

Waiting on the Wings

A review of the costs and benefits of secure psychiatric hospital care for people in the criminal justice system with severe mental health problems

Dr. Judy Renshaw



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About Laing & Buisson: Laing & Buisson is the leading provider of authoritative data, statistics, analysis and market intelligence on the UK health market. Examples of recent work include a report on the future of the independent healthcare sector for the Healthcare Commission, the seminal work conducted by Laing & Buisson on 'A Fair Price for Care' for the Joseph Rowntree Foundation and 'Improving Lives – Improving Life', a report on the key strategic issues facing the long term care sector.

About Dr. Judy Renshaw: Judy Renshaw is a researcher working with a range of organisations. Her recent work has included a study of young offenders on life and long term sentences, a cost benefit study of a resettlement programme for young offenders, evaluation of the national mentoring pilot for young people who are looked after by local authorities and a cost-benefit analysis of a housing and support service for women ex-prisoners. Previously she carried out national studies for the Audit Commission including *Misspent Youth*, *Youth Justice 2004* and mental health services for adults and older people.

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Foreword

Laing & Buisson is pleased and proud to be presenting this report – ‘Waiting on the Wings: A review of the costs and benefits of secure psychiatric hospital care for prisoners with severe mental health problems’.

The production of this report has been made possible by the support of Partnerships in Care, the largest independent provider of secure mental health facilities across the UK.

We had significant assistance and encouragement from major providers of services for people in the criminal justice system. In particular, our thanks go to Her Majesty’s Prison Service, Partnerships in Care and Serco Group plc, the international services company that run and manage four adult prisons, two young offender centres and two immigration removal centres in Britain. Without these providers of services for people in the criminal justice system, this research would not have been possible.

It has proved surprisingly difficult to extract the data and information that constitute the body of this report. The case for common data sets that can easily contrast and compare costs in criminal justice and health is compelling. Indeed it is difficult to see how policy development and planning can be effective without such comparative information. We hope that this report will act as a catalyst for informed debate at the interface of health and criminal justice.

Of the 84,000 people currently in prison, around 90% have at least one diagnosed mental illness. We believe that the vast majority of these people can be treated effectively in prison. However, there exists within the prison population a group of men and women with severe psychiatric disorders who require intensive specialist treatment. This specialist treatment is not available in prisons and so these severely mentally ill people remain in prison to the detriment of their own mental health and chances for rehabilitation.

A number of recent reports from charities and think-tanks have highlighted the need for significant action on mental healthcare for prisoners. The Department of Health and Ministry of Justice especially are taking important steps that will hopefully change the current situation. Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system contained many welcome recommendations and we hope they are implemented with vigour.

Our work with Partnerships in Care and Serco has shown us that the diversion of severely mentally disordered offenders out of prison and into secure hospitals reduces pressure on the prison system and provides real savings for society by reducing reoffending. This report seeks to quantify those savings and show that through appropriate treatment of the severely mentally ill, we can improve the criminal justice system and so prevent our prisons becoming the 21st century asylums.



William Laing
Laing & Buisson
January 2010

Executive Summary

- Mental health problems among prisoners are very common and a small minority of these prisoners require treatment in psychiatric hospital.
- Providing high quality psychiatric care for mentally ill offenders will save money for the taxpayer.
- The reduced risk of reoffending as a result of hospital treatment could lead to a saving to society of over £600,000 over a prisoner’s lifetime for each prisoner transferred out of prison into secure hospitals.
- There is a need for better mental healthcare in prisons and caring for mentally ill prisoners is very costly for the prison service.
- The risks and the costs of reoffending by severely mentally ill prisoners who do not receive appropriate treatment are high.
- High quality treatment is effective in reducing reoffending and the risks to the public are significantly lower after treatment.
- Even those with the most problematic conditions can be treated and many patients with personality disorders can be helped to change their behaviour.
- Treatment needs to be given for a sufficiently long period and staying for at least 18 months seems to be more effective than shorter stays.
- Follow up after discharge is essential and monitoring and support is likely to be needed for several years.
- In 2007, 1,458 offenders were diverted into hospital settings. However, this number should be twice as large.
- The extra hospital capacity required to meet the needs of people with severe mental illness is ready for immediate use yet existing commissioning data ignores this empty capacity.
- The immediate cost of accommodating in prison the offenders in England and Wales with severe mental health problems who have not been diverted to hospitals is more than £230 million per annum.
- Measures must be taken immediately to prevent our prisons becoming the 21st century asylums.

1. Introduction

Laing & Buisson, the leading provider of authoritative data, statistics, analysis and market intelligence on the UK health market, commissioned this report by Dr. Judy Renshaw, a specialist independent researcher focussing on health and criminal justice issues.

