A National Service Framework spells out how services can best be organised and the standards that services will have to meet. The National Service Framework for Mental Health was published in 1999 and accompanied policy developments in prison health. It laid out a list of standards for mainstream services that were to be provided – mental health promotion, services in primary and secondary care, services for carers and suicide prevention. It was hoped that these would be achieved within a ten-year timeframe. The framework emphasised the need to improve the quality of mental health services in prisons by creating closer partnerships between prisons and the National Health Service at local, regional and national levels. However, mental health in prisons has constituted a very small element of the overall range of developments demanded across all National Service Framework standards for mental health.³⁶

to five years. It recognised that this was likely to be a major challenge given that mental health services in prisons were ineffective and inflexible, and “struggling to keep pace” with developments in the NHS at large. The report called for a “move away from the assumption that prisoners with mental health problems are automatically to be located in the prison healthcare centre”; suggesting greater use of primary care, in-reach services, day care and wing-based treatments that mirror community-based mental health services.

To enable prisoners with mental health problems to remain on their normal location required the establishment of multidisciplinary mental health in-reach teams, funded by local primary care trusts, to provide specialist mental health services to prisoners in the same way as community mental health teams do to patients in the community.³⁷ Although it was anticipated that all prisoners would eventually benefit from the introduction of in-reach services, the early focus of the teams’ work was to be on those with severe and enduring mental illness. They would use the principles of the care programme approach to help to ensure continuity of care between prison and the community upon release from custody of these individuals. A target was set that promised 300 more staff to provide in-reach services by April 2004, so that 5,000

more prisoners with a severe mental illness would receive better care and treatment and have a care plan on release.

In a speech in 2002, Martin Narey, Director-General of the Prison Service, compared these extra 300 psychiatric nurses from the NHS to the “cavalry coming over the hill”, though he admitted that, because mental illness in prisons had risen sevenfold since the late 1980s, the situation they faced was “near overwhelming”.³⁸

There are now 70 in-reach teams working in prisons consisting of a core of psychiatric nurses, although access to other professionals such as psychiatrists, clinical psychologists, occupational therapists, drugs workers and counsellors is scant.³⁹

Since April 2006 responsibility for prison healthcare has been transferred fully to the NHS. There has clearly been some improvement in mental healthcare provision and a greater acknowledgement of the health needs in prison. Our report assesses the story so far and gives an idea of how far is yet to go. (A Department of Health strategy review, *Improving Health, Supporting Justice*, currently in progress, is undertaking the same task.)

In Chapter two the authors describe public attitudes to offenders with mental illness. Using our own public opinion polling conducted by YouGov, (a professional research and consulting organisation, pioneering the

36 Brooker C, Repper J, (Eds), *Implementing Mental Healthcare: A review of the National Service Framework for Mental Health*, Elsevier forthcoming September 2008

37 The community mental health teams are fully integrated teams of people from a variety of professional backgrounds, aiming to provide one point of access to mental health services for people assessed as suffering from a severe mental health problem. Their services are aimed at adults of working age

38 Narey M, “Human Rights, Decency and Social Exclusion”, Speech to The British Institute of Human Rights, 2002

39 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

use of internet polling), and similar data collected by the Department of Health, we compare differences in public attitudes to offenders with mental illness and to members of the general community with mental illness.

Chapter three examines the experience of offenders with mental health illness as they travel from the courts, through to screening on reception in prison and then onward to release and resettlement. We look at the lack of primary mental healthcare provision within prisons and assess the success of in-reach teams, the most significant policy initiative since 1996.

Chapter four analyses the state of prison mental healthcare, and assesses the successes and failures of various policy initiatives and the delivery of mental healthcare in prisons.

The analysis draws on our own surveys of in-reach team managers and PCT prison health leads, as well as in-depth interviews with the latter.

Chapter five discusses the economic factors surrounding prison mental healthcare including current spending, which it compares with spending in the community. It analyses the economic consequences of poor mental healthcare provision in prison and suggests that the cost of increased spending would be offset by even a small drop in reoffending rates.

Chapter six sets out some broad policy recommendations for improving mental healthcare in prison and provides the frame of reference for our second report later this year that will focus on policy solutions.

2

Public attitudes to offenders with mental illness

Summary

One of the aims of our research was to understand the differences between the way the public viewed offenders with mental illness and the law-abiding with mental illness. Our research includes two sets of data. The first involves public opinion polling, commissioned for this report, on the public's attitudes to offenders with mental illness.⁴⁰ The second is a Department of Health/TNS survey on public attitudes to people with mental illness in general.⁴¹ Using these two data sets it is possible to compare the public's knowledge and attitudes to offenders with mental illness and those with mental illness in the community.

The research produced two significant findings: the majority of people grossly underestimate the prevalence of mental illness in prison, and there is much less public sympathy for offenders with mental ill-

ness than for non-offenders. Both may have implications for the delivery of equivalence in care.

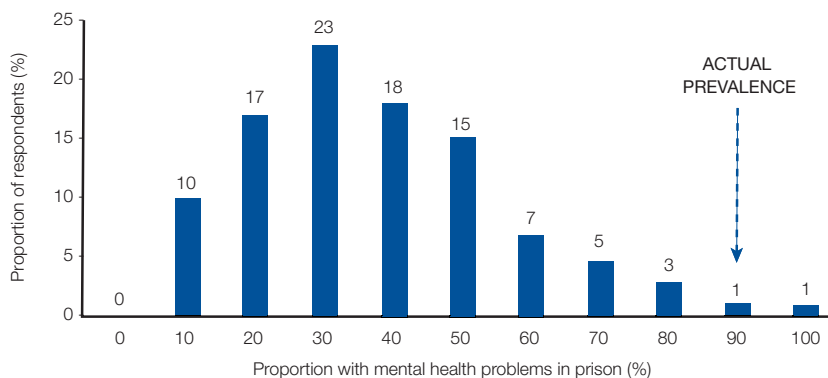
Public perceptions on prevalence of mental illness

Our survey asked respondents to estimate the proportion of people in prisons with a mental health problem. The answer is 90%, but only 1% of respondents were correct.

The vast majority of respondents (74%) estimated that the proportion of prisoners with a mental illness is 50% or less.

A similar question was used in the Department of Health/TNS survey. Respondents were asked what proportion of people in the UK might have a mental health problem at some point in their lives. The actual lifetime incidence of mental health problems is estimated to be around 1 in 4.⁴²

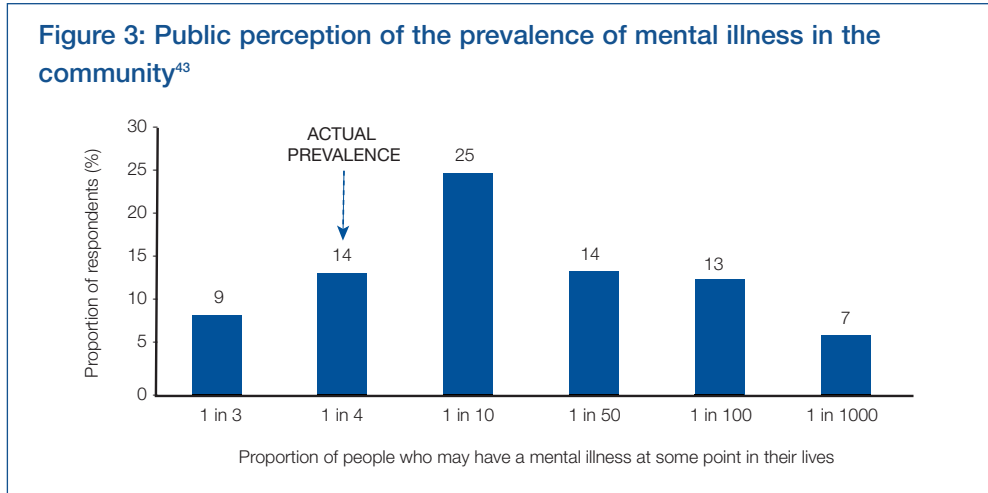
Figure 2: Public perception of the prevalence of mental illness in prisons



40 All figures on public perception of prisoners with mental illness are from YouGov unless otherwise stated. Total sample size was 2,067 adults. Fieldwork was undertaken between 12th and 14th May 2008. The survey was carried out online. The figures have been weighted and are representative of all British adults (aged 18+). The full data can be found in Appendix 2

41 The data on public perceptions of mental illness in general is taken from the study *Attitudes to Mental Illness 2008 Research Report* commissioned by the Department of Health and conducted by TNS UK

42 *Attitudes to Mental Illness 2008 Research Report*, TNS UK, 2008



Again, respondents tended to underestimate; a quarter of respondents thought the proportion is 1 in 10; 35% of respondents thought it is less than this; 14% correctly stated the overall proportion is 1 in 4, and 9% thought it was higher (18% answered “don’t know”). There is clearly a huge gap in public knowledge of the prevalence of mental illness, particularly in prisons.

Public attitudes to mental illness and crime

The Department of Health survey also posed a series of questions on attitudes to people who have a mental illness. Respondents were asked how much they agreed or disagreed with eight statements. Our survey asked the same questions but added the phrase “who commit crime”. We deliberately mirrored the questions from the DoH survey in order to compare the results (see Box 2).

Our first question aimed to measure people’s perception of the general susceptibility to mental illness and committing crime: 60% either agreed or strongly agreed that virtually anyone can become mentally ill and commit crime, whereas only 18% disagreed or strongly disagreed. In the DoH survey, 89% of respondents agreed that virtually anyone can become mentally ill (Figure 4).

The answers to the rest of our questions can be best represented using these attitudinal differences.

For example, in Figure 5, the first bar represents the 29% difference in public attitudes to people with mental illness in general and people with mental illness who commit crime.

A more tolerant attitude and the best possible care

When asked whether we need to adopt a more tolerant attitude towards people with

Box 2: Our Survey

To what extent do you agree or disagree with each of the following statements?

- Virtually anyone can become mentally ill and commit a crime
- We need to adopt a more tolerant attitude towards people with mental illness who commit crime
- We have a responsibility to provide the best possible care for people with mental illness who commit crime
- People with a mental illness who commit crime are a burden on society
- Increased spending on mental health services for people who commit crime is a waste of money
- There are sufficient existing services for people with mental illness who commit crime
- People with mental illness who commit crime are far less of a danger than most people suppose

⁴³ Attitudes to Mental Illness 2008 Research Report, TNS UK, 2008

Figure 4: Public attitudes on susceptibility to mental illness



mental illness, 84% agreed. When the phrase “who commit crime” is added on the end, the number falls to 32%. When asked whether we have a responsibility to provide the best possible care for people with mental illness, 90% are in agreement. The figure falls to 64% when related to those with a mental illness who commit crime. This may not seem particularly surprising and is merely registering people’s attitude to crime in general. However, we know from the previous question that a large proportion (60%) believes that anyone can become mentally ill and commit crime. If that is the case, we need to explain why there is

there such a low tolerance for a disposition that “virtually anyone” is capable of.

