Improving Mental Healthcare in Prisons

Lessons from California and implications for England

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Policy Summary

This report compares prison mental healthcare in California and England to identify structural differences affecting quality, safety, workforce sustainability and equity. People in prison have disproportionately high mental-health and social need; prison healthcare is therefore *both* a health-inequalities intervention and an investment in safer communities.

England relies on external secure hospitals for most prisoners who require inpatient psychiatric treatment. NHS England collates metrics on transfer time and these show median transfer waits of 49 days in 2024-25 and 40 days in 2025-26. 701 and 392 people respectively waited longer than 28 days, while the longest waits were 572 and 261 days. The Mental Health Act 2025 now provides for a statutory 28-day transfer period, subject to commencement, but legislation alone cannot create secure beds, workforce or integrated pathways.

California is a useful but challenging comparator. On 30 June 2025, England and Wales held 87,334 people in prison and CDCR reported an adult institution population of 90,584, although the jurisdictions and denominators are not identical[1]. California's system is more centralised, has in-estate acute and intermediate Psychiatric Inpatient Programs, stronger psychiatric staffing, statewide operational standards and continuing court-driven accountability; in 2025 a federal receiver was appointed to oversee the Statewide Mental Health Program.

The central learning from this Fellowship is that system architecture determines what clinicians can realistically deliver. Central planning allows expertise and specialist capacity to be shared across an estate, while continuity across custody, hospital and community settings reduces avoidable risk at transitions.

Rehabilitation also becomes more credible when it is supported by adequate staffing, meaningful activity and a shared custodial-healthcare culture.

For England, the policy direction should be to commission for continuity: build one integrated system, match clinical capacity to clinical need, and make rehabilitation, continuity and equity measurable outcomes.

Priority recommendations

- Define clinically meaningful national minimum standards for prison mental healthcare, including therapeutic activity, multidisciplinary review, risk management and rehabilitation.
- Make the 28-day transfer framework achievable through secure-bed capacity, clear escalation, transparent reporting, and clinically and legally appropriate in-estate alternatives.
- Create stronger national coordination of workforce, specialist pathways, data, serious-incident learning and service capacity across the prison estate.
- Expand and sustain the multidisciplinary prison mental-health workforce, develop training pipelines and treat workforce burnout, moral injury and retention as priority issues.
- Commission for continuity rather than custody: align prison healthcare with local NHS pathways and move away from siloed prison-only arrangements that create avoidable boundaries.
- Make rehabilitation, continuity and equity measurable outcomes, including access, treatment intensity, reducing restrictive practice, patient experience and post-release linkage to care.

[1] Because prison healthcare is devolved, the recommendations in this report concern England; the England-and-Wales population figure is used here only to demonstrate broad similarity of custodial scale.

Contents

1. Executive Summary

This Fellowship examined the delivery of mental healthcare within prison systems, with a particular focus on what England might learn from California. The purpose of the report is not to suggest that one jurisdiction can simply copy another. California and England operate within different legal, political, commissioning and cultural contexts. However, comparison is valuable because it allows us to see that some of the difficulties experienced in England are not inevitable features of prison healthcare and these difficulties can be mitigated when services are thoughtfully organised and resourced.

Prison populations represent one of the most disadvantaged groups in society. People in custody have disproportionately high rates of severe mental illness, trauma histories, neurodevelopmental conditions, substance misuse, personality difficulty, physical illness and social exclusion. For many, imprisonment follows years of unmet need, fragmented contact with services, poverty, unstable accommodation and repeated crisis. In that context, prison mental healthcare reflects major health inequalities issues in society at large.

The Fellowship explored how California has developed a more structured and systematised approach to prison mental healthcare. Its model is shaped by centralised oversight, detailed operational policies, stronger psychiatric workforce capacity, in-estate inpatient services, and legal accountability arising from longstanding class action litigation. The result is a system which is more explicit about what care should be provided, how quickly it should be delivered, who is responsible for delivery, and how performance is monitored.

The Californian system provides outpatient care, acute inpatient care and intermediate or rehabilitative inpatient care streams within the prison estate. This matters because acutely unwell people can be assessed and treated within a clinically appropriate environment without the same dependence on external hospital transfer pathways. By contrast, England remains heavily dependent on transfer to external hospitals under sections 47 and 48 of the Mental Health Act for prisoners requiring inpatient treatment.

Recent NHS England data show that median waits remained 40-49 days across 2024-25 and 2025-26, with some waits extending to many months. For the most unwell individuals in custody, living in a setting unable to meet their care needs, delay is a clinical and ethical problem. The Mental Health Act 2025 establishes a 28-day transfer framework, subject to commencement; the implementation challenge is now to ensure that pathways and capacity make that legal ambition achievable, while optimising care for those during periods of delay. [4,19]

A second major learning point concerns workforce. California appears to align its service ambition with a significantly greater psychiatric and multidisciplinary workforce capacity. This enables timely assessment, structured therapeutic programming, more robust outpatient follow-up, acute inpatient treatment, intermediate care, and multidisciplinary review. In England, lean psychiatric staffing models can lead to reactive rather than proactive care, staff burnout, moral injury, blind spots in risk management, poor retention, and reduced rehabilitative impact for prisoners.