The report examines the prevalence of mental illness within the prison system, the costs associated with treatment of those prisoners in both prison and in medium secure hospitals and the financial savings that could be made if more prisoners received more appropriate, timely treatment.

There are over 84,000 people currently in prison¹ and in 2008 134,000 people came into prison for “first reception”². This is a 60% increase on prison numbers since 1995. It is estimated that 72% of male and 70% of female sentenced prisoners suffer from two or more identified mental disorders and that one in five prisoners has four of the five major mental health disorders³. In 2000, the last time a formal audit was performed⁴, the NHS found that up to 8% of prisoners have a severe and enduring mental illness. If the incidence of severe mental illness has remained consistent, approximately 6,700 prisoners in the prison population at any point in time have a severe mental illness. Our research shows that at least 1.5% of the annual prison population at any one time have a severe mental illness that cannot be dealt with in prison and requires hospitalisation. This amounts to around 3,270 offenders who require transfer for hospital treatment each year⁵. In fact, in 2007 only 1,458 offenders were diverted into hospital settings⁶.

This report was commissioned in the wake of Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system. Lord Bradley’s independent review itself followed a number of other high profile think-tank reports from the Sainsbury Centre for Mental Health, the Prison Reform Trust, Policy Exchange and others. The key theme of these reports is that too great a proportion of people in prison have mental health problems and that more should be done to ensure that they are in receipt of appropriate treatment to meet their needs.

This report does not focus on the majority of offenders who suffer from mild to moderate mental health problems, but on the most severely mentally ill people in the criminal justice system. It finds that the needs of these people are too complex to be dealt with by mental health in-reach teams and prison staff. Even ignoring the moral imperative, the cost-benefits show that these prisoners require diversion into secure psychiatric hospitals that can provide appropriate specialist care.

¹ HM Prison Service website – Publications & Documents, Population figures: Population Bulletin – Weekly 11 September 2009

² Ministry of Justice Offender Management Caseload Statistics 2008 – published 31st July 2009

³ House of Commons Debates, column 120WH, 17 March 2004

⁴ Dept of Health, 2000: *The NHS Plan, a plan for investment, a plan for reform*

⁵ In 2008, there were 84,000 people in prison and in that year 134,148 first receptions. 1.5% of this figure equals 3,272 offenders who should be transferred to hospital.

⁶ Ministry of Justice - *Statistics of mentally disordered offenders 2007, England and Wales, MoJ Statistical Bulletin*, February 2009

The cost of diverting offenders into psychiatric hospital settings cannot be ignored. But this report shows there is a mistaken belief that it is always more costly to place an offender in a secure hospital than it is to place that offender in prison. The cited costs of keeping one offender in prison for one year, usually more than £40,000, do not take into account the extra costs required for the care of a severely mentally disordered offender in a prison setting. These costs often include single cell suicide watch, enhanced observations, extended stays in the hospital wing and possible segregation. Many of those with severe problems require special and intensive care from healthcare staff and prison officers. These individuals have to be looked after on a healthcare wing or can require an additional equivalent full-time prison officer to provide constant observation.

Where seriously mentally ill prisoners are forced to remain misplaced in prison rather than in hospital, their mental state tends to deteriorate making eventual treatment even more costly and complex than before. This report estimates that the costs of detaining offenders with severe mental health problems in prison is, on average, three times more expensive than imprisoning an average prisoner – around £120,000 per year.

Furthermore, an offender with a mental illness who is released from prison is more likely to re-offend than an offender treated appropriately in a medium secure hospital. This report found that the reoffending rate for all discharged offenders is 44% in the first year. But for patients discharged from a medium secure hospital it is only 10%.

This drastic cut in reoffending means that appropriate diversion for an offender suffering from severe mental illness will lead to significant savings for the taxpayer and society as a whole. There is an average saving of over **£600,000** over the lifetime of each prisoner with severe mental health problems who is diverted into a secure psychiatric facility. In 2007, 1,458 prisoners were diverted to secure hospitals. However, if the additional 1,814 prisoners who we have identified as being more suitably placed in secure hospital were also diverted this year, they alone would collectively provide a lifetime cost saving to the taxpayer of more than £1 billion. Thus the lifetime saving for each prisoner is considerable.

2. Care of mentally ill offenders in prisons

2.1 Prevalence of mental illness in the prison population

Prisoners are far more likely to suffer from mental illness than the general population and many prisoners have a severe mental illness. According to Singleton et al (1998; 2001) the level of psychotic disorders is 16 times as high in prison as in the general adult population; the level of personality disorders 12 times as high and the level of drug dependency nine times as high⁷. Many of those in prison have multiple disorders, such as a personality disorder combined with drug dependency. The suicide rate is 14 times as high as in the general population. Mental health problems and suicides appear to be particularly high among those on life and indeterminate sentences as was found in Lord Bradley's 2009 review of people with mental health problems or learning disabilities in the criminal justice system.