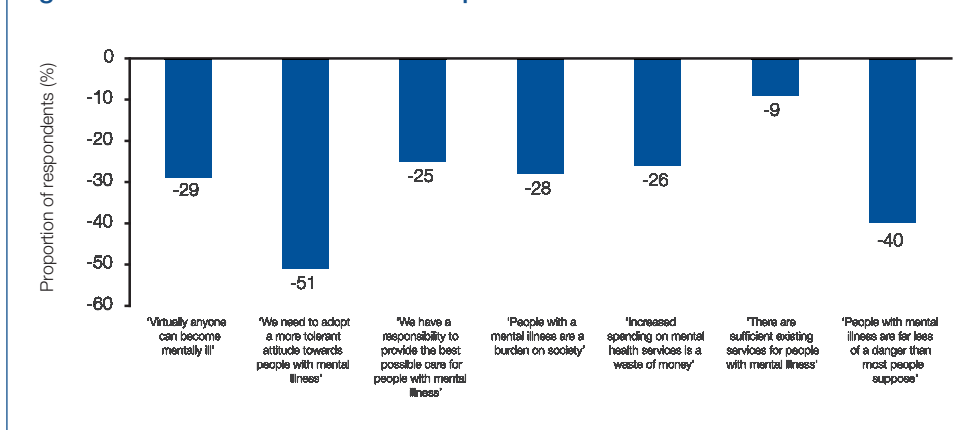
A burden on society and increased spending

Most people (78%) disagree that people with mental illness are a burden on society. This number falls to 33% when crime is entered into the equation. Most people think that those with mental illness who commit crime are a burden on society. Additionally the majority of people don’t believe that increased spending on mental health services is a waste of money (87% for mental health services in general and 57% for mental health services for people who commit crime).

So the majority view is that people with a mental illness who commit crime are a burden on society but that increasing spending on mental health services for them is not a waste of money. This suggests that there is some sympathy with the view that the social costs of reoffending triggered by mental health problems can be reduced by investing in appropriate mental health treatment.

This result is supported by the following survey question. Only 11% of people believe that there are sufficient existing services for people with mental illness who commit crime and this number rises to only 19% for those agreeing that there are sufficient exist-

Figure 5: Differences between public attitudes to people in general with mental illness and to prisoners with mental illness



ing services for people with mental illness in general. The majority of people believe there aren't sufficient existing services either for those with mental illness or for those with mental illness who commit crime.

Danger of mental illness

17% of those surveyed agree that people with mental illness who commit crime are far less of a danger than most people suppose, while 50% disagree and 33% were unsure or neither agreed nor disagreed. 58% agreed with the DoH survey statement, "people with mental illness are far less of a danger than most people suppose".

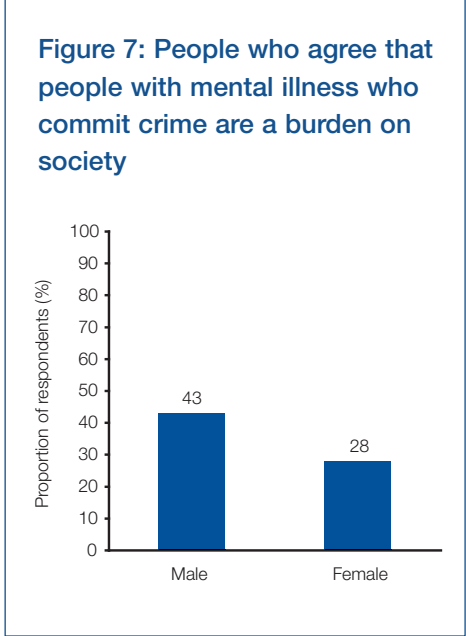
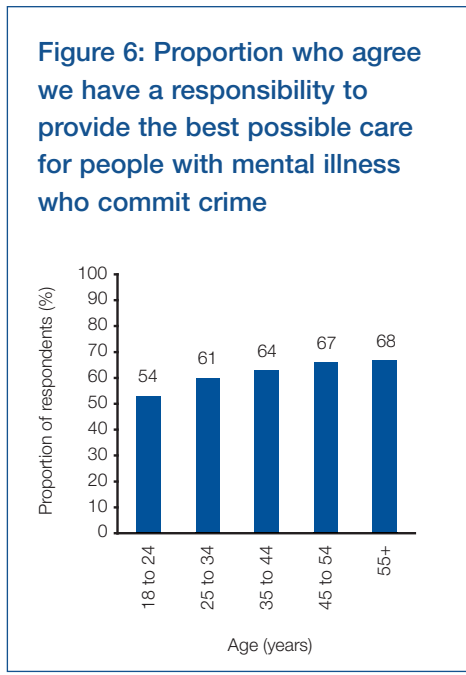
As can be seen, there is a significant difference between the way the public see mental illness in general and when it is linked to offending. In every question, respondents were much less sympathetic towards those with mental illness who have committed a crime, although opinion varies according to age group and gender.

Differences in response by age and gender

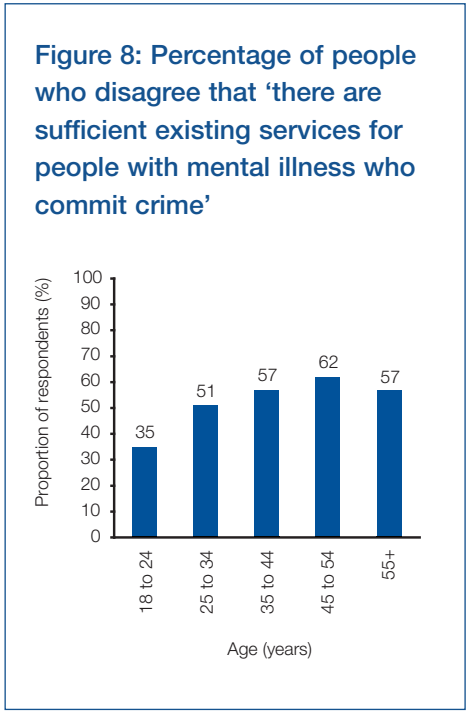
54% of young people (18-24) agree that we have a responsibility to provide the best possible care for people with mental illness who

commit crime compared to 68% for people over the age of 55.

43% of men agree that people with mental illness who commit crime are a burden on society compared with 27% of women.



35% of young people (18-24) disagree that there are sufficient existing services for people with mental illness who commit crime compared with 57% of people aged over 55.



3

The offender mental healthcare journey

Summary

An offender with mental illness who is sent to prison comes into contact with multiple services and providers along his journey from entry into prison to release. This may include a mixture of court diversion schemes, mental health screening on reception, primary mental healthcare, being placed on an in-reach caseload, referral to drug services, transfer to a secure health facility and then receiving through-care services on release. In the existing system, each part of this journey has the potential for problems.

Box 3: Overview of offender mental healthcare journey

- Court diversion
- Reception screening
- Primary mental healthcare
- Mental health in-reach
- Transfer to secure health unit
- Release and resettlement

Court diversion

Court diversion schemes were introduced in 1989 with joint Home Office and Department of Health funding. Many schemes were put in place in the 1990s after the 1992 Reed Report advocated diversion away from prison for offenders with mental health issues.⁴⁴ Their primary aim was to steer mentally ill offenders away from the criminal justice system and into acute mental health services or to

liaise with other services in order to provide care in the community. Court diversion is important for a number of reasons, not least that it ensures that offenders are directed to the appropriate care. Diversion lies at the heart of the debate surrounding the solution to prison overcrowding.

In 1997 there were 190 diversion schemes but by 2004 they had fallen to 140.⁴⁵ In practice few have been considered successful. In an article on court diversion in 1999, David James, a respected forensic psychiatrist, said that “most court diversion services are currently inadequately planned, organised or resourced, and are therefore of limited effect.”

A 2005 report found that there were insufficient schemes to divert offenders with mental health problems out of the criminal justice system and into appropriate health services.⁴⁶ In the same year a Home Office and Department of Health review of ten schemes concluded that their effectiveness depended on adequate resources and an appropriate structure that met both mental health and social care needs. But few schemes were based on needs analysis or were delivered jointly by health and social care agencies. The DoH found that targets, performance management and outcome analysis were generally not in place and that many areas in England and Wales had no court diversion services at all.⁴⁷ Others relied on just one lone worker – usually a community psychiatric nurse. Survey respondents said

⁴⁴ *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services. Final Summary Report*, Department of Health and Home Office, Cm 2088, Stationery Office, 1992

⁴⁵ *Findings of the 2004 Survey of Court Diversion/Criminal Justice Mental Health Liaison Schemes for Mentally Disordered Offenders in England and Wales*, NACRO, 2005

⁴⁶ *Ibid*

⁴⁷ *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

that underfunding coupled with the lack of clear government guidance was leading to serious gaps in service provision. For example:⁴⁸

- Only 23% of schemes had been subject to some form of evaluation since their establishment;
- 72% cited lack of beds as a barrier to success;
- 50% have no input from either a psychiatrist or a psychologist and 41% reported difficulties in obtaining psychiatric reports;
- 34% said they were using the police station as their sole “place of safety” for people detained;
- 25% had seen a decrease in staffing levels within the past year;
- 36% of schemes did not have a policy on information sharing.

The 1997 psychiatric morbidity survey suggested that between 7% and 14% of the prison population has a severe and enduring mental illness, or roughly 6,000-12,000 offenders.⁴⁹ Later studies have concurred.

There is also a large group of offenders with low-level mental disorders, often combined with drug or alcohol addiction. Depending on the severity of the crime, we believe that many of this group should also be diverted to community sentences, drug and alcohol treatment, counselling and talking therapies and various other alternatives to prison that are available to the courts.

A more recent study in 2007 came to the same conclusions as David James did in 1999. Schemes continue to be underfunded and insufficiently embedded in both criminal justice and mainstream mental health provision. Three out of four magistrates’ courts have no court diversion schemes in their area to access. And the fact that there is no overarching organisational framework continues to impede their effectiveness.⁵⁰

At the time of writing, Lord Bradley is conducting an independent review of the diversion of offenders with mental health problems or learning disabilities away from prison.⁵¹ The review will “explore diversion at any point of the offender pathway, including diversion away from the criminal justice system itself, whilst continuing to safeguard the public.”

