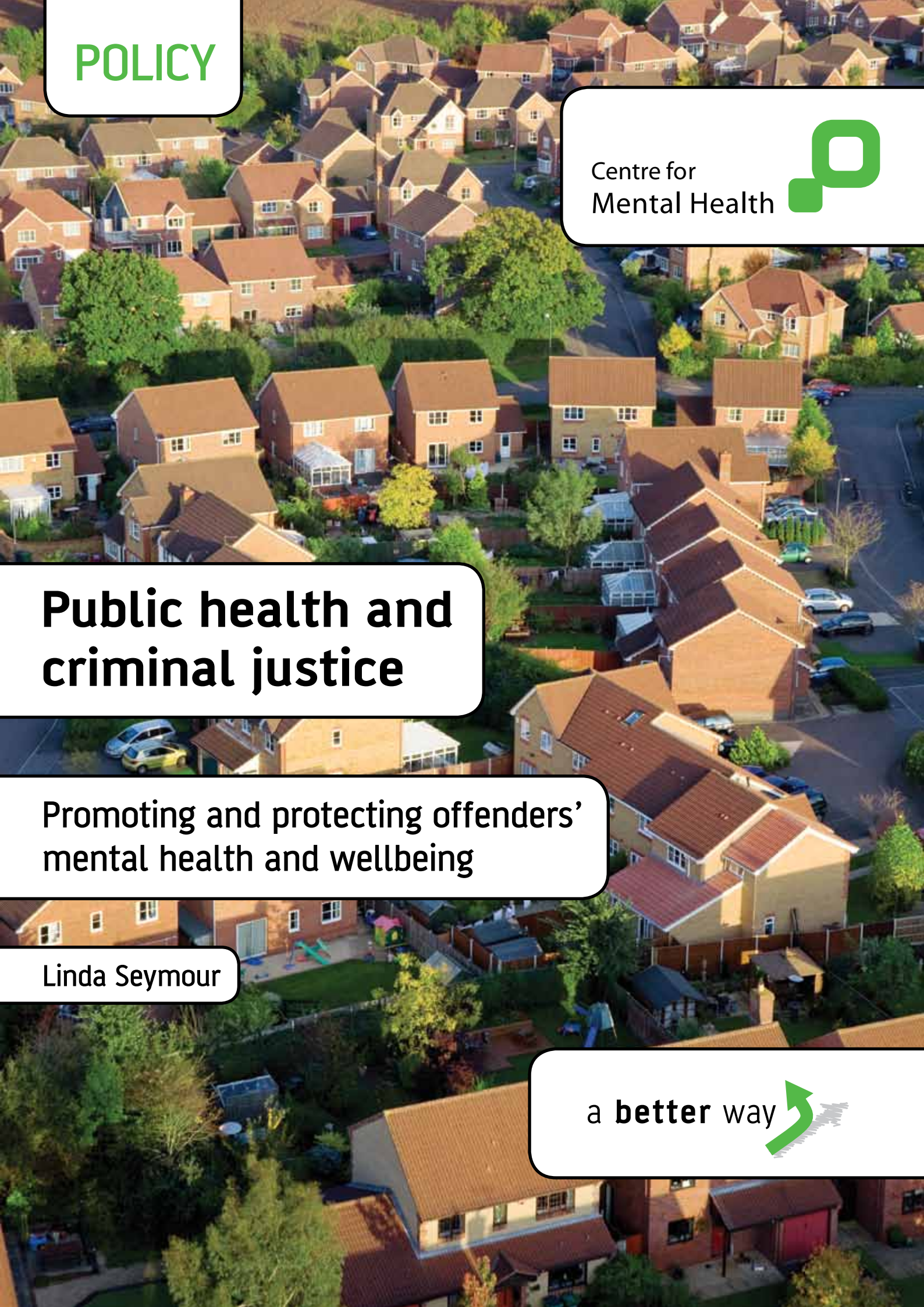
POLICY

Centre for Mental Health



Public health and criminal justice

Promoting and protecting offenders' mental health and wellbeing

Linda Seymour

a **better** way

Executive summary

The offending population experiences poor mental health on many counts, often associated with a lifetime of social exclusion and its consequences. Promoting and protecting the mental health and wellbeing of offenders and those at risk of offending can have wide-ranging benefits for individuals, their families and their communities.

This policy paper looks at a range of innovative programmes and interventions that target people and communities at high risk of social exclusion, poor mental health and offending.

Key messages for policy and practice

- **Offender mental health is a critical public health issue.**

The risk of becoming an offender starts early in life and increases from childhood onwards. It is linked strongly with social exclusion and poor mental health. Early intervention before those at risk enter the criminal justice system will reap health, social and financial returns.

Many of the risk factors for poor mental health overlap with those for offending in socially excluded groups. Mitigating these risks, such as poor maternal mental health or child conduct disorders, and enhancing protective factors, such as good parenting skills or cognitive and life skills among children and young people, will more than repay the investments made by reducing the financial burden on health and criminal justice budgets.

- **Public health practitioners have a lot to offer people in the criminal justice system or at high risk of offending.**

There is such a strong link between mental ill health, social exclusion and offending that interventions that succeed in decreasing key risk factors for any one of these issues will be likely to have wide-ranging benefits – both personal and social – in reducing the others. Public health practitioners are well placed to form collaborative partnerships to deliver effective outcomes.

Interventions that focus only on individual issues such as health, to the exclusion of the broader landscape of housing, employment, education, or social networks, will be unlikely to deliver the necessary change to produce positive outcomes for offenders, their families and communities.

Public health practitioners know how to negotiate the broad landscape of statutory and third sector agencies and can bring their understanding of the wider context in which offenders live to the design and delivery of programmes and interventions for protecting and promoting mental health and wellbeing. They can act as the glue between the cracks of currently uncoordinated services.

