



REPORT

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Short-changed

Spending on Prison Mental Health Care

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Summary

Last year, £20.8 million was spent on mental health care in prisons through inreach teams. This is 11% of total prison health care spending or just over £300 for each member of the prison population.

Prison inreach teams aim to provide the specialist mental health services to people in prison that are provided by community-based mental health teams for the population at large. But inreach teams have been hindered by limited resourcing, constraints imposed by the prison environment, difficulties in ensuring continuity of care and wide variations in local practice.

Government policy for prison health care is based on the principle of equivalence. This means that standards of care for people in prison should be the same as those available in the community at large, relative to need.

The level of need for mental health care in prisons is particularly high, because of the much greater prevalence of mental illness, especially severe mental illness, among prisoners than among people of working age in the general population.

While more is spent per head on mental health care in prisons than in the wider community, this is not nearly enough to accommodate this much higher level of need.

The resources currently available for mental health care in prisons are only about a third of the amount required to deliver the policy objective of equivalence.

Spending on prison mental health care also varies widely across the country. In London and in the North East, Yorkshire and Humber, the NHS spends more than twice as much per prisoner than it does in the East Midlands and the South West. This variation cannot be explained by different levels of need or costs: it amounts to a postcode lottery in prison mental health care.

Major investment is needed in the overall level of provision for mental health care in prisons and in its geographical allocation if equivalence is ever to be achieved.

Introduction

This report analyses public spending on mental health care in prisons. It compares spending between different regions, by type of prison and in comparison with spending on all types of health care in prisons and with mental health spending in the wider community.

The main questions it seeks to answer are:

Taking into account relevant differences in need, are standards of mental health care for people in prison broadly comparable to those available in the community at large, in line with the Government's policy of 'equivalence'?

To what extent is there a postcode lottery in the provision of prison mental health care, as reflected in differences in spending per head between localities or types of prison?

Detailed information on the sources of data used in the analysis is set out in an accompanying annex. Unless otherwise stated, all data relate to planned or estimated out-turn expenditure in England in financial year 2007/08.

As explained in the annex, our estimates of prison mental health spending relate to the cost of all services provided by mental health inreach teams in publicly run prisons. The figures thus exclude inreach costs in privately run prisons and also the costs of mental health-related primary care services in all prisons, as provided for example by local GP practices.

Mental ill health in prison

Prisoners are among the most socially excluded groups in society. Compared with the general population, they are:

- thirteen times more likely to have been in care as a child;
- thirteen times more likely to be unemployed;
- ten times more likely to have been a regular truant; and
- fifteen times more likely to have HIV (Social Exclusion Unit, 2002).

Prisoners also have very high rates of mental ill health of all kinds. An estimated 10% of remanded men and 14% of all female prisoners have experienced a psychotic illness in the previous 12 months (Singleton et al. 1998). Some 16% of all British prisoners have four or five co-existing mental health disorders. There are high rates of self-harm and suicide – it has been calculated that the risk of a prisoner committing suicide is seven times higher than for the general population (Mental Health Foundation, 1999).

Despite these high levels of mental distress, there has been relatively little investment in services for prisoners experiencing them.

Prison mental health services

In 2006, the NHS took over responsibility for health services in all prisons in England and Wales. Before that, the Prison Health Service was responsible for providing the majority of health care. Almost all services were provided in-house. Staff, including doctors, prison health care officers and nurses, were directly employed by HM Prison Service.

The development of mental health care in prisons lagged behind that on offer outside. While more mental health care in the wider community was being delivered by multi-disciplinary community mental health teams, most care in prisons was dependent on input from visiting forensic psychiatrists (Birmingham, 2003).

That began to change in 1996. The then chief inspector of prisons, David Ramsbotham, reported on the poor quality of health care available to prisoners and introduced the principle of equivalence. His report stated:

“Prisoners are entitled to the same level of health care 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.” (HM Inspectorate of Prisons, 1996)

The Prison Service and NHS Executive developed practical proposals to deliver equivalent care for prisoners in The Future Organisation of Prison Health Care (Joint Prison Service and National Health Service Executive Working Group, 1999). It rejected calls for responsibility for all prison health care to be assumed solely by the NHS on the grounds that health care staff working in prisons might become marginalised and that neither the NHS nor the Prison Service could provide health care for prisoners without the expertise or co-operation of the other. It therefore recommended partnership working, whereby the two organisations were to become jointly responsible for identifying the health needs of prisoners in their area and for planning and commissioning appropriate services.