Reception screening in prison

Any prisoner thought to be in need of a mental health service undergoes an assessment process. Most prisons use the standardised Don Grubin health screening test to assess the mental health of prisoners at reception.

Participants in a recent review of London’s prisons thought that these questions were not always effective in identifying mental health or substance misuse problems.⁵² However, at a national level there is mixed evidence about reception screening – many healthcare professionals say that it is good at picking up severe and enduring mental illness but less sensitive at identifying low-level disorders. Anne Owers told us:

Box 4: The Don Grubin Screening Test questions

- Is the inmate charged with homicide?
- Has the inmate ever received treatment from a psychiatrist for any form of mental health problem (not including treatment only in prison or one-off assessments)?
- Has the inmate ever received antidepressant or anti-psychotic medication (outside prison only)?
- Has the inmate ever deliberately harmed himself?

48 Ibid

49 Singleton N et al. *Psychiatric Morbidity among Prisoners in England and Wales*, Office for National Statistics, 1998

50 Winstone J and Pakes F, *Mental Health Effective Practice Audit Checklist (MHEP-AC): Results of a pilot study involving nine mental health teams*, Office for Criminal Justice Reform, 2007

51 Bradley K, *Independent Review of the Diversion of Individuals with Mental Health Problems from the Criminal Justice System and Prison*, Department of Health, forthcoming

52 Durcan G and Knowles K, op cit

“The current reception screening is better than what preceded it but it’s not good enough. There are lots of things that aren’t pulled out. One of the things we found is that there’s a lot of tick box stuff, which is not followed up. The box that says ‘further information required’ was often not ticked, and many prisoners did not have a secondary health screen to fill out their medical history.” (Anne Owers)

We believe that reception screening is failing to pick up the extent or diversity of need for a variety of reasons. First, screening is not properly executed or followed up by appropriately skilled staff. Secondly, the screening itself is not sensitive enough to pick up real, and particularly unacknowledged, need. This is unsurprising: the Grubin test asks only four questions related to whether the offender has had a previous mental illness or been treated for one. It is easy for those who are unaware of their (often low-level) mental illness to be missed and for those who do not want to declare their history of serious mental illness, for whatever reason, to simply answer “no” to any of the screening questions.

There are other tools that may be more appropriate: the Inspectorate of Prisons used the 12-item version of the General Health Questionnaire in a recent study of mental health in prisons. This picked up higher levels of need throughout the prison population and particularly in black and minority ethnic groups and male prisoners who respectively are much less likely to access mental healthcare in the community and who are less likely to acknowledge need.⁵³

Thirdly, reception itself can be a chaotic process in which large numbers of people arrive at one time. Screenings are conducted by primary healthcare staff who may or may not have mental health training. As a result of all these factors, prisoners with

mental health problems are often not identified and are therefore placed on an ordinary prison wing.⁵⁴ Once there it is even less likely that a mental health problem will be identified.⁵⁵

Paul Jenkins, head of the mental health charity Rethink, said that he was concerned about the “simple lack of identification of people with previous history” and “the inability to integrate people’s previous treatment plans and medication”:

“If somebody with a significant mental health problem is coming to prison, then at least getting the medication right at the outset and continuing any treatment or intervention that they have been having strikes me as a pretty fundamental principle. I think there are a lot of arguments for standardising the approach and putting more effort into getting that initial assessment.” (Paul Jenkins)

Primary mental healthcare

Primary mental healthcare is defined as mental healthcare that is provided by GPs. In the general community the distinction between primary and specialist mental healthcare is often based on whether a service user has either a common mental health problem, such as anxiety or depression, or a serious mental illness, such as psychosis.

According to the National Service Framework for Mental Health anyone not in contact with specialist services should be treated in primary care. But there is a long way to go if this principle is to be implemented in prisons.

- In-reach teams are able to cope with only a small fraction of serious mental illness, thus prisoners diagnosed with serious mental illness often end up being treated in primary care. Studies have shown that primary mental healthcare staff in prisons have to deal

⁵³ *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

⁵⁴ Parsons S, Walker S, Grubin D, “Prevalence of mental disorder in female remand prisoners”, *Journal of Forensic Psychiatry*, 12, 194–202, 2001

⁵⁵ Birmingham L, Mason D, Grubin D, “A follow-up study of mentally disordered men remanded to prison”, *Criminal Behaviour and Mental Health*, 8, 202–213, 1998

with cases displaying symptoms as severe as those treated by mainstream community mental health teams;⁵⁶

- Prison primary care staff attend to many common mental health disorders often without specialist staff; some do possess mental health expertise but the extent to which they can use it is highly variable;
- There is very little data concerning primary care mental health staff in prisons, both in terms of their professional disciplines and training;
- It is common for primary care staff to both provide reception screening and to triage (or assess) all referrals to in-reach teams. Not only is this time-consuming, but it also demands a high level of clinical skill.

John Podmore, a former governor of Brixton, Swaleside and Belmarsh prisons, described a typical situation:

“If you’re a prisoner in a small category C training prison and you’re not feeling well, not feeling good about yourself, you may well end up seeing a sessional GP who is unlikely to look at your primary mental healthcare in any strategic way.” (John Podmore)

Findings from the recent review of mental health service delivery in prisons highlight a number of these issues.⁵⁷ None of the nine GPs interviewed in the review had any training in working with prisoners with specialist mental health needs. In addition, the review elicited that few primary care services in prisons had specialist mental health nurses who could assist with screening or triage. The review recommended that there should be “sufficient resources in primary care teams to meet the high level of primary mental health need in prisoners and greater co-ordination between them and in-reach to ensure that referrals are appropriately allocated and resourced.”

In another 2007 survey, of prison in-reach, team leaders rated primary care triage of mental health referrals as “inadequate”, particularly in high security and category B prisons.⁵⁸ One in-reach team leader said:

“We have a lot of people that we pick up accidentally and they’ve never been referred although they have a psychiatric history. Primary care acknowledges the problem but they don’t refer them. They do assess them, in the sense that they tick the box, but no in-depth analysis takes place.”

Mental health in-reach teams

Mental health in-reach teams – perhaps the most significant policy initiative from the late 1990s – were first envisaged in the 2001 Department of Health report, *Changing the Outlook*:

“For those persons judged to have the greatest need, the NHS will fund the establishment of multidisciplinary teams, similar to community mental health teams (CMHTs) offering to prisoners the same sort of specialised care they would have if they were in the community.”⁵⁹

In-reach teams are employed by local NHS providers, rather than by prisons. The team, made up of mental health professionals, may receive referrals from a range of sources. There are now 70 in-reach teams working in prisons, consisting of a core of psychiatric nurses, with support from other professionals such as psychiatrists, clinical psychologists, occupational therapists, drugs workers and counsellors.⁶⁰ The composition of the teams varies across prisons, team sizes range from two registered mental health nurses to 19 whole-time equivalent staff. Their original task was to deal with cases of severe and enduring mental illness, yet the majority find that even this is too big a brief given the size and composition of their team. One expert told us:

56 Senior J, Hayes A, Pratt D, Thomas S, Fahy T, Leese M, Bowen A, Taylor G, Lever-Green G, Graham T, Pearson A, Ahmed M, Shaw, J, “The identification and management of suicide risk in local prisons”. *Journal of Forensic Psychiatry & Psychology* 18(3), 368-380, 2007

57 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

58 Brooker C, Gojkovic D, Shaw J, “The second national survey of mental health in-reach services in prisons”, accepted for publication, *Journal for Psychiatry and Psychology*

59 *Changing the Outlook: A strategy for developing and modernising mental health services in prisons*, Department of Health, 2001

60 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

“Too often we find a mental healthcare in-reach team consists of two Registered Mental Health Nurses, for example, and a forensic psychiatrist who might not even work for the same mental health trust. There are not that many teams across the country that have the full range of occupational therapists, clinical psychologists, talking therapists or even a social worker. There isn’t that same sort of multidisciplinary team that there might be in the community.”

Our research suggests also that 35% of their caseload is made up of people who have a personality disorder but no accompanying severe mental illness, and just under a third have neither a severe mental illness nor a personality disorder. Our experts agreed that in-reach teams were often used to deal with difficult and disruptive prisoners, rather than treating those with the most severe cases of mental illness whose behaviour may draw less attention. John Podmore agreed. He said:

“Where mental illness is being dealt with, it can often be targeted where it presents in prisons in a disruptive way. If poor mental health presents itself in withdrawal and personal exclusion then there is a real danger it will be missed.” (John Podmore)

The changing role of mental health in-reach teams

When in-reach teams were originally established there was a clear sense that their function was to work with people with a serious mental illness. However, by 2007, this perception had changed. Findings from the national survey of in-reach, for example, show that the majority (96%) of in-reach teams have operational policies and many of these have been changed to reflect a greater emphasis on working with

primary care.⁶¹ It is also noticeable that there has been a decrease (from 52% to 38%) in teams with operational policies that exclude those with common mental health problems.

This change in orientation, driven partly by the Department of Health through the care services improvement partnership (CSIP) is reflected in the qualitative data obtained in the survey of in-reach teams. Particularly when working with people with personality disorders who sometimes self-harmed, there was a lack of clarity about in-reach’s role. One team leader said that although the target population was always going to be people with serious mental illness, he opposed black and white dividing lines because “if someone in prison has got a personality disorder or some mental illness, substance misuse, that kind of stuff, that to me is a serious mental illness.”

This issue has not been resolved. A consultant psychiatrist said that the problem was especially acute with women, who often have severe personality disorders rather than severe mental illness. “There’s a debate as to whether in-reach take on these sorts of women or just stick to women who’ve got severe mental illness.” A nurse on an in-reach team commented:

“There is debate even among the team about who should receive secondary mental health services. I work on the premise that personality disorders are complex needs and that they are included in community mental health teams and we should be replicating that service in prison...Not everybody shares my view on that.”

In this sense, “mission creep” has been occurring because there has been a perception, driven partly by policy, that closer integration between primary care and in-reach would be beneficial.⁶² The data presented here seems to indicate that this has led to confusion about the principal function of in-reach teams.