- **Involvement with the criminal justice system presents opportunities to promote and protect mental health.**

Early intervention is by far the best route, but it is never too late to promote mental health among offenders. For example, some offenders may have missed out on schooling and learning key skills. There are schemes that can begin to address these gaps. One of the most effective routes to improving offenders' mental health and life outcomes is to help them to find secure employment.

- **Collaborative working between public health and criminal justice is key to delivering on this agenda.**

Partnership working between public health and criminal justice has been under-developed. It requires concerted efforts to build and embed effective joint working where cultures and values are very different. The time is now right to dismantle the obstacles that have impeded effective cooperation.

- **Utilise the learning from existing innovative practice.**

The complex nature of offenders' health and social problems has led to the development of many examples of innovative practice by health, social care and the third sector. These programmes address the inter-related problems of offending, mental health, drug dependency and chronic social exclusion. They aim to encourage new ways of working between the statutory and third sectors, such as offering Social Impact Bonds to fund social organisations working to reduce re-offending.

- **Reinvesting to save will bring the greatest benefits.**

There are considerable resources 'locked up' in the criminal justice system that could be used more effectively through short-term reinvestment. Medium-term investment could be used in supporting families and easing people's transitions into and out of prison as well as the long-term agenda of tackling the lottery of 'life chances' based on where people are born. Resources for building new prisons could perhaps more profitably – in broader public health terms – be redirected towards the NHS and more cost-effective services there. There is evidence that programmes addressing protection and promotion of mental health for offenders and those at risk of offending accrue multiple financial benefits. Some programmes for young offenders have been shown to produce very significant long-term economic returns.

Introduction

The offending population experiences poor mental health on many counts, often associated with a lifetime of social exclusion and its consequences. Promoting and protecting the mental health and wellbeing of offenders and those at risk of offending can have wide-ranging benefits for individuals, their families and their communities.

Many initiatives already address the mental health of at risk groups, such as children in the early years who live in poverty, or training in resilience for adolescents. But the links between lack of relevant support for the promotion of mental health among these groups and resulting offending behaviour have often not been made.

There are now a number of complementary initiatives in health and criminal justice that give cause for optimism in addressing these complex issues in a comprehensive and effective way. Integrated approaches such as in the 'Total Place' initiative offer possible solutions to the trenchant problems that materialise when trying to promote and protect the mental health and wellbeing of vulnerable groups such as offenders.

This policy paper develops the debates and discussions generated by the 2009 Sainsbury Centre Lecture, given by Professor Cheryl Easley, then President of the American Public Health Association and Dean of the University of Alaska, Anchorage, College of Health and Social Welfare (Easley, 2009). Professor Easley spoke about prison health care and the mental health of offenders from a North American perspective, and delved into why these matters should be a public health priority.

We take forward some of the ideas from the lecture and consider what mental health and wellbeing might look like for offenders and high-risk groups. We look at the incidence of poor mental health among offenders, assess the unique risk factors that influence their mental health and explore the possibilities for the protection and promotion of their mental health and wellbeing.

Mental health and wellbeing

Mental health and wellbeing are more than an absence of mental illness. The World Health Organisation describes mental health as:

"... subjective wellbeing, perceived self-efficacy, autonomy, competence, inter-generational dependence and recognition of the ability to realise one's intellectual and emotional potential."

(WHO, 2003)

These attributes enable individuals to recognise their abilities, cope with the normal stresses of life, work productively and fruitfully and make a contribution to the communities where they live.

Other commentators support this view and stress that mental health and wellbeing are not a purely individual phenomenon. The context within which a person lives is influenced by a range of broader social, economic and environmental factors, combined with personal ones such as gender, ethnicity, age and physical disability.

Schools, neighbourhoods, organisations or specific groups of people such as refugees, offenders or those in later life may have low levels of mental health and wellbeing as a result of poverty, deprivation, exclusion, isolation or low status (DH, 2001; Friedli, 2009).

People with a mental ill health diagnosis are capable of attaining positive mental health and wellbeing if they have access to good care

and treatment, supportive social networks and meaningful occupation (DH, 2001).

The ability of individuals or social groups to negotiate and respond to multiple internal and external influences has profound consequences for the public's mental health. Consequently, the protection and promotion of mental health and wellbeing are critical for the way society operates at every level.

Relevant approaches should focus on reducing and eliminating risk factors for poor mental health and augmenting and embedding protective factors for positive mental health. The aim should be to:

- **Strengthen individuals** by increasing emotional resilience, promoting self-esteem, imparting life and coping skills such as communication, negotiation, relationship building and informed parenting;
- **Strengthen communities** by increasing social inclusion and participation, improving neighbourhood environments, developing health and social services that support mental health, introducing school anti-bullying strategies, prioritising workplace health, ensuring community safety and providing childcare and self-help networks;
- **Promote enabling structures** that support mental health by reducing discrimination and inequalities, promoting access to education, meaningful employment, housing, services and support for everyone and in particular for those who are vulnerable.

There is a clear rationale for protecting and promoting mental health and wellbeing as they themselves influence a very wide range of outcomes for individuals and communities. Good mental health and wellbeing are associated with:

- Improved educational attainment and outcomes, greater productivity and remaining in employment, improved cognitive ability and quality of life and improved social connectedness;
- Reduced mortality, criminal behaviour, risk-taking behaviour e.g. smoking, and sickness absence;
- Increased resilience i.e. a greater ability to deal with life's problems and reduced risk of developing mental illness or committing suicide (DH, 2010a).

Positive mental health is both a cause and consequence of a range of manifold personal, social and economic interactions. Investment in its protection and promotion sets in train a positive feedback loop from individuals out to communities and society and back again.

Mental health of offenders

The offender population comprises those both in and out of custody. A cursory exploration of an offender's life course would seem to tip the balance towards the inevitable outcomes of compromised mental health and wellbeing and long-term association with the criminal justice system. The risk of someone becoming an offender starts early in life and increases from childhood onwards due to a number of contributory factors including:

- Low maternal bonding;
- Poor maternal mental health;
- Poor parenting skills;
- Abusive home relationships;
- Family history of involvement with criminal justice system;
- Learning difficulties;
- Truancy and exclusion from school;
- Poor educational achievement;
- 'Looked After' child status;
- Conduct/emotional disorders (Basher & Nurse, 2008).