A specific strategy for mental health, Changing the Outlook, was published in 2001 (Department of Health, 2001). It acknowledged that most prisoners with mental health problems are not so ill that they need to be detained in hospital under mental health legislation and that, if they were not in prison, they would be receiving treatment in the community. This heralded a move away from the historically held assumption that prisoners with mental health problems should be located in prison health care centres. To support prisoners with mental health problems to remain on normal location would require the establishment of multi-disciplinary mental health inreach teams, funded by local primary care trusts (PCTs), to provide specialist mental health services to patients in the same way as community-based mental health teams do to patients in the community.

Changing the Outlook anticipated that all prisoners would eventually benefit from the introduction of inreach services. But the early focus of the teams' work would be on those with severe and enduring mental illness, utilising the principles of the Care Programme Approach (CPA) to help ensure continuity of care between prison and community upon release from custody.

Implementing inreach

The Government's initial aim of recruiting 300 extra staff to implement inreach has been fulfilled. There are now over 350 mental health inreach workers providing services to people with severe mental illness in 102 prisons (Brooker, Gojkovic and Shaw, 2008).

The original intention for inreach services to target those with severe and enduring mental illness has changed. National policy has been broadened to include all those in prison with any mental health problem and, in some prisons, providing services which focus on prisoners with personality disorders (Brooker et al., 2005). Other models of community-based care now established for the wider population, for example assertive outreach and crisis resolution teams, have not yet been introduced into prisons. In order to provide an equivalent service, inreach teams should take on board these roles too.

Inreach services have developed using limited and, in some cases, idiosyncratic models of care. Official guidance on the development and operation of inreach services has deliberately been non-prescriptive (Department of Health, 2001). While this supports efforts to develop services specifically designed to suit local circumstances, innovative commissioning by primary care trusts may be necessary to sustain the initial momentum to deliver care of an equivalent standard nationwide (Steel et al., 2007).

There are a number of other extra hurdles for inreach teams to establish an equivalent service. First, it can be difficult to identify severe mental illness, particularly where inreach teams are reliant on prisoners' own reports at reception health screening. They may also get referrals of prisoners whose mental health problems are less severe but who come to the attention of prison staff because of disciplinary issues (Meiklejohn et al., 2004).

Second, it can be difficult to implement the Care Programme Approach (CPA) in secure settings. A quarter of inreach clients are not on the CPA, despite having severe and enduring mental health problems. Inreach teams have faced difficulties getting community services to engage with patients who are about to be released, particularly where there are limited resources (Meiklejohn et al., 2004) and when prisoners do not live nearby. Concerns have also been raised about how best to include prisoners' carers in the CPA process. It may be impractical or near impossible to involve family members in care planning within the prison setting. Concerns about information sharing and confidentiality may also make effective implementation and co-ordination of the CPA problematic.

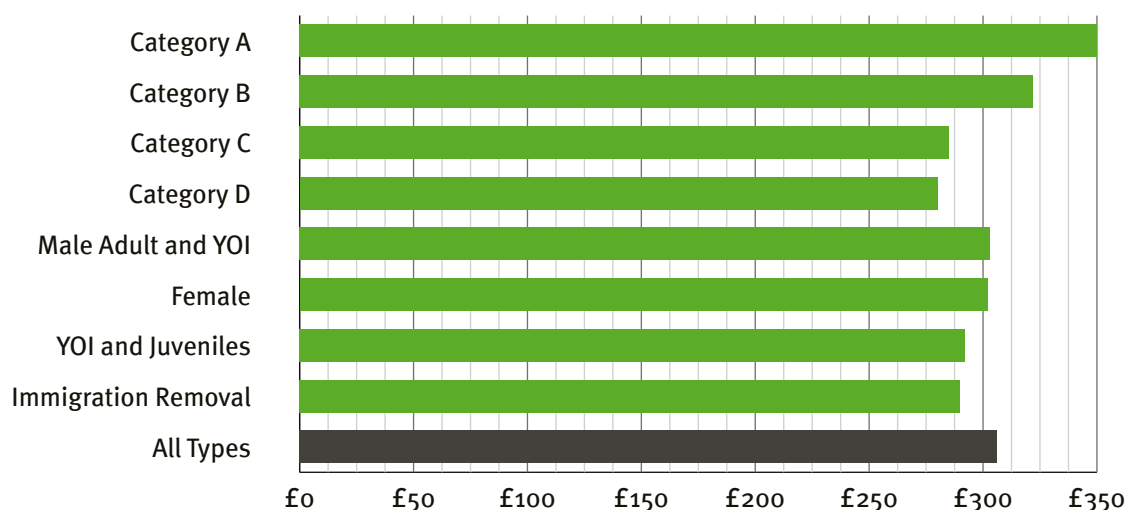
Most of the clinical activity undertaken by inreach teams is focused on assessment and liaison or support. There is very little face-to-face therapeutic activity.