However, despite the widespread acceptance of these facts, the last significant study of the prevalence of mental illness in prisons is now more than ten years old. The authors therefore suggest there is a need for a new, updated study of the prevalence of mental health problems among the current prison population.

Any new study should attempt to gauge the percentage of prisoners with any mental health problem and the percentage with severe mental illness who would benefit from psychiatric hospital care. This might require not only the application of standardised clinical screening instruments but also judgements by those responsible for caring for individuals on a day to day basis.

2.2 Shortcomings of mental healthcare in prisons

A number of reviews have also pointed out the inadequacy of mental health services in prisons to address the level of problems in this population. Brooker et al (2008) showed that spending on mental health in prisons is not nearly enough to accommodate the much higher level of need than in the wider community and that the spend per prisoner varies considerably from region to region. The authors estimate that around three times the level of spending is needed in order to deliver the policy goals of a service that seeks to provide the same level of mental health treatment to prisoners as to the general population.

A thematic review by HMIP (2007) found inadequacies in the assessment and treatment of those with mental health problems in all areas – including reception – and poor coordination with other staff in the prison. The mental health training for wing-based prison officers had been poorly implemented and most officers felt they needed more training. The Prison Reform Trust (2009) found that, although some improvements had been made since the commissioning responsibility for healthcare in prisons was moved to Primary Care Trusts (PCTs) and since in-reach teams had been established, there was still a huge gap of unmet need as the mental health needs of prisoners had expanded in number, severity and complexity in recent years.

⁷ Comparisons are weighted for average numbers of men and women in the two populations

While services for prisoners with moderate mental illnesses have improved in recent years, these reports show that there is a significant number of severely mentally ill people falling through the gaps of the prison health service who require treatment that cannot be provided by in-reach teams.

Lord Bradley's review noted that the mental health in-reach teams in prisons, established in 2001 to treat prisoners with severe and enduring mental illness, were often failing to focus on this high-need group who have fallen through gaps in provision and are unable to engage with existing programmes. Only 14% of the prisoners who did have severe mental illness had been accepted for treatment by in-reach services. The problem was often exacerbated by a lack of provision for those with more common mental health problems who could have been treated by primary care teams. Specialist services for the treatment of people with personality disorder were particularly limited even though the diagnosis is common and has now been acknowledged as a condition requiring assessment and appropriate treatment.

2.3 Medium secure capacity

The reviews by HMIP and Lord Bradley also noted a perception among prison and court staff that there are not enough appropriate secure hospital beds for severely mentally ill prisoners requiring hospital treatment, nor enough places for the group with personality disorders. However, these perceptions appear to be based on the number of NHS beds alone. The independent sector as a whole accounts for approximately 35% of total capacity for offenders diverted to medium-secure psychiatric settings. If the over 2,000 secure beds available in the independent sector were taken into account, there would be sufficient capacity in the UK to accommodate all offenders with a severe mental illness without the necessity for any further NHS capital development⁸.

The extra hospital capacity required to meet the needs of people with severe mental illness is ready for immediate use, yet this capacity is not included in official assessments⁹. Failing to properly account for existing spare capacity may be forcing people requiring hospitalisation to remain in prison while they wait for an empty hospital bed.

2.4 Transfer from prison

All the recent reviews observed that many patients still have to wait for long periods before transfer to hospital, sometimes several months, while in a state of acute distress. Although in recent years the number of prisoners having to wait more than 12 weeks to be transferred to hospital has decreased, a three-month wait is a longer than appropriate waiting time for people with severe mental health problems and exacerbates existing problems. In 2008, almost 80% of sentenced prisoners transferred from prison to hospital were transferred in the last six months of their sentences.¹⁰ Although some of these were on short sentences, for those on longer sentences experience shows that delays such as these and late transfers cause additional distress to prisoners and make eventual treatment more complex.

⁸ Laing & Buisson (2009)

⁹ House of Commons Debates, 15 June 2009, c116W

¹⁰ House of Commons Debates, 12 October 2009, c140W

In his review, Lord Bradley recommends a minimum target of 14 days' waiting time before such a transfer. He also commented on a lack of through-care facilities to provide movement between different levels of security. There is existing hospital capacity to meet this target and our evidence shows that speedier transfers would improve outcomes for people with a severe mental illness.

The Centre for Social Justice (2009) has also noted the inadequacy of mental healthcare in prison and the need for more diversion to appropriate facilities. It recommended that independent sector providers of secure mental healthcare should be more involved in capacity planning and could make a significant contribution to partnership working and diversion planning. Lord Bradley and others have identified the Care Programme Approach (CPA) as the key to continuity of care within prisons and on release. Those with severe problems should be on the enhanced level of CPA as they have complex needs and require support from more than one profession or agency.