The social characteristics of those held within the prison estate present a picture of multiple deprivation and risk factors for poor physical and mental health and social exclusion (see Table 1).

For some communities and groups there are specific risk factors. For example, people from Black and minority ethnic groups are exposed to significant levels of racial profiling by police. They represent about 10% of the UK population but 26% of the prison population, a substantial proportion of whom are foreign nationals (ONS, 2001; MoJ, 2008).

Women who enter the criminal justice system often suffer separation from children, and many are imprisoned a long way from home. The main social cost incurred by the children of imprisoned mothers – and by the state in relation to these children – results from the increased likelihood of them becoming 'NEET' (Not in Education, Employment or Training), with associated risks for mental health and offending (NEF, 2008).

Table 1: Social characteristics of people in prison and the general population

	Prison population	General population
Ran away from home as a child	47% (men) 50% (women)	11%
Taken into care as a child	27%	2%
Regularly truanted from school	30%	3%
Excluded from school	49% (men) 33% (women)	2%
No qualifications	52% (men) 71% (women)	15%
Numeracy at or below Level 1 (level expected of an 11 yr old)	65%	23%
Reading ability at or below Level 1	48%	21-23%
Unemployed before imprisonment	67%	5%
Homeless	32%	0.9 %
Drug use in previous year	66% (men) 55% (women)	13% (men) 8% (women)
Hazardous drinking	63% (men) 39% (women)	38% (men 15% (women)

(Source: Social Exclusion Unit, 2002)

People aged 60 and over are the fastest growing age group in the prison estate and more than half have some form of mental disorder, most commonly depression associated with imprisonment (Prison Reform Trust, 2009; HMCI, 2008). Like people in later life everywhere they experience chronic physical diseases such as asthma, diabetes and coronary heart disease, as well as the side effects of long-term multiple drug use.

The incidence of poor mental health among offenders is high. Reviews have found a heightened prevalence of mental illnesses among prisoners (Fazel & Danesh, 2002; Social Exclusion Unit, 2002; Singleton *et al*., 1998). Two-thirds of sentenced prisoners in England and Wales have two or more mental disorders and 20% of prisoners have four of the five major mental health disorders (Prison Reform Trust, 2009; Goggins, 2004). Rates of mental ill health among prisoners are higher than among similar groups in the general population (see Table 2).

Changes in sentencing and overcrowding in the prison estate exacerbate any mental health problems offenders bring with them into the criminal justice system. Prisoners have reported that long periods of isolation with little mental stimulus have resulted in intense feelings of anger, frustration and anxiety (Basher & Nurse, 2008). In particular some of the newer, indeterminate sentences such as Imprisonment for Public Protection have been shown to be hazardous to mental health and wellbeing (Sainsbury Centre, 2008).

Those on community sentences also display mental health needs. Existing data suggest that four in ten offenders in the community have mental health problems (Solomon & Silvestri, 2008). Women on probation appear to have higher levels of mental health need than men: at one third versus one in five (Mair & May, 2007).

There is a close correlation of risk factors for poor mental health, offending and social exclusion. The latter brings with it poor physical

Table 2: Mental health problems in prison and the general population

	Prevalence among prisoners (16+ years)	Prevalence in general population (16-64 years)
Psychosis	8%	0.4%
Personality disorder	66%	0.4%
Depression and anxiety	45%	17.6%
Drug dependency	45%	3.4%
Alcohol dependency	30%	5.9%
Source: Singleton *et al.,* 1998		Source: McManus *et al.*, 2009

health, itself a risk factor for poor mental health and wellbeing. A recent review in England demonstrates that inequalities in health exist across a range of social and demographic indicators including income, social class, occupation and parental occupation, housing condition, neighbourhood quality, geographic region, gender and ethnicity (Marmot, 2010).

The review highlights how key determinants, such as level of education, influence future outcomes. For example, a range of empirical studies provide evidence that cognitive ability is a powerful antecedent of earnings, propensity to get involved in crime and success in many aspects of social and economic life as well as health across the social gradient (Marmot, 2010 p.62; Heckman *et al*., 2006; Auld & Sidhu, 2005).

Inequalities are evident in many health outcomes including mortality, morbidity, self-reported health, mental health, and death or injury from accidents and violence (Marmot, 2010 p.45; Bambra *et al*., 2009). The risk factors can be similar for seemingly quite different outcomes such as violent and non-violent offending, mental health problems, alcohol and drug problems, school failure and unemployment.

Poor mental health and wellbeing in childhood and adolescence are also associated with a broad range of poor adult health outcomes. These include poorer adult mental health and an increased risk of suicide as well as higher levels of antisocial behaviour, involvement in crime, smoking, alcohol and drug misuse, poorer socio-economic status and lower levels of employment (Fergusson *et al*., 2005).

In summary, there is such a strong link between poor mental health, social exclusion and offending that interventions that succeed in decreasing key risk factors for any one of these issues will be likely to have wide-ranging benefits – both personal and social – in reducing the others (Farrington, 2006).

The agenda for public health

Offenders and their families are likely to be exposed to a range of risk factors for social exclusion and poor physical and mental health. Interventions that focus only on individual factors such as health, to the exclusion of the broader landscape of housing, employment, education, or social networks, will be unlikely to deliver the necessary change to turn their lives around. How can such complex programmes be designed and delivered?

Since 2006, primary care trusts (PCTs) have had the lead role for commissioning health services in the criminal justice system. Every PCT also has a statutory responsibility to provide a public health function and many Directors of Public Health are joint appointments with local authorities. As a consequence they are well placed to address complex health and social issues that require cross-agency working and an approach to health improvement, protection and promotion that includes interventions targeted at different levels of need among people of all ages and all sections of the population.