The second national survey of prison mental health inreach teams (Brooker, Gojkovic and Shaw, 2008) provides a picture of how inreach teams have developed over the preceding three year period. It reported that the median clinical team size has grown from three to four whole-time equivalents. But referrals to inreach teams have increased by 57% and caseload size has risen by one third. The overall number of prisoners now on inreach caseloads is about 4,700. It is therefore unsurprising that 85% of team leaders state that their teams are inadequately staffed.

Prison inreach spending variations

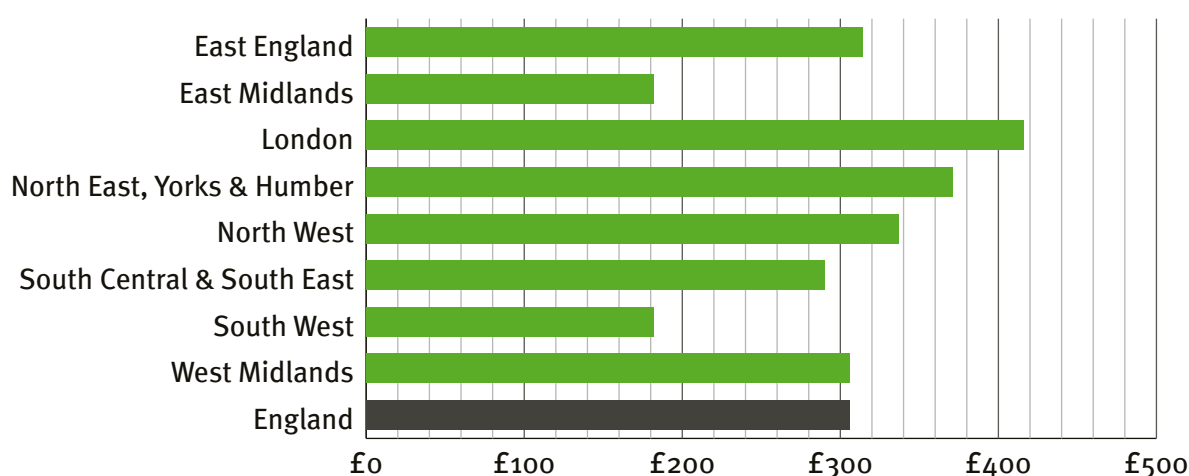
Total expenditure on prison mental health care is estimated at £20.8 million in England in 2007/08. This is equivalent to £306 per head of the population in publicly run prisons. Figures 1 and 2 show mental health expenditure per prisoner by type of prison and by region respectively.

Figure 1: Prison mental health spending by type of prison



Compared with a national average of £306, mental health spending per prisoner ranges from a low of £280 in Category D prisons to a high of £350 in Category A prisons, a difference of 25%. This is a relatively limited variation. There are no reliable figures on the prevalence and severity of mental health problems in each category of prison. It is therefore not possible to comment in any detail on the appropriateness or otherwise of the variations in spending per prisoner shown in the table. One point perhaps worth noting is that expenditure per head in female prisons looks to be relatively low, given the evidence that the scale of mental ill health among women in prison is believed to be even greater than it is among men, particularly in relation to the risk of suicide or self-harm (Corston, 2007).

Figure 2: Prison mental health spending by region



There is, however, substantial regional variation in mental health spending per prisoner. Expenditure per head ranges from a low of £182 in the East Midlands and in the South West to a high of £416 in London, a difference of nearly 130%. While 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 than in the East Midlands and in the South West.