61 Brooker C, Gojkovic D, Shaw, J, op cit

62 Steel J, et al, “Prison mental health in-reach services”, *British Journal of Psychiatry*, 190 373-374, 2007

Although prison mental healthcare was covered by the National Service Framework, no specific guidelines were provided for in-reach teams. This has probably been a cause of the teams' confusion regarding their brief. Whereas, the Department of Health has published detailed guides for the operation and staffing of community assertive outreach teams and early intervention in psychosis teams, no such guidance has been forthcoming for in-reach teams in prisons. Assertive outreach teams provide intensive support for the severely mentally ill people in the community who are "difficult to engage" in more traditional services. Many will have a criminal record and more than one disorder. Care and support is offered in their homes or some other community setting, at times suited to them. Team staff may be involved in direct delivery of practical support, care co-ordination and advocacy as well as more traditional therapeutic input. The aim of the service is to maintain contact and increase engagement and compliance. Early intervention in psychosis teams work with people aged between 14 and 35 years, who have experienced a first episode of psychosis.

Sean Duggan, director of the prisons and criminal justice programme at the Sainsbury Centre for Mental Health, told us that in-reach teams have been "overburdened".

"We gave them too much pressure; we didn't provide a national standard for in-reach. I think that's regrettable, we should have done that. We need a blue print for the operation of in-reach and a national design to inform local commissioning." (Sean Duggan)

One of the biggest difficulties that in-reach teams face is their separation from other services. Policy initiatives in this area, as in many other areas of government, have been rolled out separately. This leads to isolation and poor co-ordination across services even within prisons. Julian Corner, chief executive of

the Revolving Doors Agency, a charity dedicated to people caught up in a cycle of crime and mental illness, said that there was a chronic lack of integration between different services:

"Mental health teams are struggling to cross a cultural divide through to the rest of the prison, and this comes down to does the mental health team know what the drugs team is doing, does it know what the housing advice team is doing, or many of the others? Most of the cases are going to be dual diagnosis, so what on earth are CARAT teams and mental health teams doing operating separately?"⁶³ (Julian Corner)

Further, the modelling of in-reach on community mental health teams seems misplaced. Any evidence of treatment models that have been found to be effective in the community, such as community mental health and assertive outreach teams, cannot be directly applied to the prison population because issues of criminality can complicate the picture.⁶⁴ Constraints within the prison environment – such as security, information sharing, levels of literacy and treating prisoners without their consent – all undermine the translation of community-based treatments into secure settings.⁶⁵

Transfers to secure health facilities
Some prisoners with mental health problems will require in-patient treatment that cannot be delivered by the prison. These prisoners can be transferred to secure health settings in order to receive the appropriate care.

Under the terms of the Mental Health Act 1983, the Home Secretary may direct the transfer of a prisoner to hospital for psychiatric treatment on receipt of two separate medical reports. One of the two doctors or medical officers must be approved under section 12(2) of the Act as having recognised

63 Counselling Assessment Referral Advice, CARAT, is a drug service available in prison

64 Brooker C, Sirdiffield C, Gojkovic D, *Mental Health Services and Prisoners: An updated review*, University of Lincoln, 2007

65 Steel J et al, "Prison mental health in-reach services", *British Journal of Psychiatry*, 190 373-374, 2007

special experience in the diagnosis or treatment of mental disorder.

The key to successful secure transfers is minimal waiting times for assessment and transfer.

In November 2005, Louis Appleby, National Director of Mental Health and John Boyington, Director of Health and Offender partnerships, wrote to all strategic health authorities and PCT mental health commissioners about unacceptable delays in the transfer of acutely mentally ill prisoners to and from hospital under Sections 47 and 48 of the Mental Health Act 1983. A document was included that outlined the procedures for transferring prisoners under the Act in order to “secure and sustain significant improvements”.⁶⁶

The following year, 1,440 mentally disordered offenders were moved from the penal system into forensic psychiatric services. About one third of those (473) were initially sentenced to time in prison and later transferred to hospital; 21% (303) were diverted into forensic psychiatric care at the point of sentencing.

An audit by the Department of Health in 2006 indicated that at any one time across the prison estate there are 282 prisoners awaiting initial psychiatric assessment by an in-house or visiting psychiatrist who routinely works in the prison. Six prisons each had more than 12 people waiting for an initial assessment.

Some prisoners who are recommended by the prison for transfer to forensic services are not accepted and are kept in prison. When transfer requests have not been accepted after a second mental health assessment by an external provider’s consultant psychiatrist, 33% of the time it is because the prisoner is “not meeting the criteria for transfer under the Mental Health Act 1983”. Where prisoners are not accepted for transfer, 55% are managed on the main wing of the prison and 35% in the prison’s in-patient unit.⁶⁷

When a transfer has been agreed, lack of bed availability is the most common reason

for delay in transfers (73%). However, in June 2007, the Government stated that: “There has been a significant decrease in the number of people waiting over 12 weeks for a transfer – in the quarter ending March 2007, 40 prisoners [who had been waiting more than 12 weeks] were waiting, down from 51 in the same quarter in 2005.”⁶⁸

It is crucial that transfers to forensic psychiatric units are used where necessary and are subject to minimal delays. Removing those prisoners whose needs exceed the capabilities of the prison staff and support services could not only cut costs, but also relieve pressure on the system as a whole. A prisoner with a mental illness will incur high costs in addition to those incurred providing prison services for a healthy offender such as drug treatment or behavioural interventions.

Release and resettlement

The final part of the offender journey is release and resettlement. This is a critical stage in the future of the offender and often determines whether he will go on to reoffend.

A study by Graham Durcan found that while most prisoners who were in contact with in-reach teams were more confident about their futures than those who were not, the experience of virtually all of those who had had experience of leaving prison previously was negative. They reported that elements of care were not put in place to support them.⁶⁹ Nearly half of people with a mental health problem have no permanent residence on release, while 50% have no GP.⁷⁰ The Prison Reform Trust found that 96% of mentally-disordered prisoners were released without supported housing, including 80% of those who had committed the most serious offences; more than three quarters had been given no appointment with outside carers.⁷¹

The prisoners interviewed in Durcan’s report were negative about what they saw as the basics: “decent” accommodation, support in getting benefits, registration with a GP, referral to a mental health service or adequate

66 “Procedure for the Transfer of Prisoners to and from Hospital under Sections 47 and 48 of the Mental Health Act 1983”

67 Rutherford M, Duggan S, *Forensic Mental Health Services: Facts and figures on current provision*, Sainsbury Centre for Mental Health, 2007

68 Ibid

69 Durcan G, *From the Inside: Experience of prison mental healthcare*, Sainsbury Centre for Mental Health, 2008

70 Durcan G, “Equivalent to what? Mental healthcare in Britain’s prisons”, *The Journal of Mental Health Workforce Development*, Volume , Issue 4, 2006

71 Prison Factfile, Bromley Briefing May 2007, Prison Reform Trust

support for substance misuse. Several prisoners said that although they received little support for their mental health in prison, the prison met their basic requirements and took responsibility for many decisions concerning their day-to-day needs and activities. But when they left prison they were “suddenly back in charge”, in most cases with no support, and with no history of having “managed it all well before”.⁷²

Mentally disordered prisoners are entitled to the same arrangements as mentally disordered persons being discharged from hospital. As at other stages of the criminal justice system, the prison process allows an opportunity for intervention and linking an individual with, or back into, services in the community. The process is facilitated by the in-reach team, which liaises with the appropriate community-based services.

“The fundamental point of principle is that, whatever prisons are there for, when offenders come out you ought to give them their best chance not to go back. This is something I feel very passionately about. You need to address the range of needs that people face. So if they’ve got drug and alcohol problems or housing, employment or mental health issues, there should be access to ongoing support and treatment when they come out. It points to a need for some kind of case management approach.” (Paul Jenkins)

If the prison does not have an in-reach team, this role may be taken on by the visiting psychiatrist, criminal justice mental health liaison schemes, the prisoner’s care co-ordinator in the community, or the prison staff – most usually healthcare staff or probation officers. In some areas the crisis resolution team has been extended to undertake assessments of prisoners.⁷³

Durcan found that while the in-reach teams did give consideration to what happened after a prisoner was released, those

prisoners not in contact with these services received very little support. Healthcare staff attempted to connect some prisoners with GPs, but for many the most they would receive on release was a card with the NHS Direct phone number.⁷⁴

“There isn’t the care available before or afterwards for many people that we see. Either their first contact with mental healthcare is through criminal justice, or else they have not been dealt with before and they won’t be dealt with well afterwards. They are too often seen as a burden and they are very costly. They take a big chunk out of your budget.” (Anne Owers)

“We are talking about individuals whom nobody else wants to work with when they are in the community, and when they offend the criminal justice system picks up the responsibility. In a way that suits everybody fine because you’ve got all these awkward customers off your books and they are out of harm’s way for a while. So there is an argument for making sure somebody is responsible and can’t wash their hands of individuals however challenging their needs and however difficult they are.” (Paul Jenkins)

The care programme approach (CPA) should link the prisoner, once discharged, to appropriate community services. Otherwise any work achieved within the prison is lost, the offender’s mental health is likely to deteriorate and the chances of reoffending are high. These care plans should include suitable secure occupational activity, adequate housing and appropriate entitlement to welfare benefits. Care plans need to be attended by all the key professionals. The principle of equivalence requires that a severely ill prisoner should receive a follow-up contact with a clinician within seven days, as would be the case in the community.

⁷² Durcan G, *From the Inside: Experience of prison mental healthcare*, Sainsbury Centre for Mental Health, 2008

⁷³ A crisis resolution team provides prompt intensive support, including medication, for people with mental health crises, in their own home. The idea is to prevent hospital admissions and it stays involved until the problem is resolved

⁷⁴ Durcan G, *op cit*, 2008

4

Assessment of prison mental healthcare

Summary

We asked people working in the field for their assessment of prison mental healthcare. Their answers were bleak. The majority rated it as either average or poor. As well as describing problems with co-ordination, they highlighted staff shortages, commissioning services, overcrowding, and a lack of training. All of these factors impact heavily on the delivery of mental healthcare and make it harder to deliver on the promise of equivalence with healthcare in the community.