The prison population has remained at or near 85,000 for several months during 2010 (MoJ, 2010) and there are more than 150,000 people serving community sentences. The average PCT is thus responsible for the health of about 500 prisoners and more than 1,000 community sentenced offenders. In addition, nearly 10,000 people per PCT area are arrested by the police each year (Sainsbury Centre, 2009a). All of the people in these groups have a very high risk of mental ill health. As a consequence, there will be a growing number of ex-offenders in the community with mental health problems.

Public health interventions utilise a blend of approaches that fit together in a variety of ways. Programmes might, for example, target whole populations, different stages of the life cycle, particular at-risk groups, or those who might already have experienced significant problems. For the protection and promotion of mental health, primary public health interventions might focus on known protective factors such as mental health promotion in schools and resilience training for adolescents.

For those groups deemed to be at high risk of offending, secondary public health programmes might include identification of problems and diversion away from the criminal justice system into health care, appropriate social support, access to learning and skills, secure accommodation and employment opportunities.

Finally, for those already in contact with the criminal justice system, tertiary public health programmes to improve mental health and wellbeing might include creating healthy environments in prisons and providing literacy schemes for prisoners. Acutely ill prisoners should be transferred to appropriate care and treatment. In addition, secure forensic hospitals should provide services that focus on recovery and enable patients to 'step-down' to lower security services when appropriate.

Just as the risk factors for poor mental health, offending and social exclusion are well-known, so too are a range of effective interventions and approaches with the potential to protect and promote mental health and wellbeing at each of these levels.

The following sections provide a few examples of interventions that demonstrate public health approaches to mental health protection and promotion among people who have offended or are at risk of offending now or later in life.

Primary prevention and promotion

Poor maternal mental health, with the threats it poses to mother-child bonding, is a risk factor for endangered mental health and wellbeing, conduct disorder and also offending (Targosz *et al.*, 2003). A range of approaches can be used such as routine enquiries during pregnancy for mental health disorders and post-natally to detect depression; targeted psychosocial interventions for women who have symptoms below the diagnostic threshold for depression or anxiety; or self-help strategies such as counselling or CBT for mild-to-moderate depression (Basher & Nurse, 2008).

Good parenting skills are a significant factor in enabling a range of positive health and wellbeing outcomes for children and families. Parenting training can reduce the risk of conduct disorders and abuse in children. Long-term follow up of health visitor programmes found reduced adolescent anti-social and offending behaviour and improved educational and employment outcomes (Olds, 1997). Universal programmes aimed at the prevention of common parenting problems in communities may also improve maternal psychosocial health (Barlow *et al.*, 2001).

Universal mental health promotion in schools has also been proven to be effective. Long-term programmes promoting the positive mental health of all pupils and involving changes to the school climate are likely to be more successful than brief class-based mental illness prevention interventions. Programmes that followed a whole-school approach continuously for more than a year were the most effective (Wells *et al.*, 2003).

Secondary prevention and promotion

There are such strong links between poor mental health, social exclusion and offending that secondary interventions aimed at reducing chronic exclusion are well-suited to addressing the many different needs of this vulnerable group of people.

For the last three years the Cabinet Office has supported a dozen programmes of work for Adults Facing Chronic Exclusion (ACE) (Cattell *et al.*, 2009). Although there is no set definition of adults facing chronic exclusion, people in these groups are likely to have characteristics such as a history of exclusion, institutionalisation

or abuse; behaviour and control difficulties; trouble forming and sustaining relationships; skills deficits; poor housing or homelessness; poor physical and mental health prospects; a history of offending; and limited economic and employment prospects. Combinations of problems vary, but these adults tend to have had long-term issues – often beginning in childhood – and have not engaged in sustained support from social services.

The twelve pilot schemes have been testing out ways to improve outcomes for adults with chaotic lives and multiple needs through developing new types of intervention and changing local service provision. They are led by voluntary and public sector organisations, working in partnership with other local agencies.

Several of the pilots have been working with offenders. For example, St Mungo's in London has been using new techniques to help socially isolated substance users to form and sustain relationships. It aimed to cut substance misuse and offending behaviour and encourage engagement with other services. Another pilot, After Adoption, has been targeting female offenders whose children have been, or are at risk of being, adopted. They provide integrated support that promotes positive relationships, coping skills and the integration of ex-offenders back into the community (Cattell *et al.*, 2009).

Early intervention in childhood could produce significant long-term benefits. The most common childhood mental health difficulties are conduct problems that include a range of oppositional or anti-social behaviour. Conduct disorder affects about 6% of all those aged between 5 and 16 years and can increase the likelihood of adverse outcomes throughout life, including offending (Sainsbury Centre, 2009b). Most crime is committed by a relatively small group of prolific offenders and the prevalence of serious conduct disorders during childhood is particularly high in this group.

A variety of methods and strategies have the potential to reduce conduct problems. These include parent training, home visits, day care and other forms of pre-school support, schools-based programmes including parent/teacher training and life skills training for children, family therapy for older children and more specialised clinical interventions such as multi-systemic therapy to support children and young people with clinically significant problems (Sainsbury Centre, 2009b).

Tertiary prevention and promotion

It might appear to be too late to promote and protect the mental health and wellbeing of those who have already come into contact with the criminal justice system. However, there is a range of innovative practice that makes a difference. Indeed there are some commentators who would argue that the criminal justice system provides a promising opportunity to intervene in the lives of those who are hardest to reach (Fraser, 2009).

For example, more than half of men in prison and almost three-quarters of women have no qualifications and poor literacy and numeracy skills (Social Exclusion Unit, 2002). Adults who cannot read or write tend to try to hide the fact. So for some, prison may be the first time they have tried to learn the basic skills most of us enjoy and rely upon to make progress in the world.