Another possible explanation for regional differences in spending is variation in the mix of prisons by category or type. But this is unlikely to be a major contributor, given the evidence of relatively limited variation in per capita spending by type of prison.

It may also be argued that there are regional variations in the underlying need for prison mental health care. But it is implausible that variations in the prevalence and severity of mental health problems are on a scale sufficient to explain the observed differences in spending per head.

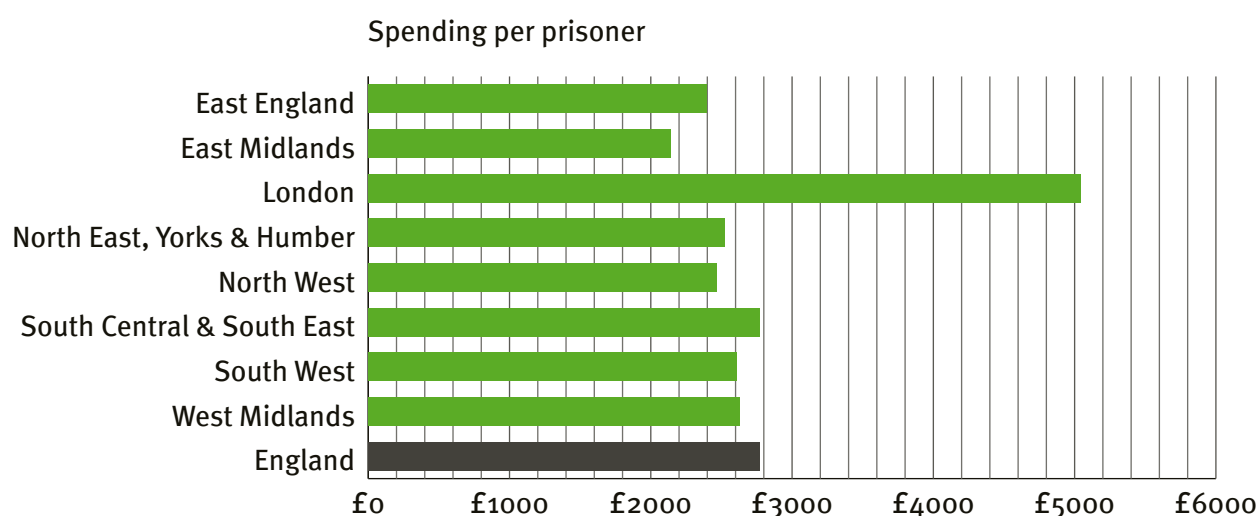
Taking into account all these points, it is hard to avoid the conclusion that standards of mental health care in prisons vary substantially depending solely on location.

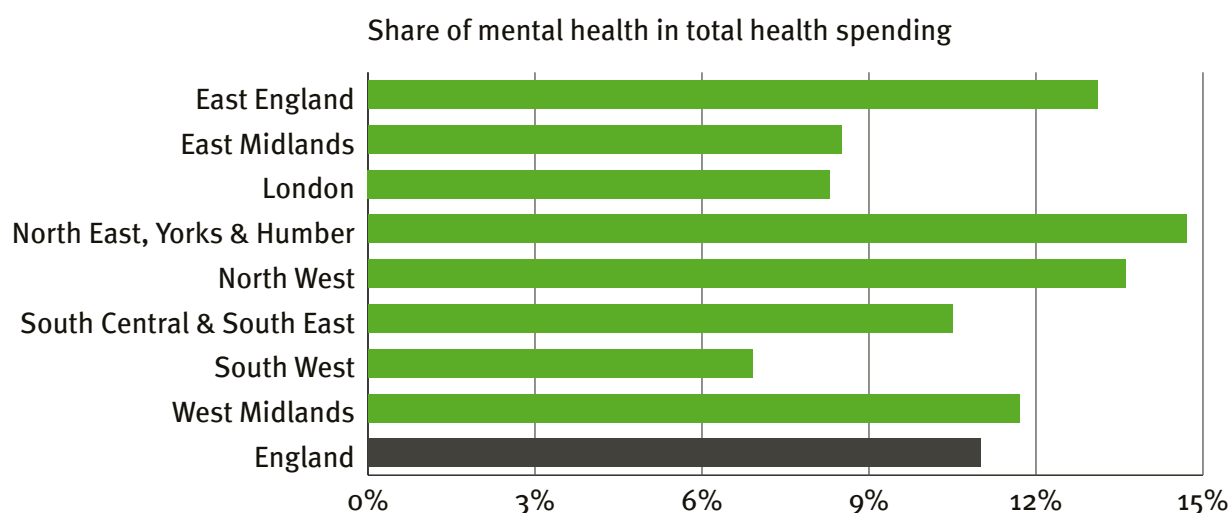
Variations in overall health spending

One possible reason for the unexplained regional variations in prison mental health expenditure described above is that they reflect wider differences in overall spending on prison health care, covering physical as well as mental health conditions.