A third learning point concerns rehabilitation. During the Fellowship, programmes such as service dog training, Braille transcription at Folsom State Prison, and industrial training including licence plate manufacturing illustrated the importance of meaningful activity, responsibility, skill development and social contribution. These examples are important because they show rehabilitation being operationalised through daily structure reflecting and connecting to the outside world.

The central theme of this report is that system design determines quality and safety. California demonstrates the benefits of centralised planning, scale, expertise-sharing, defined standards, integrated levels of care and strong external accountability. England, by contrast, is affected by fragmented commissioning, variable

provision and organisational boundaries that can make continuity and system-wide learning harder. Developments should therefore focus not only on individual service improvement, but on the architecture of the system itself, including the way prison healthcare connects with local healthcare services before, during and after custody.

2. About the Author

Dr Michael Utterson is a consultant psychiatrist with experience across prison, NHS, independent, statutory and third-sector services. His professional work has included prison mental healthcare, service development, pathway improvement, quality assurance, and interface work between healthcare, social care, regulation and justice settings.

This report is informed by clinical experience of working in English prisons as well as learning from the Churchill Fellowship. It is written from the perspective of a clinician concerned not only with the treatment of individual patients, but with the design of systems capable of delivering safe, humane, timely and equitable care.

He is currently an interim clinical director for a cluster of prisons within England and holds a national role within healthcare regulation.

3. Acknowledgements

I am grateful to the Churchill Fellowship for making this research possible, and to clinicians and operational leaders within the California Department of Corrections and Rehabilitation, as well as prison staff, programme leads, incarcerated participants and others in California who generously shared their time, expertise and reflections.

I am also grateful to colleagues in England whose work in prison mental healthcare continues under demanding circumstances and whose experience has shaped my understanding of the challenges addressed in this report.

4. Introduction

Prison mental healthcare occupies a uniquely complex space at the intersection of healthcare, public protection, criminal justice and social justice. Clinicians in custody work with people who often have severe mental illness, trauma histories, substance misuse, neurodevelopmental disorders, personality difficulty, cognitive impairment, physical illness, social exclusion and offending-related risk.

In England, prison healthcare has been increasingly integrated with the NHS, reflecting a commitment to equivalence of care. That principle emphasises that people in custody should not receive a lower standard of healthcare because they are in prison. Yet equivalence remains difficult to achieve in practice. Prison environments are not designed primarily as therapeutic spaces. They are restrictive, security-focused institutions in which clinical care must be delivered alongside custodial routines, operational pressures, staffing constraints and population churn.

Equivalence should also not be interpreted as identical inputs regardless of context. People in custody begin with greater morbidity and disadvantage, have less agency to seek alternatives, and face environmental barriers that can make treatment and recovery harder. If the objective is equitable outcomes, prison healthcare may therefore require greater intensity and resource than apparently comparable community provision. The ambition should be for full recovery and safe reintegration.

The result is a system in which clinicians may be required to manage high levels of acuity and risk with limited time, limited space, and limited access to the full range of treatment pathways available in the community or hospital sector. Where resources are stretched, care can become reactive, with urgent risk tending to absorb limited clinical capacity. This has consequences for patients, staff and the wider system.

This Fellowship was undertaken to explore whether a different model of prison mental healthcare could offer useful lessons for England.

California was selected because its prison mental healthcare system has undergone sustained reform following legal challenge, oversight and system-wide efforts to define and improve care. It is a large and complex prison system, and therefore a useful comparator for thinking about scale, governance, workforce, inpatient capacity and accountability.

A key consideration in this Fellowship is the extent to which lessons from California can be meaningfully applied to the English context. While differences between jurisdictions must be acknowledged, there are several important factors that support the validity of this comparison.
Both England and California operate large, complex prison systems managing substantial populations of individuals with high levels of mental illness, substance misuse, and social disadvantage. In both settings, prisons serve as de facto providers of care for individuals who have often experienced longstanding unmet health and social needs prior to incarceration.

The scale of the systems is also comparable. On 30 June 2025, the prison population of England and Wales was 87,334 and CDCR recorded an adult institution population of 90,584 on the same date. [1,2] These are not identical denominators and the legal and sentencing contexts differ, but the near-equivalence of scale makes comparison of multi-site planning, workforce, specialist capacity and system governance particularly meaningful. In both jurisdictions, services must operate across multiple institutions and security levels while managing substantial clinical complexity.

There are, however, important differences. These include variations in legal frameworks, sentencing structures, and broader social contexts. California's system has also been shaped by sustained legal intervention, which has driven a higher degree of standardisation and accountability. By examining how similar challenges are addressed in different contexts, it is possible to identify structural factors that support or hinder the delivery of effective mental healthcare.

This report therefore uses California as a comparative case study through which to explore how alternative approaches to system design may inform improvement in England.