There have been advances in prison learning and skills in recent years. In 2000 the Toe-by-Toe Scheme (www.toe-by-toe.co.uk) initiative was set up to enable external mentors and prisoners with literacy skills to work with those who have poor skills. There are now 128 prisons participating. The scheme is adjusted to each prison and prisoner. It relies on the good will, enthusiasm and commitment of the people working in prisons and the fact that neither mentors nor mentored see the scheme as a part of 'formal' education. An evaluation published in 2005 concluded that it was a highly effective initiative that had a positive impact on offenders, particularly where mentors were peers – former or serving prisoners (O'Brien, 2010).

Creating healthy environments in prisons has also been identified as a way of protecting and promoting the mental wellbeing of inmates (WHO, 1998, 2008; Fraser, 2009). The Enhancing the Healing Environment (EHE) programme, which initially focused on improving acute hospital environments, has been extended to delivering improvements to the environment in which health care is delivered to prisoners (King's Fund & DH, 2010). In 2007 this programme was extended to a pilot group of prisons and Young Offender Institutions (YOIs) in London to improve environments such as health care, exercise yards, association areas, waiting rooms and a First Night Centre. Some enduring benefits, for both patients and staff, include

reduced aggressive behaviour and improved staff retention rates.

Enabling a person with a history of offending to get and keep a job is probably the most effective intervention anyone can make to prevent re-offending and improve their chances of leading a better life. The evidence that enabling people to get into employment reduces re-offending is unequivocal (Lipsey, 1995). Employment is also highly beneficial for people with mental health problems, even for those with serious mental illnesses. It not only helps with recovery from mental ill health but provides a route out of the poverty, isolation and exclusion that too many still experience (Sainsbury Centre, 2009c; Waddell & Burton, 2006).

The most effective existing UK and US schemes to help offenders into employment include the following characteristics:

- Direct links with employers, to facilitate rapid job-search and overcome any prejudices among employers;
- Support that continues 'through the gates' between prison and the community;
- In-work support once a person starts a job;
- Input from ex-offenders;
- Addressing multiple needs (Samele *et al.*, 2009).

Delivering the agenda

We already know quite a lot about the risk and protective factors that influence the mental health of offenders and those at risk of offending. This section examines what hampers effective action in this area, and how the perceived barriers might be overcome.

Re-investing resources

There are considerable resources 'locked up' in the criminal justice system that could be used more effectively. Government figures show that the overall cost of the criminal justice system has risen from 2% of GDP to 2.5% over the last ten years, representing a higher per capita level than the US or any EU country (Prison Reform Trust, 2009, p.6).

Medium-term investment could be used in supporting families and easing people's transitions into and out of prison as well as the long-term agenda of tackling the lottery of 'life chances' based on where people are born. Resources for building new prisons could perhaps more profitably – in broader public health terms – be redirected towards the NHS and more cost-effective services there.

Work carried out at the Washington State Institute for Public Policy highlights some of the savings that can be realised (Drake *et al.*, 2009). They conducted a systematic review and meta-analysis of evidence-based, cost effective interventions for crime reduction among adult and young offenders. They estimate benefits from the perspectives of taxpayers and crime victims, working on the assumption that if a programme can achieve statistically significant reductions in recidivism rates, taxpayers will spend less money on the criminal justice system. Similarly, if a programme results in less crime, there will be fewer crime victims.

The findings from 25 research studies of cognitive-behavioural programmes for adult offenders in prison and community settings showed an expected reduction in recidivism rates of 6.9%. The average cognitive-behavioural programme, for groups of 10 to 15 offenders and involving 40 to 60 hours of therapeutic time, costs about $107 per offender to administer. The 6.9% reduction in recidivism rates generates about $15,469 in life-cycle benefits associated with the crime reduction.

Seven rigorous evaluations of functional family therapy (FFT) found that the average FFT programme can be expected to reduce a young person's recidivism rate by 18.1%; and that, without the programme, a young person has a 70% chance of re-offending. An FFT-trained therapist works for about three months with young people in the juvenile justice system and their families. The programme costs, on average, $2,380 per juvenile participant. The costs are higher because it is a one-on-one programme between a FFT therapist and the young person and their family. The expected 18.1% reduction in recidivism rates generates about $52,156 in lifetime benefits, measured in terms of the taxpayer and crime victim costs that are avoided because of the reduced long-term level of criminal activity of the young person. Thus, the net present value of this juvenile justice programme is expected to be $49,776 per young person (Aos *et al.*, 2004).

An important finding is that even though many of the adult corrections programmes provided

a favourable return to taxpayers, there were some programmes for juvenile offenders that produced very significant long-term economic returns. For example, in addition to FFT, many other juvenile justice programmes were also shown to be effective at reducing crime and often produced a greater reduction in recidivism than adult programmes. Such programmes included an adolescent diversion project for lower risk offenders, multi-dimensional treatment foster care, and multi-systemic therapy for young people with a high risk of offending and their families (Drake *et al.*, 2009).

This analysis demonstrated the imperative of early intervention and corresponds to a Sainsbury Centre study on conduct disorders and their impact (Sainsbury Centre, 2009b). Most crime is committed by a relatively small group of prolific or chronic offenders who typically start offending at an early age. The prevalence of serious conduct problems during childhood is particularly high in this group. Overall around 80% of all criminal activity is attributable to people who had conduct problems in childhood and adolescence, including about 30% specifically associated with conduct disorder. The lifetime costs of crime committed by a single prolific offender are around £1.5 million. The total cost of crime attributable to people who had conduct problems in childhood is estimated at about £60 billion a year in England and Wales.

The best intervention programmes can reduce offending by 50% or more and those aimed at prevention or early intervention at pre-school age are the most effective. The costs of these interventions are relatively low, particularly when set against the scale of potential benefits. For example, group based pre-school parenting programmes cost only £600-£900 per child. Just 1% of the law and order budget would be sufficient to fund a comprehensive programme of pre-school support for 30% of all children born each year.