Planned spending on all types of health care in prisons amounted to £189 million in England in 2007/08, equivalent to £2,769 per prisoner. As noted above, spending on mental health care was £20.8 million, which represents 11% of the total. Relevant figures for each region are shown in Figure 3.

Figure 3: Overall spending on prison health care





Leaving aside 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 spent 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 health care per prisoner as any other region in the country. This is why London 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 health care generally than the North East, Yorkshire & Humber region, but less than half as much on mental health care. While this is an extreme example, it does imply that there are major inequities in the resourcing of prison mental health services around the country which merit further investigation.

The observed differences in spending do not appear to be explicable on the basis of regional variations in wider prison health spending or any other objective factor.

Equivalence

We also examined whether the standards of mental health care available to people in prison are broadly the same as those available to the population at large. To determine this we need to know:

What is the underlying level of need for mental health care in prisons relative to the level of need in the wider community?

Taking into account any such differences in need, how does mental health spending per head compare in the two settings?

The prevalence of mental health problems is extremely high in the prison population, in this country as elsewhere. Table 1 compares the prevalence of mental health problems among prisoners compared with prevalence among adults of working age in the general population.

Table 1: Prevalence of mental health problems

Type of problem	Prevalence among prisoners	Prevalence in general population (adults of working age)
Psychosis	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%
Source	(Singleton et al., 1998)	(Singleton et al., 2001)

Note: men account for about 95% of people in prison. The prevalence rates shown above are therefore weighted averages (with weights of 0.95 for men and 0.05 for women) both for people in prison and for people of working age in the general population, to ensure that the comparisons are on a like-for-like basis.

Over 90% of prisoners have at least one kind of mental health problem, a rate of prevalence which is four times the corresponding rate in the wider community. Taken at face value, this difference in underlying need suggests that, to achieve equivalence, spending per head on prison mental health care should similarly be around four times as large as the equivalent level of spending on working-age adults generally.

In fact, this simple comparison significantly understates the level of spending needed in prisons, for two main reasons. First, multiple problems are much more common in the prison population than in the wider community. More than seven out of ten prisoners have two or more problems (against one in 25 in the general population) and those with a psychosis are likely to have three or four other problems at the same time. Multiple diagnoses add significantly to the complexity and hence the costs of care.

Second, the differences in prevalence vary greatly by type of mental health problem and are largest in relative terms for the most serious disorders, particularly psychosis. Common conditions such as depression and anxiety are by far the most widespread types of mental health problem in the general population. They are very largely dealt with in primary care, rarely requiring specialist provision from community-based mental health teams. These common mental health problems are about three times as prevalent in prisons as in the general community.

In contrast, the prevalence of psychosis is 15-20 times higher among prisoners than in the population at large. This accounts for the bulk of specialist mental health provision, in prisons and the community. The estimated number of people in prison with psychosis (at a prevalence rate of about one in 12) is about 6,500, whereas the total number of prisoners on inreach caseloads is currently about 4,700.

In broad terms, the principle of equivalence would require mental health spending to be about 20 times larger per head than in the general population, taking into account both the much higher prevalence of severe mental illness in prisons and the greater complexity of cases associated with multiple diagnoses.

Comparing spending in prisons and the community

Spending on prison mental health care 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 (Mental Health Strategies, 2007), total expenditure on mental health care for adults of working age is estimated at £169 per head in 2007/08.

To compare this directly with the figure of £306 for prison mental health care would not, however, be a like-for-like comparison, as the community figure includes spending on a range of services which are not covered in the estimate for prisons, most obviously inpatient and residential care.