The aim of this report is to identify transferable principles such as what happens when standards are specified, workforce capacity is aligned with clinical need, continuity and connection to the outside world are prioritised, inpatient care exists within the prison estate, rehabilitation is built into daily structure, and system-wide oversight allows learning and problem-solving across institutions.

5. Aims and Objectives

The primary aim of this Fellowship was to identify lessons from Californian prison mental healthcare that could inform improvements in England, particularly where they apply to the most unwell prisoners. The underlying question was: what kind of system is required to deliver timely, safe, therapeutic and equitable mental healthcare for people in custody?

Objectives

- To understand how prison mental health services are structured and delivered in California.
- To examine the role of centralised oversight, legal accountability and operational standards in shaping care quality.
- To consider how outpatient, acute inpatient and intermediate or rehabilitative care streams operate within the prison estate.
- To reflect on workforce capacity, psychiatric staffing and multidisciplinary working.
- To identify rehabilitative programmes that provide meaningful activity, responsibility and skill development.
- To compare learning from California with current challenges in England, particularly around delays, fragmentation, workforce pressure and health inequalities.
- To develop practical recommendations for policymakers, commissioners, regulators and clinical leaders in England.

6. Methodology

This Fellowship used a qualitative and reflective approach. Learning was drawn from site visits, discussions with clinicians and operational leaders, observation of services and programmes, and review of relevant policy documents.

The Fellowship included visits to Californian prison settings and discussions with individuals involved in prison mental healthcare, operational management and rehabilitative programming. These conversations explored how services are structured, how patients move between levels of care, how risk is managed, how staffing models support delivery, and how rehabilitation is embedded into the prison environment.

Policy documents provided by Californian colleagues were reviewed to understand the operational framework underpinning care. These included policies on treatment minimums, referral and admission, treatment planning, suicide prevention and response, and patient and staff safety. These documents were particularly useful because they demonstrate not only what the system aims to do, but how expectations are translated into operational requirements.

Limitations should be acknowledged. The Fellowship involved a limited number of visits and cannot represent the entirety of the Californian prison system. Comparisons between California and England must also take account of differences in law, governance, prison-estate design, healthcare financing, litigation history and political context.

7. Context

7.1 England

Prison healthcare in England is commissioned through NHS England, with services delivered by a mixed economy of NHS and independent providers. This model reflects an attempt to improve quality through commissioning, contract management and regulation. However, it also creates complexity. Responsibility is distributed across commissioners, providers, prison governors, the Ministry of Justice, regulators and local health and social care systems.

This diffuse structure can make system-wide change difficult. Individual prisons may develop excellent practice, but scaling that practice across the estate is not straightforward. Providers may operate under different contracts, staffing models, and performance expectations. Competitive commissioning can also create an unintended tension between contract level delivery and whole-system learning.

A particular challenge is access to inpatient psychiatric care. In England, prisoners who require inpatient treatment generally need transfer to hospital under the Mental Health Act. This means that prison mental healthcare is dependent on external hospital capacity, legal processes, bed availability and coordination between multiple organisations. Delays are therefore built into the structure of the pathway.

Independent inspection and coronial evidence provide important context for the English position. HM Inspectorate of Prisons' thematic review "*the long wait"* found that fewer than 15% of the transfer cases examined were completed within 28 days. It identified limited secure-bed access as the key barrier, even when prison staff were actively advocating for patients. [5] Prevention of Future Deaths reports are case-specific rather than prevalence estimates, but they show how these systemic weaknesses can result in harm.

In the Diana Grant PFD report, the coroner heard evidence that people judged to require immediate admission to secure mental healthcare could wait on average 80-90 days because of restricted capacity, and that their needs could not be fully met in prison. [6] In the Sarah Boyle PFD report, evidence from HMP Styal described a mental health team caring for complex women awaiting hospital assessment or beds despite not being set up to provide that level of treatment, creating additional pressure on an already stretched service. [7]

Other reports illuminate different points of system fragility. The Steven Hart PFD report identified failures in timely mental health assessment, communication of risk, handover and observation practices. [8] Taken together, these cases do not demonstrate that every English prison service fails in the same way, but do show recurrent vulnerabilities around capacity, information flow, escalation and continuity. These seem to be the areas most likely to deteriorate when services are lean, fragmented or dependent on external pathways.

The consistency of these themes across inspection and coronial sources supports the conclusion that the difficulties in English prison mental healthcare reflect structural vulnerabilities, including workforce capacity, limited therapeutic infrastructure, fragmented responsibility and delays in access to the appropriate level of care. [5-8]

7.2 California

California provides a contrasting model. Its prison mental healthcare system operates within a more centralised statewide framework, with defined care levels, statewide policies, strong external oversight and dedicated prison-based inpatient services. Psychiatric Inpatient Programs provide acute and intermediate levels of care within the correctional estate, allowing many patients to be treated in settings designed for psychiatric care while remaining within the same overall system. [10]

This in-estate model changes the nature of the system response to acute mental illness. Rather than needing to wait for an external hospital bed, the system has internal resources for assessment, admission and treatment, creating a fundamentally different baseline of capability.