A different but equally innovative approach to reducing re-offending is the use of Social Impact Bonds. The bond is a contract between a public sector body and social impact bond investors, in which the former commits to pay for an improved social outcome. Investor funds are used to pay for a range of interventions to improve the social outcome. By enabling non-government investment to be utilised, Social Impact Bonds could lead to greater spending on preventative services. These interventions can have a direct impact on costly health and social problems (www.socialfinance.org.uk/services/index.php?page_ID=15).

Commissioning expertise

Commissioners do not always have the expertise in commissioning services that address these complex issues. There may be a misapprehension that this issue does not apply to a PCT without a local prison – and then only to purchase forensic services. Yet mental health and offending are major social and health inequalities in every community, throughout the life course and from generation to generation.

Where commissioners do invest in relevant services, they need a set of metrics to measure progress and contribute to the performance framework for public services. Public Service Agreements (PSAs) provided one means of testing progress against a range of indicators. Introduced more than ten years ago as part of the previous Government's comprehensive spending review process, PSAs played a vital role in stimulating public service delivery and driving major improvements in outcomes.

For example, PSA 16 aimed to reduce social exclusion among adults. It included two national indicators (NI) that related to offenders:

NI 143: Proportion of offenders under probation supervision living in settled and suitable accommodation at the end of their order or licence (relevant to resettlement and diversion);

NI 144: Offenders under probation supervision in employment at the end of their order or licence (relevant to resettlement, diversion and the project on employment of offenders).

Through a process of joint strategic needs assessments, local areas were able to prioritise their top 30 national indicators from among the 198 against which they have had to deliver (IDeA, 2010).

Partnership working

Partnership working between public health and criminal justice is under-developed. Work in this area is complex and demanding, requiring persistence and an understanding of how to influence and manage change in organisations

where the cultures and values are very different from those of public health.

A variety of approaches could be taken to develop the knowledge and skills of public health professionals, such as raising the profile of this issue at national conferences and regional and local seminars, improving opportunities during training and providing specialist supervision for work in criminal justice settings. These could be supported by the development of a special interest group for public health professionals working in criminal justice.

Likewise, a range of opportunities for multidisciplinary training, student placements, rotations and secondments could improve access to public health training opportunities for professionals across offender management agencies and institutions.

Local partnerships could do more to raise awareness of public health issues and engage and involve professions located at the margins of offender management in the health improvement of offenders – for example youth workers, accommodation providers and Jobcentre Plus staff (Shakespeare, 2006).

Total Place is a recent initiative to create a collaborative approach to service design and delivery. It has given local public services new freedoms from central performance and financial controls and involved services for a population of more than a million people (HM Treasury & DCLG, 2010).

One of the pilot sites in Luton and Central Bedfordshire identified an integrated offender management programme as one of its priorities. Not only did the pilot identify a surfeit of costly and complicated systems, it also found that the ineffective processes had been self-perpetuating and did not assist offenders to move beyond a life of criminality and exclusion. The pilot scheme tackled the inter-related issues of drug dependency, mental health and the broader issues of worklessness, access to benefits, jobs and social services. They also capitalised on existing multi-agency partnerships to improve the mental health and wellbeing of offenders (Mooney, 2010).

Conclusion

It is clear that many of the causes of offending are the same as those for mental ill health and wider social exclusion. The health and justice systems have converged in many ways to address the needs of offenders with mental health problems over the past two decades (Rutherford, 2010). What we now need is to extend that growing partnership to preventing mental ill health and offending and to promoting wellbeing among those in contact with the criminal justice system.

The Government has made clear its commitment to improving the population's health and to tackling health inequality (HM Government, 2010). A truly modern approach to these ambitions would be to pull together action to reduce offending and social exclusion with action to improve public health. Taking these important steps together is not only more likely to be cumulatively more effective in each domain, but also less costly to the public purse overall.

A national level champion would help to knit all of these strands into a coherent whole. The appointment of Professor Louis Appleby as the first National Clinical Director for Health and Criminal Justice holds out the promise that these diverse elements may now be combined to produce more effective outcomes (DH, 2010b).

Protection and promotion of the mental health and wellbeing of offenders goes far beyond, but still includes, care and treatment for those who are unwell. This policy paper has pointed to some of the many innovative programmes and interventions that target people and communities at high risk of social exclusion, poor mental health or offending. Public health practitioners, with their well-established multi-disciplinary roles, can lead and coordinate the vital work required to make a difference to the lives of individuals, their families and all of our communities.

In short, public health practitioners and their partners need to address the following question: "*What would we need to do to get the greatest number of children to the age of 21 years old in the best possible physical and emotional shape – ready for work, ready to develop good quality relationships, and able to support future generations effectively?*"

Interventions at a structural, community and individual level can improve public health. A humane society should be able to offer something of value even to those of its members with entrenched experiences of disenfranchisement. Our recommendations provide pointers to how this can be achieved.

Recommendations

Mapping exercise: There is a lot of money in the system, but too often it is spent in traditional and ineffective ways. It is imperative to map where investment is allocated, both locally and nationally. That map will identify the current balance of investment against what the ideal balance might be to achieve agreed outcomes. It will also inform a range of investment opportunities that highlight those most likely to achieve improved public mental health – a combination of quick wins plus longer-term results.

Risk profiling for commissioners: There is a pressing need for an effective way of profiling risks for commissioners that effectively describes the lives of these vulnerable groups. Any system must be as sensitive as possible to identifying and acting on individual, family, community and structural risks and their connections. Ideally a set of indicators that predict risk should be developed to enable commissioners to design and deliver effective services and to disinvest in those that are ineffective.

Connect work on mental health, social exclusion and offending: Those localities with prisons on their patch are not the only areas that should take an interest in offenders. The inextricable links between poor mental health, social exclusion and offending point to the importance of all primary care trusts and local authorities ensuring that these inter-connected policy and practice concerns are integral in their strategies for improving the mental health of their local population.