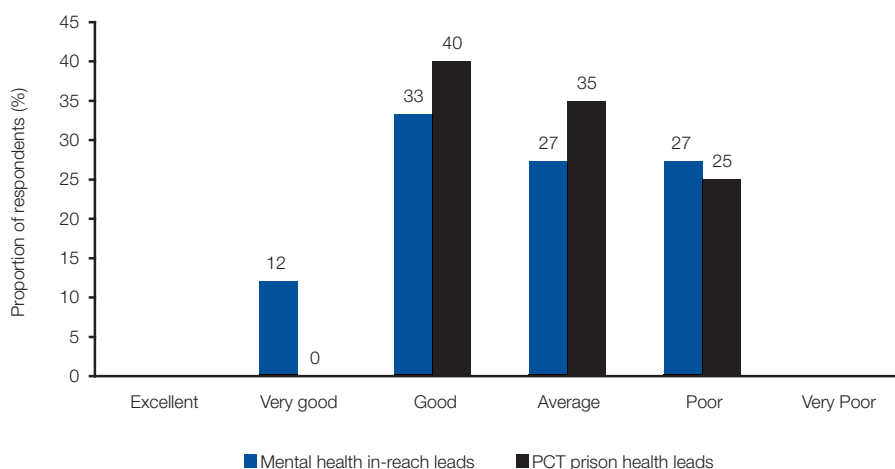
Self-assessment of mental healthcare in prisons

The research team surveyed two groups directly involved in delivering prison mental

healthcare; in-reach team leaders and PCT prison health leads. Both groups were asked to assess the current status of mental healthcare in prisons.⁷⁵ 54% of in-reach leaders said that mental healthcare was either average or poor; 34% said it was good. No respondents rated it as either excellent or very poor. 60% of PCT prison health leads said that mental healthcare was either average or poor; 40% said it was good, and none rated it as excellent, very good or very poor.

When this data is combined the percentage of respondents who assessed mental healthcare in prisons as either average or poor is 54%. It is of concern that over half of all health providers in prison assess prison mental healthcare as average or poor – particularly for a self-assessment.

Figure 9: What is your general assessment of mental healthcare in prisons?



⁷⁵ The surveys were conducted in March 2008 with a response rate of 49% and 35% respectively. For the mental health in-reach teams the sample size was 70 and the number of respondents was 34. For the PCT prison health leads the sample size was 60 and the total number of respondents was 21

Staffing

Staff shortages

Our interviewees repeatedly referred to staff shortages. The majority of the mental healthcare budget is spent on salaries. If, as we argue later, there is inadequate funding for prison mental healthcare, we would expect this to be reflected in the level of staff resources.

The Prison Reform Trust report on the mental health needs of men in prison highlights the inequities in staffing between prison and the community.⁷⁶ In the report, Adrian Grounds argues that a typical large local prison, with 1,000 places and a turnover of 5,000 receptions a year, will have about the same caseload of serious mental illness as a town of 20,000 with 100,000 people arriving and leaving each year. According to Department of Health guidance for community mental health teams, a typical team, with a caseload of 350 service users (only half of who present complex problems) would consist of three to four community psychiatric nurses; two to three social workers; a minimum of one full-time clinical psychologist; a support worker and administrator; and two full-time psychiatrists: in total between 12 and 14 professionals.

A recent Sainsbury Centre report calculated that working-age adult community mental health service staffing represented 55% of what was needed to implement the Government's mental health policies.⁷⁷ The same paper estimated that a typical category B men's prison with 550 inmates would require an in-reach service of 11 full-time equivalent specialist mental health staff to meet the needs of its population.

Those prisons for which information is available indicate that the average size of an in-reach team in 2007 was just over four full-time clinical staff.⁷⁸ Provision relative to need is therefore only a third of what is required and in many cases characterised by teams consisting solely of nurses rather

than the multidisciplinary teams envisaged by policymakers.⁷⁹ A large local prison is likely to have at least the caseload that would be served in the community by a full community mental health team, and in the prison there will be additional demands such as providing assessments for courts, arranging aftercare for those leaving custody, and trying to look after seriously ill prisoners who should be in hospital though places are unavailable. However, an in-reach team is very unlikely to have the personnel that would be found in community mental health services.

We believe that multidisciplinary teams are of crucial importance to such an isolated service. For example, very few social workers contribute to in-reach teams, when the evidence shows that social needs on release are a crucial determinant of reoffending.⁸⁰

Overcrowding and its effect on mental healthcare

Overcrowding affects all prisoners, and particularly those with mental health problems. The Inspectorate of Prisons noted in its 2007 review that it was:

“Activity and support from staff and other prisoners that were the two things thought to be most helpful by prisoners with mental health and emotional problems, and the absence of these crucial elements was thought most likely to make things worse. In overcrowded, under-resourced prisons, these essential elements of care are, however, at a premium.”⁸¹

It is worth understanding the sheer scale of the overcrowding problem and how it specifically impacts on the delivery of mental healthcare. On 22nd February 2007, the prison population in England and Wales reached 82,068 – 96 over its usable operational capacity and exceeding its highest normal level for the first time.

76 Rickford D and Edgar K, *Troubled Inside: Responding to the Mental Health Needs of Men in Prison*, Prison Reform Trust, 2005

77 Boardman J and Parsonage M, *Delivering the Government's Mental Health Policies: Services, staffing and costs*, Sainsbury Centre for Mental Health, 2007

78 Gojkovic D and Brooker C, *Secondary analysis of prison mental health in-reach survey data In submission*, PhD Thesis, University of Lincoln, 2008

79 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

80 Social Exclusion Unit, *Reducing Reoffending by Ex-prisoners*, Office of the Deputy Prime Minister, 2002

81 *The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs*, HM Inspectorate of Prisons, 2007

Table 2: The ten most overcrowded prisons in England and Wales at March 2008⁸²

Establishment	In use CNA	Operational Capacity	Population Total	Percentage Overcrowding
Kennet	171	342	333	195
Shrewsbury	175	340	319	182
Swansea	240	422	421	175
Preston	429	750	734	171
Altcourse	794	1,024	1,315	166
Lincoln	436	738	708	162
Dorchester	145	259	234	161
Durham	577	981	931	161
Leicester	210	385	329	157
Northallerton	153	252	232	152

The useable operational capacity of the Prison Service is the sum of all prisons’ operational capacity less 1,700 places.⁸³ The figures meant that for the first time the Prison Service had almost 100 more inmates in jail than the numbers governors want to hold to ensure a controlled and secure regime.

According to the Prison Service’s standard of certified normal accommodation (CNA) – the decent standard of accommodation that the service aspires to provide all prisoners – the prison population is now 8,000 more than it should be.

The bloated size of the prison population is undermining any work the Prison Service is trying to do in terms of making life inside constructive for the majority of prisoners. In 2001-02 the Prison Service failed to meet its own target of providing prisoners with at least 24 hours of purposeful activity a week. Only three out of 40 of the local prisons for men (those holding predominantly remand and short sentence prisoners), which suffer the worst overcrowding, managed to meet this target.

But a lack of “purposeful activity” is not the only consequence of overcrowding. In a desperate attempt to find empty beds, prisoners are being transported all over the

country. In 2001, 37,000 prisoners were being held over 50 miles away from home; 5,000 of these were being held more than 150 miles from their home town. This dislocation has cost the taxpayer millions of pounds in transportation and delays to the criminal justice system as a result of late arrivals for court appearances. It also jeopardises family relationships and the chances of successful integration back into the community on release – two of the most important factors in reducing reoffending.

“The present overcrowding means that far too many are away from their base. To me the resettlement process doesn’t really work unless the person who is going to be responsible for the resettlement makes contact with the person before they are released and then is ready to receive them.” (Lord Ramsbotham)

In an interview with *The Times* on 12th July 2007, Jack Straw, Secretary of State for Justice, stated: “We cannot just build our way out of crowding.” He called for a national conversation on the use of prison and said that he would still want this to take place even if he could “magic an extra 10,000 places” into being.⁸⁴

⁸² *Population in Custody, Monthly Tables, March 2008 England and Wales*, Ministry of Justice, 2008

⁸³ This 1,700 is known as the operating margin and reflects the constraints imposed by geographical distribution and the need to provide separate accommodation for different classes of prisoner (ie by sex, age, security category, conviction status, and risk assessment)

⁸⁴ Prison Factfile, Bromley Briefing, May 2007, Prison Reform Trust

Table 3: Prison overcrowding in England and Wales in the last 15 years (mid-year)⁸⁵

Year	Number of places (CNA)	Number of prisoners	Percentage overcrowding
1994	48,291	48,929	101
1995	50,239	51,086	102
1996	53,152	55,256	104
1997	56,329	61,467	109
1998	61,253	65,727	107
1999	62,369	64,529	103
2000	63,346	65,194	103
2001	63,530	66,403	105
2002	64,046	71,112	111
2003	66,104	73,627	111
2004	67,505	74,468	110
2005	69,394	76,079	110
2006	70,085	77,962	110
2007 ⁸⁶	71,374	79,734	112
2008 ⁸⁷	72,512	81,759	113

Commissioning

Since the transfer of the prison healthcare budget to the Department of Health, the control of spending has been delegated to primary care trusts. All PCTs are now responsible for commissioning (purchasing) services for prison health but the Government admits that it has not yet seen the benefits of this change. A source from the Department of Health told us: “We have transferred the commissioning responsibility, but we are yet to fully modernise the service whether it’s mental health or drugs or communicable diseases. There is still some way to go. I think it’s going to take a few years for the PCTs to really bite on that.”

A prisoner who is diagnosed with two mental disorders may be involved with as many as five different providers. Healthcare commissioning in prisons is complex and the system has not proved sophisticated enough to deal with such issues. Local PCTs usually commission primary care, specialist substance-misuse workers and mental healthcare. Providers still work in “silos” and communication about basic issues, such as the

assessment of complex disorders, is inadequate. Julian Corner told us that matters are made more difficult for community commissioners because the profile of a prison is likely to change every year or so and so may be very different from the local population.

More thought needs to go into the ways in which integrated mental healthcare should be commissioned in prisons. Structures and systems which promote far greater co-ordination between agencies and services are essential. Our experts were very clear that there is still a reluctance in PCTs to deal with these potentially difficult clients and a tendency to employ various ways of ensuring that they stay off their books.

“It is important to examine where prisons are in relation to PCT’s priorities, and where mental health fits. The PCT is key. If we’re going to deal with mental health issues, drugs and alcohol, prisons need to be much higher up their agenda.” (John Podmore)

85 All figures from Prison Factfile Bromley Briefing May 2007, Prison Reform Trust, unless otherwise stated

86 *Population in Custody Monthly Tables June 2007 England and Wales*, Ministry of Justice, 2007

87 *Population in Custody Monthly Tables March 2008 England and Wales*, Ministry of Justice, 2008

Prison staff training

One of our interviewees suggested that the closest prisoners get to having a “carer” in prison is through contact with individual prison officers (POs). Despite the very high incidence of mental health disorder in prisons, mental health awareness is still not a mandatory component of POs’ basic introductory training. Although healthcare staff are in charge of the clinical care of prisoners, the discipline staff clearly also have an important role to play. And although there have been various mental health awareness training schemes delivered in the past, interviews with our experts, in-reach leaders and PCT prison health leads suggest that there is still a need and desire for more.