Better planning and taking advantage of existing capacity in the non-state sector would lead to better diversion for those with severe mental illnesses and would help to meet Lord Bradley's 14 day target. This would immediately reduce the number of men and women in prison waiting for an empty bed and therefore relieve the pressure on in-reach teams (from this particular group).

2.5 Resources used in tackling severe mental illness in prisons

The level of severe mental health problems in prison is very high. According to Singleton et al (1998), around 8% of individuals within the prison population, approximately 6,600, have schizophrenia or a delusional disorder. The NHS Plan (2000) estimated that some 5,000 people with a severe mental illness were in prison. Although the Singleton study and NHS Plan statistics referred to are now out of date, given the absence of any more recent statistics and the numerous recent studies that point to the exacerbation of the problem of mental illness in prisoners rather than its solution, the authors must assume that their findings are still valid.

Our research provided further evidence that, despite the development of diversion schemes at earlier stages and the introduction of specialist in-reach teams, there is still a very high number of prisoners with severe mental illness. These estimates indicate that at least 1.5% of offenders in the prison population at any one time have a severe mental health problem such that they require specialist care and probably compulsory treatment.

We obtained estimates of the number of such extreme cases in three local prisons. The first estimated that 1% at any time have a very severe mental health need. The second prison estimated that 0.6% require constant 'bed-watch' at any time and an additional 2% need to be kept on a restricted regime due to their erratic or difficult behaviour. The final prison estimated that 24% need immediate medical attention on reception for a mental health or substance problem, 3.4% at any time have a severe mental health need and a special regime and 1.5% at any time have a problem so severe that they should be receiving compulsory treatment under the Mental Health Act.

Under existing arrangements, these people are not getting the treatment that they require. At present, this cannot be provided in a prison because prisons do not have the power to compel treatment under the Mental Health Act and all participation in treatment is voluntary. These individuals appear to have slipped through the net of diversion at an earlier stage, such as upon transfer from court or upon reception into the prison. They have no chance of recovery and very little chance of rehabilitation if their needs are not appropriately met.

2.6 The costs of treating severe mental illness in prisons

The costs of imprisoning people with mental illnesses of this degree of severity are much higher than for other inmates because of the need for frequent observations, monitoring and support, as well as dealing with difficulties with other inmates and staff. In the first prison mentioned above, the staff ratio for those on the healthcare wing is 4.5 times as high as a normal wing. If constant watch is required, the ratio rises to 45 times that of a normal prisoner. In the second, the 'bed-watch' requires a staff ratio of around 40 times that of a normal prisoner. In both prisons, the additional staffing is provided through overtime payments to existing staff. In the third prison, the healthcare wing has a staff ratio of 13 times that of a normal wing, plus three staff to one prisoner for brief periods when the most highly disturbed individuals are taken out of their locked cells for personal functions such as washing. This is a huge drain on staff resources and greatly increases the cost of imprisoning a severely mentally ill prisoner compared to that of an average prisoner.

There are no empirical cost measurements available for how much more expensive a mentally ill prisoner costs to keep in prison in the UK. The best data available is the James (2006) study based on American data. James (2006) has provided evidence, from expenditure on staff overtime in prisons in Florida, USA, that caring for mentally ill prisoners costs more than twice the average daily cost for those without mental illness. Prisons in other areas of the USA reported similar figures. This would seem to be a very conservative estimate compared with the figures taken from the three UK prisons described above where, in some instances, costs are up to 4.5 times higher. Taking into account enhanced staffing ratios and other resources, the data from American studies and the figures provided by the British prisons that we surveyed, we have assumed a figure of three times the average cost of a prison place as a basis for the present analysis.

According to Home Office figures, the average cost of a prison place in 2007 was £42,858 per year. Our findings show that the cost of accommodating a prisoner with a mental health problem so severe that they need additional care would be approximately £128,574. The annual cost of accommodating all the prisoners in England and Wales with such severe mental health problems (3,272 prisoners) would be more than £420m. In 2007, 1,458 prisoners were transferred. The 1,814 prisoners we identify who are left to remain in prison when they should be in hospital are costing the prison service more than £230m per year to accommodate. Moreover, these immediate costs do not take into account the life-time costs that are borne by society as a whole as a result of reoffending. These costs are treated in subsequent chapters of this report.