A brokerage role for Public Health: Public health has the potential to be a key player in drawing together the various services that work with this vulnerable group of people who often lead chaotic lives. Its long-established methods of collaborative working and expertise in addressing population health and wellbeing make it ideally placed to initiate prevention and promotion activities to protect and promote mental health among offenders and those at risk of offending.

Time for a public discourse on offending and mental health: Given how much is known about the issues of offending, mental health and social exclusion, what gets in the way of action? There are polarised debates about offending and crime, and public attitudes that are sometimes skewed towards retribution alone. An opportunity now exists to address these issues. The public will be engaged in debates in the coming period on a range of issues critical to society as a whole, such as the fiscal deficit and how best to manage its reduction. This process provides an opportunity to connect with people at all levels and to shift public perception.

Acknowledgements

This paper was written by Linda Seymour, Head of Policy at the former Sainsbury Centre for Mental Health. The final content was much improved by the input of a range of colleagues.

Centre for Mental Health colleagues who offered advice and guidance were:

Sean Duggan

Bob Grove

Lorraine Khan

Graham Durcan

Thanks also to the following colleagues for their contributions and helpful comments:

Dr Jo Nurse, National Lead for Public Mental Health and Wellbeing, Department of Health

Dr Steve Feast, Deputy CEO, NHS Luton

Alex Gatherer, WHO Health in Prisons Project

Angela Mawle, CEO, UK Public Health Association

Dr Ruth Shakespeare, Department of Health South West

Eoin McLennan-Murray, President, Prison Governors Association

Savas Hadjipavlou, Ministry of Justice

Helpful support and resources

The National Mental Health Development Unit (NMHDU) (www.nmhdu.org.uk) has produced a number of useful tools to facilitate commissioning for mental health. In particular its Joint Strategic Needs Assessment Toolkit (NMHDU, 2009) offers a practical guide to commissioning for both mental health and mental wellbeing services.

The Association of Public Health Observatories (APHO) (www.apho.org.uk) represents a network of 12 public health observatories (PHOs) working across the UK. It produces information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community. Each Observatory takes a lead on a range of different topics and the North East Observatory (www.nepho.org.uk) has responsibility for both mental health and offender issues.

The UK Public Health Association (UKPHA) (www.ukpha.org.uk) is an independent voluntary organisation that brings together individuals and organisations from all sectors who share a common commitment to promoting the public's health. UKPHA provides a unifying and powerful voice for the public's health and wellbeing in the UK, focusing on the need to eliminate inequalities in health, promote sustainable development and combat anti-health forces. It has a special interest group which focuses on public mental health (www.ukpha.org.uk/special-interest-groups/public-mental-health.aspx).

References

Aos, S., Lieb, R., Mayfield, J., Miller, M. & Pennucci, A. (2004) *Benefits and costs of prevention and early intervention programmes for youth: Technical appendix (Document No. 04–07–3901)*. Olympia, WA: Washington State Institute for Public Policy.

Auld, M.C. & Sidhu, N. (2005) Schooling, cognitive ability and health. *Health Economics*, **14** (10) 1019-1034.

Bambra, C., Joyce, K. & Maryon-Davis, A. (2009) *Task Group on Priority Public Health Conditions: Final Report. Submission to the Marmot Review.* (www.ucl.ac.uk/gheg/marmotreview/consultation/Priority_public_health_conditions_summary)

Barlow, J., Coren, E., & Stewart-Brown, S. (2001) *Systematic Review of the Effectiveness of Parenting Programmes in Improving Maternal Psychosocial Health.* Oxford: Health Services Research Unit, University of Oxford.

Basher, D. & Nurse, J. (2008) *Regional Public Health Group Fact Sheet. Offender Health*. South East Regional Public Health Group. (www.sepho.org.uk/viewResource.aspx?id=11539)

Cattell, J., Hitchins, T. & Mackie, A. (2009) *ACE Evaluation Interim Report*. (www.cabinetoffice.gov.uk/media/342005/ace231209final.pdf)

DH (2001) *Making it Happen: A guide to delivering mental health promotion*. London: Department of Health. (www.publications.doh.gov.uk/pdfs/makingithappen.pdf)

DH (2010a) *Confident Communities, Brighter Futures. A framework for developing well-being*. London: Department of Health. (www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114775.pdf)

DH (2010b) *First Health and Criminal Justice Tsar announced*. Press Release 23 March. (www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_114478)

Drake, E.K., Aos, S. & Miller, M.G. (2009) Evidence-based public policy options to reduce crime and criminal justice costs: implications in Washington State. *Victims and Offenders*, **4**, 170-196. (www.wsipp.wa.gov/rptfiles/09-00-1201.pdf)

Easley, C. (2009) *Prison healthcare and public health. Sainsbury Centre Lecture* (see www.centreformentalhealth.org.uk).

Farrington, D.P. (2006) Childhood Risk Factors. In: Maguire, M., Morgan, R. & Reiner, R. (eds). *The Oxford Handbook of Criminology* (4th edition). Oxford: Oxford University Press.

Fazel, S. & Danesh, J. (2002) Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. *The Lancet,* **359**, 545-550.

Fergusson, D.M., Horwood, L.J. & Ridder, E.M. (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology*, **46**, 837-49.

Fraser, A. (2009) Mental health in prisons: a public health agenda. *International Journal of Prisoner Health,* **5** (3) 132-140.

Friedli, L. (2009) *Mental Health, Resilience and Inequalities*. Copenhagen: WHO Regional Office for Europe. (www.euro.who.int/document/e92227.pdf)

Goggins, P. (2004) Minister for prisons and probation speaking in a debate on prisons and mental health. *Hansard,* 17 March 2004.

Heckman, J.J., Stixrud, J. & Urzua, S. (2006) The effects of cognitive and noncognitive abilities on labor market outcomes and social behavior. *Journal of Labor Economics,* **24** (3) 411-482.

HM Chief Inspector of Prisons for England and Wales (2008) *Annual Report 2006-07*. London: HM Inspectorate of Prisons.