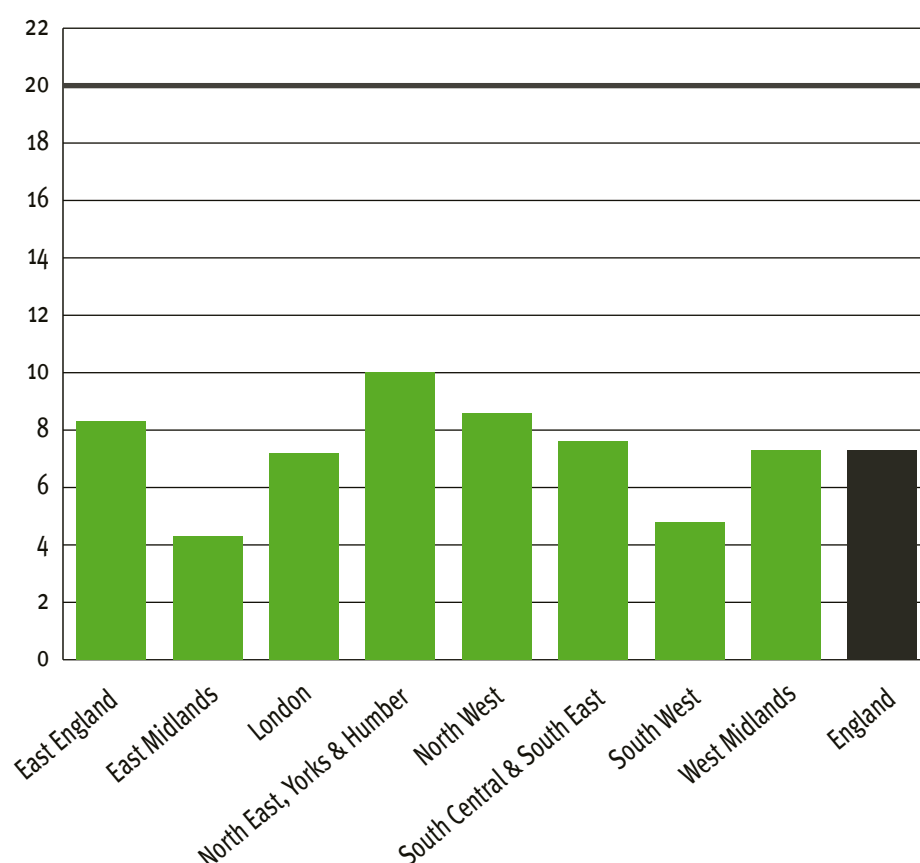
In general terms, prison inreach teams are intended to provide broadly the same type and mix of services to prisoners as are available to people with severe mental health problems who are living at home. In the absence of a precise definition of what this provision should include, two alternative measures are suggested here: a broad one including spending on all non-inpatient/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 health care is between 3.9 and 7.3 times as large as per capita spending in the adult population at large. This is a significant difference, but still well short of the broad multiple of 20 that is needed.

In short, it seems that substantial extra provision of mental health care is required in prisons to achieve equivalence.

Figure 4 sets out estimates by region of comparative spending on mental health services in prisons and in the community at large (using the narrower of the two measures described above).

Figure 4: comparison of mental health spending in prisons and in the wider community



Using the narrow definition of community spending for ease of exposition, per capita spending on prison mental health care ranges from 4.3 times per capita spending on working-age adults living in the community in the East Midlands region to 10.0 times in the North East, Yorkshire & Humber region. Even in the latter case, the multiple is only about half the figure of 20 suggested by the data on prevalence.

As on other measures, the East Midlands and South West regions can be depicted as low spenders on prison mental health services and the North East, Yorkshire & Humber and North West regions as relatively high spenders. Again the general picture which emerges is one of substantial regional variation in spending on mental health care, whether this is measured in absolute terms or relative to levels of mental health spending in the wider community.

Conclusions

Recent years have seen significant changes in the organisation, funding and staffing of mental health services for people in prison. The key policy objective underlying these changes is to achieve equivalence: so that standards of care for prisoners with mental health problems are broadly comparable to those available to their counterparts in society at large. The key delivery mechanism for equivalence has been to set up dedicated prison mental health inreach teams. Considerable progress has been made in implementing the inreach programme, but coverage remains patchy and there is much variation between localities in the way that the teams operate.

Based on a detailed analysis of spending data, linked to national survey information on the prevalence of mental health problems among prisoners, this paper provides some new evidence on the extent to which equivalence has so far been secured and also on the extent of geographical variation in the provision of prison mental health care.