“A lot of prison officers say to you that they can’t get access to training, they didn’t have the training, but they would like it and so I don’t think it’s working properly.” (Sean Duggan)

“The Prison Officers’ Association and the professional association, the Prison Governors’ Association are united – and they are not always – in wanting to stop being asked to look after people who are mentally ill if they have offended very seriously and warrant imprisonment. Time and again they say how bad it is for their members to have to do jobs they are not trained for.” (Juliet Lyon)

The very nature of prison and its prime focus on security can hinder the necessary spread of awareness about mental illness and its treatment. Prison officers have to care for a very vulnerable group of people but are not recruited on that basis nor are they trained to create a therapeutic, healthy environment – though a

number end up with that kind of role. If the primary task of the prison is about security, then that will drive every aspect of what happens to an inmate. If the primary task is to provide a secure *healthy* environment then that task will filter down to everything that goes on including who gets recruited, who gets trained, and what the skills of the senior management team are. Ensuring that this overarching primary task is enforced is the responsibility of the prison governor but it is not always easy.

Governors

Prison governors have overall responsibility for determining the culture in a prison. However, the knowledge that governors possess about mental health is variable. Paul Tidball of the Prison Governors’ Association recently stated in evidence to the Home Affairs Select Committee:

“...a substantial majority of people in prison had significant mental health, drug and alcohol abuse problems and many had committed only minor offences. More treatment and support services in the community were needed to convince the courts that non-custodial sentences for them were viable.”

It is often difficult for a governor to drive change in a prison because of the short time he or she will stay in the post (currently an average of two years).

“The governor doesn’t stick around to drive change over a sufficiently long period of time. How can you transform an institution from one state of affairs to another if the average stay of a prison governor is two years?” (Julian Corner)

Governors play the most important role of all in determining the atmosphere of a prison. As with prison officers, we believe that all future prison governors' training should include a mandatory element of mental health awareness training.

The principle of equivalence

Twelve years after David Ramsbotham made the case for equivalence, it is still a long way from being achieved. But even if Government provided the same level of mental health services in prison as in the community it would not achieve equivalence because of the psychiatric morbidity of the prison population.

One of the core documents to guide the provision of equivalent services is the National Service Framework (NSF) for Mental Health which it was envisaged would

encompass prisons as well as the general community. But the reality has fallen short of the theory.

“We don't have crisis teams generally going into prisons, we don't have early intervention teams for psychosis and assertive outreach teams, and those are the big parts of the psychological service. Those are the big parts of the National Service Framework, that should apply to prisons and they don't.” (Sean Duggan)

The numbers of prisoners with a mental health disorder is not fixed. Improvements in the diversion system, for example, will necessarily reduce them and the system must be flexible enough to accommodate such changes.

5

Spending, staff and savings

Summary

The proportion of the community healthcare budget spent on mental health is 15%. The proportion of the total prison healthcare budget spent on mental health is only 11%, even though mental illness is much more pervasive in prison than the community at large.⁸⁸ Our research shows that shortages in staff recruitment and confusion over in-reach caseloads lead to inefficiencies in spending. We estimate that more than a third (£8.5 million) of the total mental healthcare budget is not being spent efficiently.

Various studies have suggested that the current spending of £20.4 million on prison mental healthcare would need to be tripled in order to reach levels equivalent to that spent within the community. We

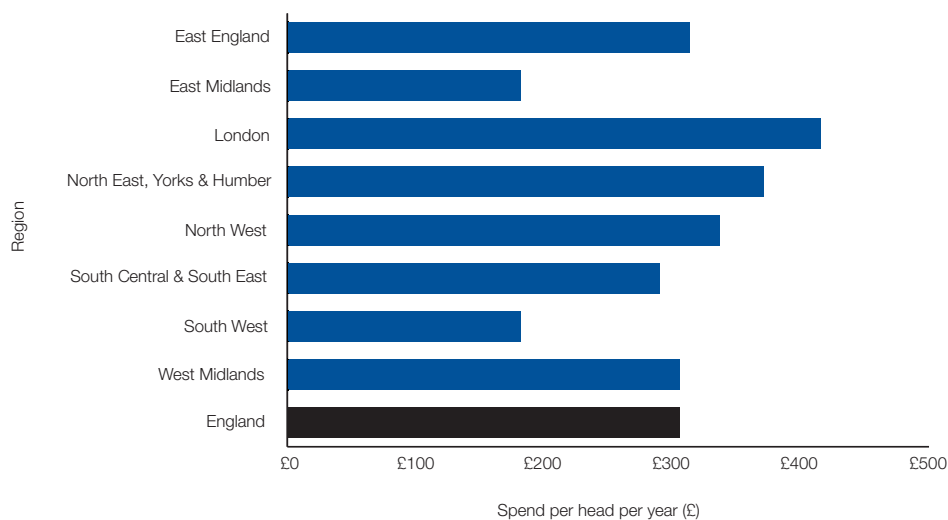
argue that, coupled with more efficient spending, this extra cost would be offset by a reduction in reoffending, which is strongly associated with social exclusion (mental illness is a factor). A less than 1% reduction in reoffending rates would cover the cost of tripling spending.

Spending

Regional variation in mental healthcare spending

The total expenditure on prison mental healthcare in England in 2007-08 is £20.8 million equivalent to an average of £306 per prisoner in publicly run prisons.⁸⁹ When broken down by region, there are some differences in the amount spent per prisoner.

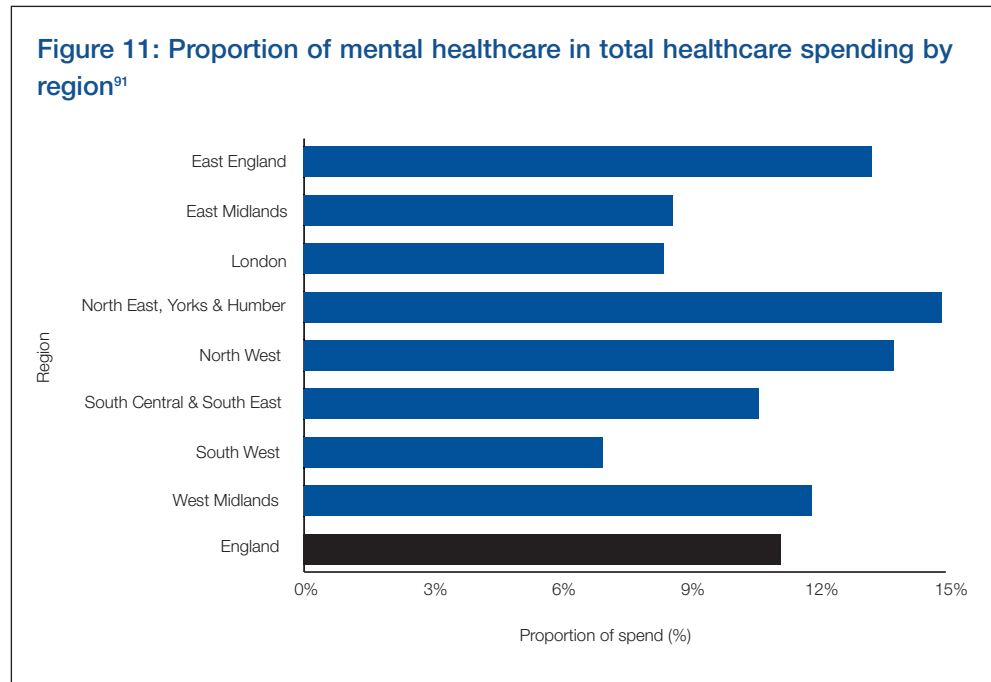
Figure 10: Prison mental health spending per head of prison population by region⁹⁰



88 Brooker C, Duggan S, Fox C, Mills A, Parsonage M, *Short-changed: Spending on Prison Mental Healthcare*, Sainsbury Centre for Mental Health, 2008

89 Ibid

90 Ibid, reproduced by kind permission of Sainsbury Centre for Mental Health



Expenditure per head ranges from a low of £182 in the East Midlands and the South West to a high of £416 in London. Although costs in London are higher than in other parts of the country, this explains only a small part of the observed differences in spending. It is also notable that expenditure per prisoner is more than twice as high in the North East, Yorkshire & Humber region as in the East Midlands and in the South West.⁹²

It is unlikely that the regional prevalence and severity of mental health problems vary on a scale sufficient to explain the differences in spending per head.

Variations in overall health spending

One possible explanation is that they reflect differences in overall spending on prison healthcare, covering physical as well as mental health conditions. Planned spending on all types of healthcare in prisons amounted to £189 million in England in 2007-08, equivalent to £2,769 per prisoner.

Apart from London, there is much less variation between regions in overall health spending per prisoner than there is in spending on mental health. In the case of

mental health, the highest spending region outside London spends more than twice as much as the two regions with the lowest spending. In the case of general health expenditure, the corresponding difference is less than 30%.

London is a clear outlier, spending nearly twice as much on prison healthcare per prisoner as any other region in the country. This is why the capital appears to be a low spender on prison mental health when this is measured as a share of total prison health expenditure.

The North East, Yorkshire & Humber and the North West regions are high spenders on prison mental health, whether this is measured in absolute or relative terms, and the South West and East Midlands are low spenders, again on both bases of comparison.

This suggests that, except in the case of London, regional variations in mental health spending per prisoner cannot be explained by corresponding variations in overall prison health spending. For example, the South West region spends more per head on prison healthcare generally than the North East, Yorkshire & Humber region, but less than half as much on men-

91 Ibid

92 Ibid, reproduced by kind permission of Sainsbury Centre for Mental Health

tal healthcare. Although this is an extreme example, it does imply that there are major inequities in the funding of prison mental health services around the country that merit further investigation.

The differences in spending are not explicable on the basis of regional variations in general prison health spending or any other objective factor. It is hard to avoid the conclusion that standards of mental healthcare in prisons vary substantially. This result chimes with findings from our polling of in-reach team leaders and PCT prison health leads, which showed that while some rated prison mental healthcare as “good” more than half rated it as either “average” or “poor”.

Comparison of mental healthcare spending in prisons and the community

Spending on prison mental healthcare is estimated at £306 per person in prison. This is almost twice the average level of mental health spending on working-age adults living in the community. Based on the latest annual survey of investment in adult mental health services carried out for the Department of Health, total expenditure on mental healthcare for adults of working age in the general population is estimated at £169 per head in 2007-08.⁹³

The £20.8 million spent on prison mental healthcare represents 11% of the total spent on prison healthcare. To compare this directly with the figure of £306 for prison mental healthcare would not, however, be a like-for-like comparison, as the community figure includes spending on a range of services that is not covered in the estimate for prisons, most obviously inpatient and residential care.