Key chapter findings and recommendations:

- **There is a need for a new, updated study of the prevalence of mental health problems among the current prison population.**
- **Commissioners of secure psychiatric care at all levels should include independent sector capacity in commissioning decisions in order to be fully informed and make best use of resources. Such an approach will enable attainment of the 14-day transfer target proposed by Lord Bradley in his recent report.**
- **The cost of accommodating in prison the offenders in England and Wales with severe mental health problems who have not been diverted to hospitals is more than £230 million per annum.**

3. Reoffending rates for offenders with severe mental illness*3.1 Reoffending rates for an 'average' prisoner*

According to Ministry of Justice statistics (2008b) on average, 44% of all prisoners released from custody are reconvicted within one year and 58% within two years. The costs to society incurred by further offending after release are high.

The lifetime costs for an 'average' former prisoner have been estimated at £221,190¹¹. These costs were based on government figures for two-year reconviction rates, the number of convictions per recorded offence and extrapolated to age 50 on the basis of known offending patterns at different ages.

These include costs to the criminal justice system (police, CPS, courts, legal aid, prisons, probation service etc.), victim services, lost output, health services, physical and emotional impact on victims, insurance and 'defensive expenditure' (extra security etc.).

The pattern of offence types was assumed to be similar to those shortly after release and costs were provided by the Home Office¹².

3.2 Reoffending rates for a severely mentally ill prisoner

The lifetime costs are based on an 'average' prisoner, of whom 8% have a psychotic disorder and 66% have a personality disorder of any kind. However, those with a severe mental illness, such as severe psychosis, severe personality disorder or a combination of these, pose a far higher risk of committing further serious offences. The offences they commit are often more serious and therefore more costly. A single homicide, on average, costs society £1,689,201¹³ including costs to victims and the criminal justice system.

The risk of reoffending has been shown to be higher among certain diagnostic groups, especially those with personality disorder or a history of substance misuse. Individuals with these diagnoses were found to be more likely than those with mental illness or mental impairment to commit further offences¹⁴. Therefore, such individuals pose a greater risk. Other research evidence has confirmed the high-risk status of prisoners with personality disorders. Coid et al (2007) found that prisoners with a dangerous and severe personality disorder were significantly more likely to have been reconvicted after two years than those without such a disorder. Parsonage (2007) also noted that offenders with a diagnosis of personality disorder were more difficult to treat and manage than those with a mental illness diagnosis.

¹¹ Matrix Knowledge Group, 2007. All costs throughout the report have been adjusted to 2009 prices except where stated (Office for National Statistics, 2009)

¹² Duborg and Hamed (2005)

¹³ Duborg and Hamed (2005)

¹⁴ Gray et al (2005)

3.3 Reoffending rates after treatment in medium secure settings

The medium secure hospitals managed by Partnerships in Care (PiC), the largest independent sector provider in the UK, are used here as an illustration and are assumed to be representative of all such providers. All of the patients transferred from the criminal justice system to PiC hospitals have a severe mental illness, personality disorder or mental impairment and consequently pose a far higher than average risk.

The PiC hospitals generally serve a higher proportion of patients with personality disorder (who pose the greatest risk of reoffending) than NHS hospitals. Across its 24 facilities, 31% of the patients have a personality disorder or combined personality disorder and mental illness, 47% have a mental illness, 17% have mental impairment (learning disability) and 4% have a brain injury. In contrast, the detained patients admitted to low, medium or high secure NHS psychiatric hospitals in 2004 comprised of fewer with personality disorder (7%) or mental impairment (2%) and a higher percentage with a diagnosis of mental illness (86%)¹⁵. For this reason, the PiC patient group might be expected to be more difficult to manage and to require a more intensive and longer intervention to achieve the same reduction in offending.

Evidence that the PiC patients pose a high risk to society comes from the 'index offences' they committed that led to their arrest and imprisonment. Among the current patients, 13% have committed homicide, 15% serious sexual offences and 52% serious violent offences. This contrasts with the ordinary prison population, of whom 36% have committed only property offences such as theft and burglary, 20% have committed violent offences, 8% drug offences, 9% motoring offences and 3% sexual offences¹⁶. Our findings support the proposition that offenders with a severe mental illness commit more serious crimes than average offenders.

The evidence available also shows that offending can be reduced following effective mental health treatment in medium secure hospitals. Using evidence provided by the PiC database at Cardiff University¹⁷, Gray et al (2005) followed a cohort of 1,182 former patients for at least two years and provided information on reconvictions at one year, two years and up to 9 years¹⁸. This shows that 10% of the patients discharged from a sample of four hospitals between 1990 and 2001 were reconvicted after one year, 18% after two years and 28% after a period of up to 9 years¹⁹.

These reoffending rates are considerably lower than the two-year rate of 56% for all offenders²⁰. In addition, the rates of reoffending after discharge from secure hospitals are likely to have reduced further since the 1990s as more effective drug treatments for mental illness such as Clozapine have been developed.

¹⁵ Ministry of Justice (2009)

¹⁶ Ministry of Justice (2008a)

¹⁷ Now running for over 10 years, this is the largest single longitudinal forensic psychiatry outcome study in Europe.