7.3 Legal Oversight and System Reform in California

A defining feature of California is the extent to which prison mental healthcare has been shaped by sustained legal intervention. The Coleman litigation, originally filed in 1990, concerned the adequacy of care for incarcerated people with serious mental illness. In 1995 the federal court found constitutionally inadequate care and identified deficiencies including staffing, screening, treatment programmes, records, medication management and suicide prevention. For decades a Special Master monitored remedial work. In 2025, the court appointed a receiver to oversee the Statewide Mental Health Program. The action remains ongoing. [17]

This history is important because it prevents an overly simple reading of California as a naturally high-performing system. Instead, it demonstrates the potential for improvement which I hope the English system can learn from. Much of what impressed me was built in response to serious failure and sustained external pressure. Legal oversight required the state to define what adequate mental healthcare should look like, collect data on delivery, invest in staffing and infrastructure, and continue iterating when standards were not met.

This context matters for England because it illustrates the role of accountability in driving system design. California's standards are embedded in statewide policies and linked to external scrutiny. England has accountability through commissioning, regulation, inspection, professional standards and, increasingly, statute, but responsibility remains more diffuse. The 2025 iterations to the Mental Health Act provide for a statutory 28-day prison-to-hospital transfer period, although the relevant provision has not yet commenced. This represents important progress, but a statutory deadline cannot by itself create secure-bed capacity, resolve interface problems or provide immediate therapeutic care for people who remain acutely unwell in prison.

7.4 Prison Mental Health as a Health Inequalities Issue

People in prison experience profound health inequalities. High rates of mental illness, substance misuse, trauma, physical ill-health, learning disability, neurodevelopmental disorder and social exclusion are common. These needs are often compounded by poverty, racism, homelessness, disrupted education, unemployment and limited access to effective care before imprisonment.

This means that prison healthcare has a dual role. It must provide care within custody, but it also has an opportunity to interrupt patterns of exclusion and unmet need. When adequately resourced, prison healthcare can be a point of stabilisation, diagnosis, treatment, rehabilitation and reconnection. Where provision is inadequate, it can compound trauma, worsen illness and deepen inequality.

The Fellowship reinforced the importance of seeing system design itself as a determinant of health equity. In a highly variable system, people with similar needs may receive different care depending on where they are imprisoned, which provider holds the contract, what workforce is available and what local operational pressures exist. In a more standardised and monitored system with greater internal capacity, there is greater potential to reduce unwarranted variation and ensure that those with the greatest need receive timely and appropriate care. Equity may require proportionately greater resource in prison, not merely for ‘equivalent’ access compared to community metrics, but because custody itself creates additional barriers to recovery.

8. Findings

8.1 Defined Treatment Intensity and Therapeutic Structure

One of the clearest features of the Californian policy framework is the extent to which care is specified in operational terms. CDCR policy requires that patients admitted to Psychiatric Inpatient Programs be offered a minimum of 20 programming hours per week, including at least 10 hours of core treatment. [9]

Core treatment includes interventions such as nurse-led therapeutic groups, individual clinical contacts, interdisciplinary treatment team input, and structured groups with specific learning objectives. Supplemental treatment may include fewer formal activities but is still distinguished from unstructured yard or dayroom time.

This is helpful because it defines a 'therapeutic dose' of intervention, rather than leaving treatment intensity entirely to local custom, staffing availability or informal expectations which can be the experience in English prisons. Having a minimum standard helps with practicalities such as scheduling but also helps with accountability as it can be audited. Where a patient cannot participate in the full programme for clinical reasons, the rationale must be documented through a modified treatment plan where the intention is still to optimise therapeutically meaningful contact time.

In many English prisons, the intensity and consistency of therapeutic provision can vary considerably. It is the author's experience that in some prison healthcare wings, patients can be limited to just 15 minutes outside their cell each day in which they must choose whether to access time on the yard *or* have a shower.

Staffing shortages, operational lockdowns, regime restrictions and competing demands may all reduce access to structured therapeutic activity. In such circumstances, care may become dominated by basic administration, such as monitoring physical observations, with less capacity for sustained therapeutic or rehabilitative work.

From an inequalities perspective, variable access to treatment is especially concerning. Those with the most complex presentations may be least able to advocate for care, most likely to deteriorate in restrictive environments, and most dependent on services being proactive. A defined minimum standard would also be an equity mechanism for ensuring disempowered individuals access humane care.

8.2 Access to Inpatient Care: Delays in England and Immediate Treatment Capacity in California

Recent data released by NHS England highlights the scale of the challenge in transferring prisoners to hospital under sections 47 and 48 of the Mental Health Act. In 2024-25, 1,003 prisoners required transfer. The median time between assessment and transfer was 49 days, 701 prisoners waited longer than 28 days, and the longest recorded wait was 572 days. [19]

In 2025-26, 612 prisoners required transfer. The median wait was 40 days, 392 prisoners waited longer than 28 days, and the longest recorded wait was 261 days. [19]

These figures show that delay remains a persistent systemic feature despite repeated policy attention. Even where there appears to have been improvement between years, median waits of 40-49 days remain clinically significant.