HM Government (2010) *The Coalition: Our programme for government*. London: Cabinet Office. (www.cabinetoffice.gov.uk/media/409088/pfg_coalition.pdf)

HM Treasury & DCLG (2010) *Total Place: A whole area approach to public services*. London: HM Treasury. (www.hm-treasury.gov.uk/psr_total_place.htm)

IDEA (2010) *LAAs 2008-2011 – including 2010 refresh*. (www.idea.gov.uk/idk/core/page.do?pageId=8399555)

King's Fund & Department of Health (2010) *Enhancing the Healing Environment*. (www.kingsfund.org.uk/current_projects/enhancing_the_healing_environment/findings.html#inbrief)

Lipsey, M. (1995) What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents? In: McGuire, J. (ed) *What Works: Reducing Reoffending: Guidelines from research and practice*. West Sussex, England: John Wiley & Sons.

McManus, S., Meltzer, H., Brugha, T., Bebbington, P. & Jenkins, R. (eds) (2009) *Adult Psychiatric Morbidity in England: Results of a household survey.* The NHS Information Centre. (www.ic.nhs.uk/pubs/psychiatricmorbidity07)

Mair, G. & May, C. (2007) *The Use and Impact of the Community Order and the Suspended Sentence Order*. London: CCJS, p.9.

Marmot, M. (2010) *Fair Society, Healthy Lives. The Marmot Review.* (www.ucl.ac.uk/marmotreview)

Ministry of Justice (2008) *Statistics on Race and the Criminal Justice System – 2006-7*. London: Ministry of Justice.

Ministry of Justice (2010) *Prison Population and Accommodation Briefing for April 23 2010*. (www.hmprisonservice.gov.uk/resourcecentre/publicationsdocuments/index.asp?cat=85)

Mooney, H. (2010) Total Place – Part 2: Why working together boosts independence. *Health Service Journal,* 11 February, pp.22-23.

NMHDU (2009) *Joint Strategic Needs Assessment and Mental Health Commissioning Toolkit: A Practical Guide*. London: NMHDU. (www.nmhdu.org.uk/silo/files/joint-strategic-needs-assessment-and-mental-health-commissioning-toolkit-2009.doc)

New Economics Foundation (2008) *Unlocking Value: How we all benefit from investing in alternatives to prison for women offenders*. London: New Economics Foundation.

O'Brien, R. (2010) *The Learning Prison*. London: RSA. (http://www.thersa.org/projects/past-projects/prison-learning-network/reports/the-learning-prison#report)

Office for National Statistics (2001) *2001 Census*. (www.statistics.gov.uk/cci/nugget.asp?id=263)

Olds, D.L., Eckenrode, J., Henderson, C.R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, P., Pettitt, L.M. & Luckey, D. (1997) Long-term effects of home visitation on maternal

life course and child abuse and neglect: fifteen year follow up of a randomised trial. *Journal of American Medical Association,* **278** (8) 637-43.

Prison Reform Trust (2009) *Bromley Briefings. Prison Factfile*. (www.prisonreformtrust.org.uk)

Rutherford, M. (2010) *Blurring the Boundaries: The convergence of mental health and criminal justice policy, legislation, systems and practice*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre (2008) *In the Dark: The mental health implications of Imprisonment for Public Protection*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre (2009a) *Commissioning Mental Health Care in the Criminal Justice System: 10 Top Tips for PCT Boards*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre (2009b) *The Chance of a Lifetime: Preventing early conduct problems and reducing crime*. London: Sainsbury Centre for Mental Health.

Sainsbury Centre (2009c) *Briefing Paper 37: Doing what works, individual placement and support into employment*. London: Sainsbury Centre for Mental Health.

Samele, C., Keil, J. & Thomas, S. (2009) *Securing Employment for Offenders with Mental Health Problems: Towards a better way*. London: Sainsbury Centre for Mental Health.

Shakespeare, R. (2006) *Discussion Paper: Strengthening delivery of a public health approach to offending*. (Unpublished)

Singleton, N., Meltzer, H. & Gatward, R. (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office for National Statistics.

Social Exclusion Unit (2002) *Reducing Re-offending by Ex-prisoners*. London: Office of the Deputy Prime Minister.

Solomon, E. & Silvestri, A. (2008) *Community Sentences Digest. Second edition*. London. Centre for Crime and Justice Studies. (www.crimeandjustice.org.uk/opus946/community-sentences-2008.pdf)

Targosz, S., Bebbington, P., Lewis, G., Brugha, T., Jenkins, R., Farrell, M. & Meltzer, H. (2003) Lone mothers, social exclusion and depression. *Psychological Medicine,* **33** (4) 715-722.

Waddell, G., & Burton, K. (2006) *Is Work Good for your Health and Wellbeing?* London: Stationery Office.

Wells, J., Barlow, J. & Stewart-Brown, S. (2003) A systematic review of universal approaches to mental health promotion in schools. *Health Education,* **103** (4) 197-220.

World Health Organisation (1998) *Mental Health Promotion in Prisons: Report on a WHO meeting. The Hague, Netherlands 18-21 November 1998*. (www.who.dk)

World Health Organisation (2003) *Investing in Mental Health*. Geneva: WHO. (www.who.int/mental_health/media/investing_mnh.pdf).

World Health Organisation (2008) *Background Paper for Trencin Statement on Prisons and Mental Health: Towards best practices in developing prison mental health systems.*

Public health and criminal justice

Promoting and protecting offenders' mental health and wellbeing

Linda Seymour

Register for our monthly email bulletins and copies of new briefing papers at www.centreformentalhealth.org.uk

Centre for Mental Health

Realising a better future

Centre for Mental Health
134–138 Borough High Street, London SE1 1LB

T 020 7827 8300

F 020 7827 8369

www.centreformentalhealth.org.uk

Charity registration no. 1091156. A Company limited by guarantee registered in England and Wales no. 4373019.