¹⁸ To capture all the convictions within one or two years it is necessary to wait an extra year, as it can take some 9 months for a conviction to appear on the HO Offenders Index, then apply retrospectively to the Home Office to ensure that all reconvictions within the period are recorded.

¹⁹ Gray et al (2005)

²⁰ Shepherd and Whiting, (2006). Reconviction rates are recorded for the 2 years following a community based sentence or 2 years after release for a custodial sentence. The MoJ figures were taken from the 2000 cohort, in order to be as similar as possible.

Other studies have also found that people admitted to psychiatric hospitals directly from court have a lower rate of reconviction than the general population of sentenced offenders. James et al (2002) studied 450 individuals admitted to hospital from the court. In the two years after discharge only 28% were reconvicted compared with 38% in the year prior to admission, a statistically significant difference. The reconviction rate was less than half of that for all offenders at a similar period (58%)²¹. The number of admissions to hospital after treatment was also reduced by 23% in comparison with the two years before the index admission.

Later studies by Maden et al (2004) and Snowden et al (2007) confirmed the efficacy of treatment in a medium secure unit for mentally ill offenders with a two year follow up reconviction rate of violent offences of 6% and 5.4% respectively.

Ministry of Justice figures for reconvictions of 1,104 restricted patients released from low, medium or high secure psychiatric hospitals between 1999 and 2005 found that 7% were reconvicted within two years. Only 2% were convicted for violent or sexual offences²². Our findings clearly demonstrate the effectiveness of secure hospital settings in drastically reducing the rates of reoffending among people with a severe mental illness. Restricted patients tend to stay longer in hospital and are compulsorily supervised in the community.

Parsonage (2009), reviewing diversion schemes for offenders with mental health problems at various points in the criminal justice system, states that 'the balance of evidence suggests that mental health-related interventions have some positive impact on reoffending'. A review by Davis et al (2008) for the National Audit Office (NAO) also concluded that there is strong evidence for the effectiveness of mental health interventions.

Even among those who do re-offend after hospital treatment, their crimes are generally far less serious than before they were convicted. The most common index offences that led to admission to a PiC hospital were violent offences, sexual offences and murder or manslaughter. However, after treatment, we found that the risk to the public was greatly reduced thus improving public safety and ensuring a cost-benefit for the taxpayer.

Table 1 shows that the pattern of offending is very different after discharge from the kinds of offences that resulted in imprisonment. After discharge, the most common offences were property offences, motoring and other offences, such as 'nuisance' offences. These do not generally pose a serious threat to the community. The initial offences committed by ordinary prisoners without mental health problems are shown for comparison. The majority of these are property and more minor offences.

²¹ Shepherd and Whiting (2006)

²² Ministry of Justice (2009)

Table 1: The ‘index offences’ committed by PiC patients in the survey before treatment and offences committed after discharge

Offence type at admission	Index offence - PiC Residents (%)	Follow up offences, from database (%)	Index offence of ordinary prisoners (%)
Violent (assault, ABH, threats, wounding, battery, affray, weapons, kidnap)	52	15	20
Murder, manslaughter, attempted murder	13	0	< 1
Sexual offences (rape and sexual assault)	15	1	3
Property offences (burglary, theft, handling, robbery, damage)	9	49	36
Arson	7	0	0
Other, including breaches, obstruction, public place offences	4	14	24
Motor offences	0	15	9
Drug offences	0	6	8

Sources: Gray et al (2005); PiC April 2009; Ministry of Justice (2008a)

In addition, the high risk to the public posed by most of the patients in secure hospitals before admission is indicated by the level of security in their previous location. After discharge, only a small minority were considered to be a risk. Most were admitted from a secure setting such as a prison, medium secure unit or special hospital but most were able to ‘step down’ to be discharged to a non-secure setting such as a psychiatric hospital or into the community (see Tables 2 and 3).

Table 2: Sources of admission for PiC hospital patients 2006 – 2009

Source of admission	Patients admitted (%)
Other medium secure unit	44
Prison	34
Low secure unit	11
Special hospital (Broadmoor/Rampton)	5
Acute hospital	4
Community	3

Source: PiC April 2009²³

²³ Due to rounding the percentages may not equal 100%

Table 3: Discharge destinations for PiC hospital patients 2006 – 2009

Discharge destination	Patients discharged (%)
Open psychiatric hospital	59
Community/own home with minimal support	9
Other medium secure hospital	8
Long stay residential unit/low secure hospital	7
Prison	6
Hostel	6
Death	3
High secure hospital	3

Source: PiC April 2009²⁴

Many of those discharged to psychiatric hospitals would subsequently be able to be supported in community settings. This indicates that they were considered to pose a substantially lower risk of committing serious offences that would make them a danger to the public than before their admission. There is considerable evidence that this is true even for those patients who suffer from the most severe mental illnesses and personality disorders and therefore tend to be most costly to the prison service to accommodate.