NHS England's 2021 guidance set a 28-day expectation, and the Mental Health Act 2025 now provides for a statutory 28-day period subject to commencement. [3,4] The significance of the new law will therefore depend on whether implementation addresses the underlying constraints rather than simply measuring them more formally. Nor does the statutory deadline alone improve the quality or intensity of care available to an acutely unwell person while they remain in prison awaiting transfer.

The people affected by these delays are the most acutely unwell in the prison system. Prolonged waits may lead to deterioration in mental state, increased risk of self-harm or suicide, prolonged segregation or crisis containment, pressure on prison staff, and extended exposure to environments not designed for therapeutic care. Delayed transfer can also erode trust in services, both for patients and staff.

California offers a fundamentally different model. Acute and intermediate inpatient psychiatric care is provided within the prison estate through dedicated psychiatric inpatient programs. These services have

staffing, facilities, legal and operational frameworks, and multidisciplinary structures that allow acutely unwell prisoners to receive inpatient-level treatment within the correctional healthcare system. [10]

England operates a transfer-dependent model: the prison identifies need, but treatment at the required level depends on access to an external hospital bed, coordination across organisational boundaries and a secure-care system balancing finite capacity and acuity across competing referrals.

California operates a more integrated in-estate model: the prison healthcare system contains acute and intermediate psychiatric treatment capacity. This affects timeliness, continuity, safety and accountability.

8.3 Suicide Prevention and Risk Management

The Californian suicide prevention policy demonstrates a highly structured approach to risk management. It requires suicide prevention training across relevant staff groups, suicide risk evaluation following admission, rapid response to suicidal statements or behaviours, enhanced observation where clinically indicated, and formal review structures following serious incidents. The policy also establishes multidisciplinary oversight through focused improvement processes. [11]

This has relevance for England. Serious incident inquiries repeatedly demonstrate that failures in mental health care often arise from cumulative weaknesses: incomplete information sharing, poor escalation, workforce pressure, fragmented responsibility, over-reliance on individual judgement, and insufficient attention to changing risk. Prison settings amplify these risks because clinical deterioration may be masked by behavioural disturbance, segregation, substance misuse, fear, shame or distrust of services.

A strong prison mental healthcare system therefore needs both clinical expertise and reliable systems. It requires staff who can formulate risk dynamically, but also processes that make deterioration harder to miss. Training is therefore vital, as are structured therapeutic observation, reliable escalation and an embedded whole-system approach to suicide prevention.

8.4 Multidisciplinary Care and Treatment Planning

California's treatment planning policies place strong emphasis on an interdisciplinary treatment team. Treatment planning is the central mechanism through which needs are assessed, goals are set, interventions are coordinated, and progress is reviewed. Policies specify expectations for assessment, patient involvement, measurable objectives, review intervals and multidisciplinary communication. [12]

The value of this approach is that it operationalises multidisciplinary care. Many systems describe themselves as multidisciplinary, but in practice the quality of multidisciplinary working can vary. A structured model creates expectations about who is involved, when reviews occur, how decisions are documented, and how treatment plans are revised.

For England, the lesson is to ensure that multidisciplinary review has enough staffing, time, authority and continuity to influence care meaningfully. When services are constrained, meetings can become rushed, overly risk-focused, or disconnected from actual therapeutic provision.

8.5 Clinical Management of Behaviour and Safety

The Californian patient and staff safety policy is notable for its explicit emphasis on addressing behaviour clinically wherever possible. It seeks to reduce unnecessary restraint and ensure that behavioural disturbance is understood within a treatment framework. Misconduct may still require custodial response, but the policy requires consultation with clinical staff and consideration of treatment plan revision, behavioural intervention and positive incentives. [13]

This reflects an important philosophical position: behaviour in a psychiatric population should not be understood only as rule breaking. It may also be communication, symptom expression, trauma response, fear, frustration, cognitive limitation or environmental stress. A clinical system must retain the capacity to ask what the behaviour means, what need it reflects, and what intervention might reduce recurrence, but this requires adequate staffing and expertise as well as processes for joint working between healthcare and prison operational staff.

If services are under-resourced, there is a risk that behaviour arising from mental illness is managed primarily through restriction, segregation or punishment. That may preserve short-term order, but it can worsen illness, increase trauma and undermine rehabilitation.

8.6 Rehabilitation and Purposeful Activity

A striking feature of the Fellowship was the visibility of meaningful rehabilitative activity within Californian prisons. Programmes such as service dog training, Braille transcription and industrial training demonstrated that rehabilitation opportunities can be created through daily structure, responsibility, skill acquisition and social contribution. This normalisation of a reciprocal exchange with the outside world seems to be an important guard against institutionalisation and a loss of hope.