While more money is spent per head on mental health care in prisons than in the community at large, the extra expenditure falls well short of the amount required to deliver comparable standards of care given the very much higher prevalence of mental ill health, particularly severe mental illness, in the prison population. Our broad assessment is that the resources currently available for mental health care in prisons are only about a third of the level needed to achieve equivalence.

Spending on prison mental health care varies substantially around the country. Expenditure in the two highest spending regions is more than twice as high per head as in the two lowest spending regions. It does not appear that these variations can be explained, other than in small part, by objective reasons such as geographical differences in costs (for example of staffing). Nor are they associated with variations in spending on prison health care more generally. In other words, standards of mental health care in prisons vary substantially depending solely on location.

Both these forms of inequality carry important messages for national policy makers and for local commissioners and providers of prison mental health services. The concept of equivalence must mean not just the comparability of standards between prisons and the wider community but also between prisons in different parts of the country. Significant improvements are needed in the overall level of provision for prison mental health care and in its geographical allocation to secure this fundamental objective of policy.

Annex: Data Sources

Three sets of expenditure data for England in financial year 2007/08 are used in the analyses presented in the main body of the paper. These are:

1. Expenditure on mental health services in prisons

As noted in the main text, these data relate to the cost of services provided by prison mental health inreach teams operating in publicly run prisons (which account for 90% of the total prison population in England). Costs are based on the numbers of staff working in inreach teams in 2007, as reported in the second national survey of inreach teams (Brooker, Gojkovic and Shaw, 2008). The survey provides data on a prison-by-prison basis.

Using the assumption that prison inreach teams are broadly the same as community mental health teams (CMHTs) in terms of staff mix and grading, staff numbers have been converted to expenditure equivalents using the estimated unit cost of a representative member of a CMHT, as given in the PSSRU publication 'Unit Costs of Health and Social Care 2007' (Curtis, 2007). The costs include wage/salary costs, on-costs such as national insurance contributions, and also an allowance for overheads such as administrative and management costs. The unit costs given in the PSSRU publication relate to 2006/07 and have been uprated to 2007/08 values on the assumption that the NHS pay and prices index increased by the same percentage amount in 2007/08 as in the previous year. A figure for the latter increase is given in the PSSRU report.

These calculations yield estimates of total spending on mental health inreach services for every individual prison in England in 2007/08, which can then be aggregated by region and by type of establishment. Figures for spending per prisoner are based on data for the numbers of prisoners in each prison given in HM Prison Service (2007).

2. Expenditure on all health services in prisons

These are Department of Health figures relating to planned spending on all prison health services in 2007/08, at national and regional levels.

3. Expenditure on mental services in the general population of working age

The estimates of expenditure on these services are based on figures given in the 2006/07 national survey of investment in mental health services, prepared for the Department of Health by the consultancy firm Mental Health Strategies (Mental Health Strategies, 2007). The survey gives details of all spending on the specialist mental health services provided by the NHS and local authorities for adults of working age in England, including breakdowns of expenditure by region and by type of service (CMHT services, inpatient services, day services etc).

The data have been converted to 2007/08 equivalents on the assumption that spending increased in 2007/08 by the same percentage amount as in the previous year. Figures for spending per head are based on the population numbers for 2006/07 quoted in the Mental Health Strategies report, increased by 0.4% to allow for growth in the size of the working-age population in 2007/08, in line with official projections (Government Actuary's Department, 2007).

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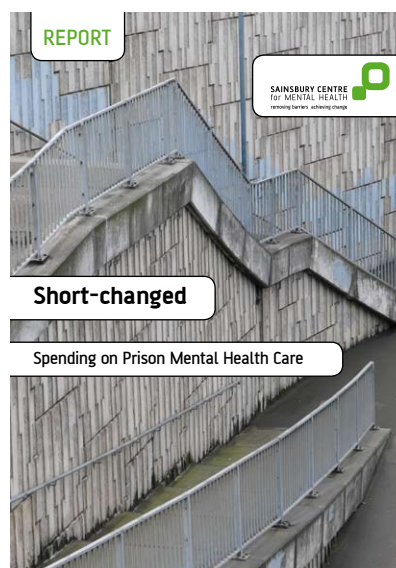
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