3.4 Reoffending rates for offenders with personality disorders after treatment in medium secure settings

As shown above (section 3.3), independent sector hospitals provide for a high percentage of patients with personality disorder, a group who are especially difficult to treat. A substantial proportion of individuals with personality disorder can be helped to change their behaviour if they are given appropriate treatment. Effective treatment depends on a range of healthcare professionals who have sufficient, appropriate training and support.

Evidence from Marshall (1997) demonstrated that high-risk prisoners, many of whom had a condition such as personality disorder, who had been treated in the therapeutic community of HMP Grendon were significantly less likely to be reconvicted within four years of release than a comparison group that had not been treated.

The impact of the therapeutic community appeared to be greatest for those with the most dangerous records of offending, such as repeat convictions for sexual or violent offences. Multiple sex offenders who had been in Grendon were much less likely to be reconvicted of a sexual offence (18%) than the control group (43%), making a 58% difference, which was highly statistically significant. In addition, multiple violent offenders in the Grendon group were significantly less likely to be reconvicted within four years (35%) than the control group (49%), making a 28% difference.

²⁴ Due to rounding the percentages may not equal 100%

Offenders who spent longer than 12-18 months in Grendon prison were less likely to be reconvicted than those who stayed a shorter time²⁵. A stay of 18 months in Grendon was estimated to produce a reduction in reconviction and subsequent imprisonment of around one quarter. This can be maximised if there is a system in place to maintain contact with offenders after they have been discharged. It is important to note that prisoners at Grendon and other penal therapeutic settings are volunteers for their treatment regime and are not required to participate in treatment. In medium secure psychiatric hospitals, treatment can be made mandatory and so can reach offenders that a prison-based setting such as Grendon could not.

Those who were treated for longer periods in PiC hospitals were found to be less likely to re-offend at all or to commit serious offences afterwards than those who spent less time in hospital²⁶. Those who did not re-offend stayed almost twice as long (519 days on average) as those who did re-offend (277 days on average).

Key chapter findings and recommendations:

- **Offending can be reduced following effective mental health treatment in medium secure hospitals.**
- **Early diagnosis and speedy diversion into psychiatric hospitals is the best way to minimise the rate of reoffending.**
- **Not only does appropriate mental health treatment significantly reduce the likelihood of new offences, it also reduces the seriousness of any new offences that are committed.**
- **Staying for at least 18 months seems to be more effective than shorter stays.**
- **The risk to the public is greatly reduced after treatment in medium secure settings.**

²⁵ Marshall (1997)

²⁶ Gray et al (2005)

4. Cost savings from appropriate treatment of offenders with severe mental illness

Given the information presented above, it is possible to look at the potential cost-savings that could be delivered through more appropriate treatment for mentally ill offenders, particularly high risk prisoners with severe mental illness who are the most costly group for the prison service.

Treatment in a PiC hospital for the recommended average period of 18 months costs £284,700²⁷. Most PiC patients move from medium secure care into a more open hospital environment for an estimated average length of stay of one year and an average cost of £73,365 (£201 per day²⁸). We would encourage further research into length of hospital stay for severely mentally disordered offenders following treatment in medium security. In addition there would be value in properly calculating lifetime costs of ongoing health and social care. There is no data available for this but we surmise that it would be significantly less than readmission into either prison or hospital.

The savings from not needing to accommodate a prisoner with severe mental health problems for 2.5 years would be £321,435 to the prison service and so would involve a net extra cost of £36,630 covering the 18 month period. This extra sum would be more than recouped by preventing even an average prisoner (without mental health problems) from reoffending, whose lifetime costs of reoffending are £221,190²⁹ (see section 3.1).

However, those who enter secure hospitals suffering from a severe mental illness are a considerably higher risk than this. Most of them have been convicted of serious violent offences. Comparing the rates of serious offences committed by 'ordinary' prisoners, the mentally ill group admitted to a secure hospital were 2.6 times more likely to have committed a violent offence, 13 times more likely to have committed a homicide and five times more likely to have committed a serious sexual offence (Table 1). If the patients admitted to hospital had remained in the community and continued offending at the same rate, their risk of committing serious offences would be at least three to five times that of the 'ordinary' prison population. It should be noted that the average cost of a single homicide to victims and the justice system is £1.68m³⁰.

The lifetime costs of reoffending for such high risk prisoners with severe mental illness, taking into account the seriousness of their crimes, can be estimated at around three times as high as the normal prison population, or £663,570 (based on the experience of our research, we believe this to be a very conservative estimate). On this basis, over half a million pounds – £626,940 – over the lifetime of each offender could be saved to society through providing appropriate mental healthcare for each high risk prisoner with severe mental illness (see Table 4).