Programmes involving incarcerated people training service dogs are especially powerful because they require patience, consistency, emotional regulation and care for another living being. CDCR describes programmes in which incarcerated participants train and socialise dogs for eventual placement with people with disabilities or veterans, while developing responsibility and social skills themselves. [16] Such work can support identity change: the participant is not only a prisoner or patient, but a trainer, carer, learner and contributor. During the Fellowship, incarcerated people conveyed a vivid sense of pride and excitement when discussing this work.

Through the Braille transcription programme at Folsom State Prison, incarcerated individuals transcribe material for blind and visually impaired learners. This is skilled, precise and socially meaningful work that requires sustained training and recognised certification. A CDCR account reports that close to 100 graduates had left the programme and only one had returned to custody. [14] The wider significance is that the work produces a direct benefit for people outside the prison and gives participants a credible, skilled identity.

The licence plate manufacturing programme at Folsom also demonstrates the scale of industrial training. [15] Whatever one's wider view of prison industries, the programme illustrates the potential for structured work to provide routine, skill development, production standards and a connection between prison activity and civic infrastructure. Importantly, meaningful work also reduces time spent in-cell, which can be de-skilling, disconnecting and counter-therapeutic.

These examples raise an important question for England: how often do prison regimes provide activity that is genuinely meaningful, skill-building and rehabilitative? Where prisoners spend long periods locked in cells, rehabilitation opportunities are lost. In some English prisons, the range of purposeful roles can be narrow and provide limited opportunities for transferable skill development or the development of a productive identity. One of the most impressive elements of the Californian prisons was the effort to cultivate a genuine rehabilitative milieu.

Another striking feature of the Californian system was the consistency with which both healthcare and custodial staff articulated a shared commitment to rehabilitation. Across multiple sites, staff described their

role not solely in terms of managing risk or maintaining security, but in supporting individuals to return to the community in a more stable and functional state.

This perspective was often expressed in simple but powerful terms: most incarcerated people would ultimately return to society, and staff wanted them to return as more stable, capable and mentally well members of their communities. Several staff framed this personally as their 'future neighbours.' That reframing connected rehabilitation directly to public safety, community wellbeing and responsible use of public money.

This shared ethos appeared to underpin many aspects of service delivery, including the emphasis on structured therapeutic activity, multidisciplinary care, and rehabilitative programming. It also appeared to foster greater alignment between custodial and healthcare staff, reducing the tension that can sometimes arise between security and therapeutic priorities.

8.7 Workforce Capacity, Burnout and Moral Injury

A critical enabling factor in the Californian services observed was workforce capacity. At one institution visited, I was told that up to 12 psychiatrists could work across different programmes and patient pathways within a prison of a scale that might receive only part-time psychiatric input in England. This is an observational comparison rather than a statewide staffing audit, but the order-of-magnitude difference was striking. It enables genuinely varied care streams: outpatient mental healthcare, acute inpatient treatment, intermediate or rehabilitative inpatient care, and specialist multidisciplinary review.

Workforce capacity matters because it determines what kind of care is possible. A service with sufficient psychiatric and multidisciplinary staffing can assess patients promptly, review treatment, contribute to formulation, support risk management, supervise complex cases, and help develop programmes of care. A service with lean staffing may still contain excellent clinicians, but those clinicians are forced to ration attention or risk dangerously overloading themselves with impossible workloads.

In my experience, many English prison services operate lean psychiatric staffing models, with consequences beyond access. Sustained high-risk work without sufficient time, support or recovery can contribute to burnout and poor retention. It can also create moral injury where clinicians know what good care should look like but repeatedly experience the inability to provide it because of systemic constraints. Over time, this can damage professional identity, confidence and commitment.

Lean staffing also creates blind spots. When clinicians are stretched, subtle deterioration may be missed. Risk formulation may also become episodic rather than continuous, reflective practice may be reduced or removed and multidisciplinary discussion may become compressed. Care becomes reactive with the most urgent crises receiving attention, while prevention, rehabilitation and relational work are lost.

This creates a vicious cycle where workforce shortages increase pressure on existing staff. Pressure contributes to burnout and turnover, with turnover further reducing continuity, institutional memory and confidence. Patients experience less consistent care, and prisons become less attractive places to work. Workforce planning should therefore be understood as a central determinant of safety, quality, equity and rehabilitation.

8.8 Prisons as Training Environments

One of the clearest opportunities for England is to embrace custodial environments as training settings for healthcare professionals. Prison healthcare exposes clinicians to complexity that is highly relevant across

mental health services: severe mental illness, trauma, substance misuse, personality difficulty, neurodevelopmental disorder, risk, safeguarding, multi-agency working and ethical tension.

Early exposure to prison healthcare could improve recruitment by reducing fear and unfamiliarity associated with the idea of working in a custodial setting. Many clinicians may never consider prison work because it is absent from mainstream training pathways, or because they associate it primarily with risk and restriction rather than clinical richness and public value. Structured placements could allow trainee healthcare professionals to see the skill, humanity and importance of this work.