In general terms, prison in-reach teams are intended to provide broadly the same type and mix of services to prisoners as are available to people with severe mental health problems who are living at home. In the absence of a precise definition of what this should include, two alternative meas-

ures are suggested here: a broad one including spending on all outpatient/residential services in the community and a narrow one covering only expenditure on community-based mental health teams.

Using these measures, spending on adult mental health services for the general population is estimated at £79 per head on the broad definition and £42 per head on the narrow definition. Per capita spending on prison mental healthcare is between four and seven times as large as per capita spending in the general adult population. However, given the much greater prevalence of mental illness in prison, this figure would need to be around 20 times as large to provide equivalent care.

“We are way behind what we would need to provide decent mental health services. If we are going to provide equivalent services as in the community and take into consideration the higher rates of mental disorder within prison, then we’re 70% adrift.” (Sean Duggan)

Allocation of resources

In addition to the problem of under-resourcing and varying standards across regions, budgets are not being spent in the most efficient way. This is most obvious in two areas: the recruitment of staff and the composition of the caseloads of in-reach teams.

When the in-reach teams were first established, funding was provided for a certain number and type of staff. In practice, due to shortfalls in recruitment, the money hasn’t always been spent. Table 4 shows the average number of whole-time-equivalent (wte) staff per prison who were budgeted for on the establishment in comparison with the number of staff who were actually recruited.

The difference between the establishment whole-time-equivalent total and the actual whole-time-equivalent is 0.5. This means that 10.4% of the total allocated spending on prison mental healthcare, or £2.1 million of

93 Mental Health Strategies, *The 2006/7 National Survey of Investment in Mental Health Services*. Department of Health, 2007

Table 4: Comparison of in-reach staff establishment and actual recruitment

	Establishment wte per prison	Actual wte per prison	Percentage of the establishment which is staffed
Nursing	3.4	3.04	92
Social workers	0.24	0.21	87.5
Psychiatry	0.29	0.28	96.5
Clinical psychology	0.25	0.17	68
Occupational Therapist	0.21	0.18	86
Probation	0.01	0.01	100
Support workers	0.11	0.10	91
Admin/secretarial	0.65	0.58	89
Other members of staff...	
Total wte	4.80	4.3	90
	members of staff (median value)	members of clinical staff (median value)	

the total £20.4 million, is not used due to shortfalls in staff recruitment.⁹⁴

This is not the only inefficiency: the £20.4 million for prison mental healthcare is not being spent in line with the declared policy objectives (as laid out in the NHS plan). As discussed in Chapter 3, in-reach caseloads hold up to a third of prisoners that have neither a serious mental illness nor a personality disorder.

Using these figures it is estimated that over a third of the budget, or £6.4 million, is being spent on prisoners who have neither a severe and enduring mental illness nor a personality disorder.

Reducing reoffending

Even with savings from greater efficiency it is likely that the overall budget will need to be increased to provide equivalent services for prisoners with mental illness. We

believe that the resulting reduction in reoffending would make such an investment cost effective.

In 2002 the Government’s Social Exclusion Unit published a report on reducing reoffending by former prisoners.⁹⁵ It noted that prison sentences are not succeeding in turning the majority of offenders away from crime. Of those prisoners released in 1997, 58% were convicted of another crime within two years, and more than a third had been re-imprisoned. The system struggles particularly to reform younger offenders: 72% of 18-20 year-old male prisoners were reconvicted over the same period; 47% received another prison sentence.

Building on criminological and social research, the Social Exclusion Unit identified nine key factors that influence reoffending:

- education;
- employment;

94 It is worth noting that in mainstream nursing in community psychiatry, the vacancy rate is only 1.5%.

95 Social Exclusion Unit, *Reducing Reoffending by Ex-prisoners*, Office of the Deputy Prime Minister, 2002

96 Brooker C, Gojkovic D, Shaw J, "The second national survey of mental health in-reach services in prisons". Accepted for publication, *Journal for Psychiatry and Psychology*, 2008

Table 5: Comparison of in-reach teams caseload composition⁹⁶

	Severe and enduring mental illness alone	Both severe mental illness and personality disorder	Neither severe mental illness nor personality disorder
Caseload proportion	32%	9%	31%

- drug and alcohol misuse;
- mental and physical health;
- attitudes and self-control;
- institutionalisation and life skills;
- housing;
- financial support and debt;
- family networks.

For example, being employed reduces the risk of reoffending by between a third and a half; having stable accommodation reduces the risk by a fifth.

If untreated, mental health problems in prison can become worse and will reduce the chances of finding a home and keeping a job later. Time in prison can present a valuable opportunity to address some of these health issues. However, even where progress is made, further community support is needed on release.

All of our experts accepted that there was a link between poor mental health and reoffending, via the medium of social exclusion.

“Regardless of whether we have a strong evidence base, it seems to me to be palpable common sense that there is a strong relationship between unmet mental health need and offending. It impacts on somebody’s ability to maintain stable accommodation, to move into stable employment, to keep away from drugs or to kick drug habits. It is also heavily associated with all manner of crises such as financial crises, family relationships etc. It seems to me to be the pervasive factor in whether you can get all the other stuff together and I just don’t see how somebody can do this, if mental health need isn’t properly sorted out.” (Julian Corner)

Stigmatisation of people with mental health problems is pervasive throughout society. Despite a number of campaigns, there has been little significant change in attitudes. Fewer than four in ten employers say they would recruit someone with a men-

tal health problem. Many people fear disclosing their condition, even to family and friends, and this can be particularly true for prisoners living in crowded conditions, often with people they do not choose.

The costs of reoffending

The Social Exclusion Report estimated that the financial cost of reoffending by former prisoners, calculated from the overall costs of crime, is staggering and widely felt. In terms of the cost to the criminal justice system of dealing with the consequences of crime, recorded crime alone committed by ex-prisoners comes to at least £13 billion a year (adjusted for inflation).⁹⁷

The costs of reoffending are varied and include the direct costs of keeping someone in prison to the indirect costs of unemployment benefits, childcare provision and so on. If there is a link between poor mental health and reoffending, then by increasing and improving mental healthcare provision in prisons, it would be possible to drastically reduce that £13 billion.

Various studies have suggested that the £20.4 million spent on prison mental healthcare would need to be tripled in order to reach levels equivalent to that spent within the community. A conservative reduction of only 0.3% in reoffending rates (a cost reduction of £40 million) would be required to make the tripling of the mental healthcare spending cost effective.

“What we are aiming to do in prisons is to bring about much greater social inclusion on release – and improving mental health is essential to that aim. If former prisoners can get a job, have a positive social relationship and generally be socially included, then re-offending is less likely and expenditure within the Criminal Justice System much more effective.” (John Podmore)

⁹⁷ Social Exclusion Unit, *Reducing Reoffending by Ex-prisoners*, Office of the Deputy Prime Minister, 2002

6

Recommendations

Summary

A follow-up report, to be published by Policy Exchange later in 2008, will look at best practice in England and Wales, as well as various international models, in order to formulate a number of policy recommendations to improve mental healthcare in prison. But it is already clear which areas these recommendations will focus on. The investment in mental healthcare in prisons is too low and varies widely and arbitrarily across regions. The provision of primary mental healthcare is severely lacking and the integration with in-reach teams is variable often resulting in poor care co-ordination for service users.

The authors' preliminary recommendations are:

- **Multidisciplinary teams – all mental health staff should be integrated into one multidisciplinary team**

The relative isolation of each team (in-reach, primary care, CARATs) working separately is resulting in poor co-ordination of services and a lack of through-care. The blurred line between what is primary and secondary care results in prisoners being passed between the two or even lost completely. A single mental health delivery team, with the range of skills and practitioners of community mental health teams would go a long way to improving the quality of care.

- **Training for Prison Staff – all prison officers and prison governors should have some form of mandatory mental health awareness training**

Prison officers have the most contact with prisoners day-to-day and as such can act as their primary carers. With such a high prevalence of mental illness it is essential that prison officers have the skills to identify and deal with mental illness. Training is not sufficient and in some cases is not compulsory. Prison officers do not feel qualified to deal with prisoners with mental disorders and in order to gain that confidence they must all be given thorough and continuous training. Prison governors play the most important role of all in determining the atmosphere of a prison. As with prison officers, the authors believe that all future prison governors' training should include a mandatory element of mental health awareness training.

- **Release planning – every prisoner should have a co-ordinated care plan on release.**

The biggest determinants of reoffending need to be carefully considered in an offender's resettlement plan. If no one takes responsibility for organising the basics (access to a GP and accommodation) for an ex-offender on release then it is more likely that he will go on to reoffend. Ensuring that everyone with a mental health problem who is released has a proper care plan is crucial in reducing reoffending rates. This should already happen for prisoners with a severe mental illness through the CPA.

- **Increased funding – funding for mental healthcare in prisons should increase to a level that corresponds to the mental health needs profile of prisoners.**

Funding should be based on rationally assessed needs, rather than historical precedent from the days when the Home Office allocated funds to the Prison Service. The staffing levels of prison in-reach teams are far below their equivalent in the community where there is much less mental illness. A sophisticated health needs assessment should be undertaken in order to find the real funding necessary for providing for the prison community.

- **Further research into the link between mental health and reoffending**

Although it is easy to call for increased funding, it is not always economically viable or politically palatable. However, in this case there is a case to be made that improving mental healthcare in prisons would have a significant effect on reoffending rates – and thus the costs associated with reoffending. Research on the link between untreated mental illness and reoffending is scarce, but most experts the authors interviewed agree that there is such a link. There is a need to commission more

research in this area in order to understand the possible economic consequences of effective mental health treatment for prisoners.

- **Improve court diversion – implement a robust and properly funded court diversion scheme for offenders with mental illness**

Although not dealt with specifically in this report, the need to divert a large number of prisoners with mental illness away from prison is clear. Not only does it ensure that they are treated in an appropriate setting, but it would also go some way to alleviating overcrowding and the myriad problems chronic overcrowding causes the Prison Service. The authors look forward to the recommendations of the Bradley Review on this issue.

- **Integrating mental health policy**

The structure of policymaking (Offender Health is a separate directorate within the Department of Health) makes it difficult to integrate mainstream health developments in prisons, such as increasing access to psychological therapies. PCTs would be more likely to consider prison populations as part of their local communities if a more integrated approach to policymaking was evident at the top.

Glossary

ACCT: Assessment, Care in Custody and Teamwork

The ACCT approach is a case management system which aims to identify individual need and offer individualised care and support to prisoners in advance, during and after a crisis. It replaces the current F2052SH risk management system.