²⁷ Treatment costs £520 average per day (spot purchase price). 18 months costs £284,700 on average.

²⁸ Curtis (2008)

²⁹ Matrix Knowledge Group (2007)

³⁰ Duborg and Hamed (2005)

Table 4: Summary of costs and savings due to high quality psychiatric care for prisoners with severe mental illness (per case)

	Cost per case (£)
Lifetime cost of reoffending by an 'average' prisoner	221,190
Estimated lifetime cost of reoffending by a high risk prisoner with severe mental illness (assuming they are three times more likely to offend than an average prisoner)	663,570
Cost of treatment in secure hospital for 18 months	284,700
Cost of treatment in an open psychiatric hospital for one year	73,365
Savings to prison service	321,435
Net cost of treatment	36,630
Net savings to society over the lifetime of each offender transferred	626,940

Our findings show that at least 1.5% of the total annual prison population suffers from a mental illness so severe that they require hospitalisation. This amounts to around 3,200 people, yet in 2007, only 1,458 people were transferred to secure settings. This means that in 2007 there were, at any one time, around 1,800 people in prison who were not benefitting from prison mental health treatment who should have been in a secure hospital. If this 2007 cohort of offenders had been diverted, they would collectively be providing a cost saving of more than £1 billion.

Key chapter findings and recommendations:

- **People with a severe mental illness tend to commit more serious and therefore more costly, offences than the 'average' prisoner.**
- **The potential cost savings available to the taxpayer through increased diversion are very significant.**
- **Our research suggests that over the course of one year, more than 3,200 people will be in prison when the most appropriate setting for their needs would be a secure hospital.**
- **Over the lifetime of each of these offenders who are diverted into a secure hospital, the taxpayer will receive a cost benefit of over £600,000.**

5. Conclusions

- There is a need for a new, updated study of the prevalence of mental health problems among the current prison population.
- Commissioners of secure psychiatric care at all levels should include independent sector capacity in commissioning decisions in order to be fully informed and make best use of resources. Such an approach would enable attainment of the 14-day transfer target proposed by Lord Bradley in his recent report.
- The cost of accommodating in prison the offenders in England and Wales with severe mental health problems who have not been diverted to hospitals is more than £230 million per annum.
- Reoffending can be reduced following effective mental health treatment in medium secure hospitals.
- Early diagnosis and speedy diversion into psychiatric hospitals is the best way to minimise the rate of reoffending.
- Not only does appropriate mental health treatment drastically reduce the likelihood of reoffending, it also reduces the seriousness of any new offences that are committed.
- Hospitalisation for at least 18 months in a secure unit is more effective than shorter stays.
- The risk to the public is greatly reduced after treatment in medium secure settings.
- People with a severe mental illness tend to commit more serious and therefore more costly offences than the 'average' prisoner.
- The potential cost savings available to the taxpayer through increased diversion are very significant.
- This saving can be repeated for all offenders with a severe mental illness in the criminal justice system and over the lifetime of these prisoners will save the tax payer billions.
- Our research suggests that over the course of one year, more than 3,200 offenders will be in prison when the most appropriate setting for their needs would be a secure hospital.
- Over the lifetime of each of these offenders who are diverted into a secure hospital, the taxpayer will receive a cost benefit of over £600,000.

The overwhelming majority of men and women in prison suffer from at least one diagnosable mental illness. Many of these people are dealt with effectively and efficiently by mental health in-reach teams which operate within prisons. However, there is a minority of people in prison whose mental health needs are so acute that their needs cannot be met by existing prison provision and they require immediate transfer to a secure hospital.

The total size of this group is at least 1.5% of the total number of people who experience prison in any given year. In 2008, this number was just under 220,000 people meaning that in 2008, around 3,200 offenders should have been transferred to secure hospitals from prison. The most recently available figures from 2007 show that only 1,458 offenders were transferred to secure hospitals in that year. Although this is an increase on previous years, many more prisoners remain in prison unable to receive the treatment that they require, despite there being spare capacity in the independent sector.

The prison system is currently spending more than £230m each year simply to accommodate and keep safe prisoners with a severe mental illness. The potential savings available through appropriate diversion are clear and more should be done to ensure that prisoners are diverted into psychiatric hospitals in greater number and at an increasing speed. Though the number of prisoners being diverted to secure hospitals has increased in recent years, we found that the number being diverted should be more than twice as large. The mental health problems of this group are so severe that they are unable to benefit from in-prison treatment programmes and require hospitalisation to have a genuine chance of rehabilitation. Transferring these prisoners into hospital and providing them with appropriate treatment will reduce their possibility of reoffending and drastically reduce their cost to society.

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