This is also relevant beyond prisons. General adult, community, liaison, crisis and inpatient mental health services all manage risk, complexity and forensic histories. The Nottingham Inquiry is explicitly examining the understanding, assessment and management of risk to others, as well as multi-agency working and information sharing. [20] That wider national focus reinforces the value of stronger forensic awareness, formulation and confident management of complex risk across mental health services. Prison placements could help develop these skills across the wider workforce.

Prisons should therefore be recognised as environments where clinicians can develop expertise in complexity, risk and systems working. This supports a strong case for maintaining easy and fluid connections with universities, NHS training schemes and local clinical networks. It is also another reason to avoid commissioning models that isolate prison healthcare from the wider professional ecosystem within a particular locality.

9. Comparative Analysis

9.1 Centralisation, Scale and System Performance

The most important difference between California and England is not a single policy or programme, but the underlying system architecture. California operates more like a coordinated statewide system. Centralised oversight allows standards to be defined, expertise to be shared, specialist services to be developed, and patients to move between institutions according to need. This enables the system to leverage scale because not every prison needs to provide every specialist service if the estate can plan collectively and transfer patients to appropriate settings.

Centralisation also supports problem-solving across institutions. If one site develops an effective approach, learning can be shared across the state. Similarly, if a problem emerges in multiple institutions, it can be identified as a system issue rather than treated as a local anomaly.

England compares unfavourably in this respect. Diffuse commissioning and multiple providers can create fragmentation. Local flexibility has value, but it can also lead to variation, duplication, inconsistent standards and difficulty spreading best practice. Competitive contract environments may incentivise organisations to optimise delivery within the boundaries of an individual contract rather than the whole patient pathway. The relevant question should not be which provider can deliver a prison contract at the lowest unit cost, but which model creates the greatest whole-system value through continuity, rehabilitation, workforce stability, fewer crises and safer reintegration.

This is not an argument against local innovation, nor is ownership alone a sufficient measure of quality. Rather, it is an argument that local innovation needs a system capable of recognising, supporting and spreading it, and that commissioning should minimise avoidable organisational boundaries. The goal should be coordinated flexibility: national standards, shared learning, specialist capacity and local adaptation within a coherent framework.

England is not without precedent for this kind of regional or national specialist provision. The Offender Personality Disorder pathway, jointly commissioned by NHS England and HMPPS, includes specialist treatment services, therapeutic communities and Psychologically Informed Planned Environments (PIPEs) to which prisoners may progress according to need.

PIPEs demonstrate that the English prison estate can organise specialist provision across institutional boundaries and create environments designed around a particular clinical or rehabilitative need, rather than expecting every prison to provide every intervention locally. However, PIPEs are psychologically informed progression environments rather than facilities providing acute or rehabilitative psychiatric treatment for severe mental illness.

The contrast exposes an important gap. England has developed sophisticated cross-estate pathways for some forms of psychological and personality-related need, but there is no equivalent network of regional prison-based psychiatric facilities capable of providing acute and longer-term therapeutic care for people with severe mental illness. Those prisoners remain largely dependent on transfer out of the prison estate to secure hospitals, with the delays described elsewhere in this report. Therefore, England would not need to invent the principle of specialist regional provision, but extend a principle already accepted within the prison system to a population whose needs are currently underserved.

9.2 System Design and Health Inequalities

The comparison also shows that system design is a health inequalities issue. In a fragmented system, unwarranted variation is more likely. A prisoner's access to therapeutic activity, psychiatric review, inpatient care or rehabilitative opportunity may depend on where they are held, which provider is commissioned, what staff are available, and what local regime pressures exist. For a high-need population, this is inequitable.

People in prison often have less power, less voice and fewer alternatives than patients in the community. They cannot choose another service, seek a second opinion easily, or remove themselves from a harmful environment. The system therefore has a heightened responsibility to ensure quality.

California's model suggests that defined standards, monitoring and central oversight can reduce some forms of variation. England could adopt a stronger equity lens in prison healthcare, measuring who gets access, how quickly, to what intensity of care, and with what outcomes.

Transitions between services, providers, and care settings represent critical points of vulnerability within healthcare systems, and in prison mental healthcare they may act as multipliers of health inequality and risk. Individuals with severe mental illness in custody often have complex, multi-agency needs, and continuity of care is essential to maintaining stability and reducing the likelihood of relapse, self-harm, or reoffending. Where care is fragmented across organisational boundaries, transitions may be associated with loss of information, delays in follow-up, and reduced accountability, increasing the potential for adverse outcomes.

The same problem can arise when a prisoner is remitted from hospital back to custody following treatment. A person may move from an environment providing intensive multidisciplinary psychiatric care, structured therapeutic activity, occupational input and frequent clinical review to a prison mental health service operating with a much leaner workforce and more limited rehabilitative capacity. Even where the individual is clinically well enough to leave hospital, this can represent a cliff-edge in therapeutic intensity at precisely the point when consolidation of recovery may be important. The transition therefore risks becoming another discontinuity in care rather than a planned step-down within a coherent pathway.