Assertive Outreach teams

Assertive outreach teams provide intensive support for the severely mentally ill people who are 'difficult to engage' in more traditional services. Many will often have a forensic history and a dual diagnosis. Care and support is offered in their homes or some other community setting, at times suited to them. Workers can be involved in direct delivery of practical support, care co-ordination and advocacy as well as more traditional therapeutic input. The aim of the service is to maintain contact and increase engagement and compliance.

BME: Black and minority ethnic community

CARAT worker: Counselling, assessment, referral, advice, and through-care worker

CARAT workers co-ordinate the care of those prisoners on their caseloads; workers can also provide basic information about drugs and their effects and ways to reduce harm; they may offer some structured one-to-one support and group work to prisoners who want to give up or cut down on their habit. They can also refer a prisoner to a drug treatment rehabilitation programme.

CMHT: Community mental health teams

These are multidisciplinary teams aiming to provide one point of access to mental health services to those diagnosed with a

severe mental health problem. Their services are aimed at adults of working age with mental health problems that seriously impair their ability to function.

CPA: Care programme approach

CPA is the case management system adopted by all secondary care mental health services in the community (ie outside prison) in England. A care co-ordinator is appointed to link various elements of care and to organise multidisciplinary reviews of care. CPA should involve both users and carers in planning and reviewing.

Crisis Resolution Team

A crisis resolution team provides intensive support for people in mental health crises in their own home: they stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers.

CPN: Community psychiatric nurse

DoH: Department of Health

Early Intervention Teams

Early intervention teams work with people aged between 14 and 35 years, who have experienced a first episode of psychosis.

In-Reach: See mental health in-reach teams

Mental health in-reach teams

Modelled on the CMHTs, mental health in-reach teams are designed to provide assessment, care and treatment for those in prison who are experiencing serious mental health problems and form part of a national policy aimed at improving mental healthcare within prisons.

HMIP: Her Majesty's Inspectorate of Prisons

Her Majesty's Inspectorate of Prisons for England and Wales (HMI Prisons) is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions and immigration removal centres.

Nacro

Nacro is a charity that focuses on crime reduction. Its mission is to make society safer by finding practical solutions to reducing crime. Since 1966 it has worked to give ex-offenders, disadvantaged people and deprived communities the help they need to build a better future.

NHS: National Health Service

The NHS provides healthcare to anyone normally resident in the UK with most services free at the point of use for the patient though there are charges associated with eye tests, dental care, prescriptions and many aspects of personal care.

NSF: National Service Framework (for Mental Health)

National Service Frameworks are policies set by the National Health Service to define standards of care for major illnesses such as cancer, coronary heart disease, mental health and diabetes. A National Service Framework spells out how services can be best be organised to cater for patients with particular conditions and the standards that services will have to meet. NSFs are also defined for some key patient groups including children and older people.

PCT: Primary care trust

Primary care trusts covering all parts of England receive budgets directly from the Department of Health. Since April 2002, PCTs have taken control of local healthcare while strategic health authorities monitor performance and standards. Since the transfer of the prison healthcare budget to the Department of Health, the control of spending has been delegated to PCTs. All PCTs are now responsible for commissioning (purchasing) services for prison health.

Appendix 1

List of prisons served by the PCTs
and mental health in-reach teams
surveyed

HMP Altcourse
HMP Ashwell
HMP Belmarsh
HMP Blakenhurst
HMP Blundeston
HMP Bronzefield
HMP Coldingley
HMP Dorchester
HMP Dovegate
HMP Downview
HMP Drake Hall
HMP Durham
HMP Edmunds Hill
HMP Everthorpe
HMP Featherstone
HMP Frankland
HMP Gartree
HMP Gloucester
HMP High Down
HMP Highpoint
HMP Hollesley Bay
HMP Holloway
HMP Hull
HMP Kennet
HMP Lancaster Castle
HMP Leeds

HMP Leicester
HMP Liverpool
HMP Long Lartin
HMP Lowdham Grange
HMP Manchester
HMP Nottingham
HMP Peterborough
HMP Preston
HMP Send
HMP Shrewsbury
HMP Stafford
HMP Stocken
HMP Stoke Heath
HMP The Mount
HMP The Verne
HMP Wakefield
HMP Wealstun
HMP Wellingborough
HMP Whatton
HMP Wolds
HMYOI Brinsford
HMYOI Deerbolt
HMYOI Feltham
HMYOI Glen Parva
HMYOI Lancaster Farms
HMYOI Low Newton
HMYOI Northallerton
HMYOI Onley
HMYOI Portland
HMYOI Warren Hill

Appendix 2

YouGov Survey Results: Sample Size: 2067, Fieldwork: 12th - 14th May 2008

	Gender			Age					Social Grade	
	Total	Male	Female	18-24	25-34	35-44	45-54	55 +	ABC1	C2DE
All GB Adults	2067	992	1075	227	384	350	372	734	1116	951
Unweighted Sample	2067	976	1091	261	371	331	376	728	996	1071
	%	%	%	%	%	%	%	%	%	%

The next question is about mental illness...

To what extent do you agree or disagree with each of the following statements? [Please tick one option on each horizontal row]

Virtually anyone can become mentally ill and commit crime

Strongly agree	15	15	16	13	15	19	15	15	15	16
Agree	45	44	46	37	39	42	49	49	45	45
Neither agree nor disagree	17	18	17	18	17	17	18	17	16	19
Disagree	14	15	13	17	17	14	13	12	15	13
Strongly disagree	4	4	4	3	5	3	3	4	5	3
Don't know	5	5	4	12	6	4	2	3	4	5

We need to adopt a far more tolerant attitude towards people with mental illness in our society who commit crime

Strongly agree	7	8	6	6	8	7	7	8	7	7
Agree	25	22	29	22	23	22	25	29	24	26
Neither agree nor disagree	30	30	29	31	31	31	29	28	30	29
Disagree	25	26	25	23	28	28	22	25	26	24
Strongly disagree	8	11	6	7	6	8	15	7	9	8
Don't know	4	4	4	10	5	4	2	2	3	5

We have a responsibility to provide the best possible care for people with mental illness who commit crime

Strongly agree	17	17	17	12	19	19	17	16	18	15
Agree	47	46	48	42	42	45	50	52	48	46
Neither agree nor disagree	20	20	21	22	23	23	19	18	19	22
Disagree	9	10	7	10	9	7	9	9	8	9
Strongly disagree	3	3	3	5	2	2	4	3	3	3
Don't know	4	3	4	9	5	4	1	3	3	5

People with mental illness who commit crime are a burden on society

Strongly agree	6	7	4	7	5	5	7	5	6	5
Agree	29	36	23	27	28	29	24	33	32	26
Neither agree nor disagree	29	28	31	29	28	32	30	28	27	32
Disagree	25	20	29	21	26	21	28	25	24	25
Strongly disagree	8	7	9	7	8	10	10	6	9	7
Don't know	3	3	4	9	6	2	1	2	2	4

Increased spending on mental health services for people who commit crime is a waste of money										
Strongly agree	3	4	3	2	3	4	4	4	3	4
Agree	11	12	9	12	10	11	9	11	8	13
Neither agree nor disagree	24	25	24	26	23	27	23	23	23	26
Disagree	39	37	40	35	40	34	42	39	40	36
Strongly disagree	18	17	20	15	18	20	20	18	21	15
Don't know	5	6	4	11	6	4	2	4	4	6
There are sufficient existing services for people with mental illness who commit crime										
Strongly agree	2	2	2	1	1	1	2	3	2	2
Agree	9	10	8	8	9	7	8	12	8	11
Neither agree nor disagree	20	19	20	22	21	21	18	18	17	22
Disagree	34	32	35	25	37	34	34	35	36	31
Strongly disagree	20	19	21	10	14	23	28	22	22	18
Don't know	15	17	13	34	18	14	10	11	15	15
I would not want to live next door to someone who has been mentally ill										
Strongly agree	7	9	5	7	5	8	8	6	7	6
Agree	17	19	15	17	21	16	14	16	17	17
Neither agree nor disagree	37	37	36	24	32	37	39	41	35	39
Disagree	26	23	29	24	26	27	28	26	28	24
Strongly disagree	10	9	11	16	12	9	8	9	11	9
Don't know	4	4	4	12	4	3	3	2	2	6
People with mental illness who commit crime are far less of a danger than most people suppose										
Strongly agree	4	4	4	3	5	5	3	4	5	3
Agree	13	12	14	10	12	8	14	16	14	12
Neither agree nor disagree	25	25	25	24	28	31	24	21	25	24
Disagree	34	35	34	34	34	34	31	36	34	35
Strongly disagree	16	16	17	14	15	15	21	16	17	16
Don't know	8	8	7	15	7	6	6	7	7	9
Which of the following is closest to the proportion of people in prisons in the UK that you think might have a mental health problem?										
0% (no-one in prison)	0	0	0	0	0	0	0	0	0	0
0.1	9	11	7	14	6	7	9	10	8	11
0.2	15	20	11	16	14	18	16	13	15	15
0.3	21	21	20	15	25	24	17	20	21	20
0.4	16	15	17	18	16	16	18	14	17	15
50% (half of those in prison)	13	12	14	9	13	14	13	14	12	14
0.6	7	5	8	7	7	4	8	6	7	6
0.7	5	3	6	6	6	5	5	4	6	4
0.8	2	2	3	3	2	3	2	2	3	2
0.9	1	0	1	1	1	1	1	1	1	1
100% (all of those in prison)	1	1	0	0	1	0	1	1	0	1
Don't know	11	10	11	10	8	9	10	13	9	12

Our prison population is at its highest ever. Of the 82,000 prisoners in England and Wales it is estimated that nine out of ten have one or more mental health disorders. Although treatment of mental illness in prison has improved over the past decade, mental healthcare is not given the attention it deserves. The rates of mental illness among prisoners suggest that the Prison Service has become a catch-all social and mental healthcare service, as well as a breeding ground for poor mental health.

In 1996, Lord Ramsbotham, then Chief Inspector of Prisons, wrote a report that was heavily critical of prison healthcare services. And although matters have improved since then, progress is slow. *Out of Sight, Out of Mind* argues that Lord Ramsbotham's findings are as relevant today as they were 12 years ago: research contained in this report suggests that a third of the spending on mental health services in prison is spent inefficiently and that prison mental healthcare remains very poor. Professor Charlie Brooker and Ben Ullmann argue that levels of staffing would need to be tripled in order to reach service levels equivalent to that of the wider community but that rates of reoffending would have to fall by less than one per cent to make this improvement cost effective.



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