The Californian model offers a useful contrast because acute inpatient, intermediate or rehabilitative inpatient, and outpatient care sit within a more continuous prison mental-health system. This creates greater scope for patients to move between levels of intensity according to clinical need rather than crossing organisational and commissioning boundaries each time their level of care changes. For England, the objective should similarly be to create a graded pathway of psychiatric care, so that return from hospital does not mean falling from intensive treatment directly into a substantially less therapeutic environment with inadequate provision.

In the English system, transitions including movement between prisons, transfer to hospital and release into the community often involve multiple organisations with differing systems, priorities and contractual responsibilities. This can create gaps in care when vulnerability and risk are at their greatest. At Californian sites visited, in-house social workers were actively considering post-incarceration arrangements for people with mental health difficulties. The more unified state-run structure appeared to make responsibility for continuity more intuitive and to support coordinated release planning rather than treating release as the point at which a prison healthcare provider's responsibility simply ends.

From a health inequalities perspective, the ability to maintain continuity across transitions is critical. Individuals with the greatest needs are often those least able to navigate complex systems independently. Systems that minimise fragmentation and support coordinated transitions are therefore better positioned to reduce inequities and improve outcomes for this population.

9.3 Workforce as a Structural Determinant of Safety

The comparison further demonstrates that workforce is a structural determinant of safety. A system that expects clinicians to deliver complex care without sufficient staffing will drift towards crisis response. It may maintain basic functions, but it will struggle to provide proactive, relational, and rehabilitative care.

California's stronger workforce base enables the delivery of defined standards. England's leaner staffing model risks creating gaps in provision which heighten inequalities and risks. Recommendations about therapeutic activity, timely review or rehabilitation would only be credible if matched by workforce investment and retention strategies.

9.4 Prison Healthcare as Part of the Local Healthcare Ecosystem

A key insight from this Fellowship is the importance of positioning prison mental healthcare as an integral component of the wider healthcare ecosystem. The prison wall is a security boundary, but it can also often become an unnecessary clinical boundary.

Individuals move between community, custody and inpatient settings over time. For many, prison represents only one point within a broader care pathway. The effectiveness of prison mental healthcare therefore depends not only on the quality of care delivered in custody, but on whether treatment plans survive the transition into prison, between prisons, into hospital and back into the community.

In England, prison healthcare is frequently delivered by organisations that are distinct from local community and secondary mental-health providers. Those arrangements can work well where relationships and information systems are strong, but they also create additional interfaces.

Discontinuity in access to records, clinical handovers, different referral thresholds and oversight of the whole pathway can become points of risk. Transitions are therefore not neutral administrative events and in a high-need population, they can act as multipliers of inequality and adverse outcomes.

Discontinuity can result in delayed follow-up, loss or dilution of clinical information, disruption to treatment plans and reduced engagement after release. These risks are particularly important from a health inequalities perspective because people with the most complex needs are often least able to navigate fragmented systems independently. Continuity is therefore an equity intervention as well as a quality intervention.

Models that align prison healthcare more closely with local health systems through shared providers where practicable, interoperable records, joint governance and coordinated pathways offer greater potential for continuity. CDCR's own mental-health programme explicitly links system-wide information sharing and continuity of care with successful reintegration. [18] This supports a model in which national standards, oversight and accountability for prison healthcare are combined with locally integrated delivery. Prison healthcare would operate to a consistent national specification, acknowledging the challenges of custodial healthcare provision, while being provided by organisations embedded within the surrounding community and secondary-care system. Such an approach could combine the equity and scale advantages of centralisation with the continuity and intuitive pathways created by local integration.

Provider structure matters because every organisational boundary creates a potential handover. Where healthcare is fragmented across multiple organisations with separate contracts, data systems and incentives, continuity requires active effort rather than occurring by design.

Competitive prison-only contracts can create risks when they are organisationally disconnected from surrounding NHS pathways. Over time, England should move away from siloed contracts that demonstrably fragment care, with a presumption in favour of NHS-led and tightly integrated partnership models.

10. Recommendations

The detailed recommendations below can be understood as three strategic priorities:

(1) build one integrated prison mental-health system;

(2) match clinical capacity to clinical need; and

(3) make rehabilitation, continuity and equity measurable outcomes.

These priorities are deliberately interdependent because standards without workforce become unfunded aspirations, while workforce without integrated pathways leaves clinicians working harder inside the same fragmented architecture.

10.1 Establish Meaningful and Clinically Relevant National Minimum Standards for Prison Mental Healthcare

> **Action: NHS England, working with HMPPS, clinicians and people with lived experience, should define a nationally consistent minimum therapeutic offer for people with significant mental-health needs in prison.**

England should develop national minimum standards for prison mental healthcare that define what good care looks like in care delivery, rather than purely contractual terms, using language that is accessible to frontline clinicians.

These standards should include expectations for assessment, treatment planning, psychiatric review, therapeutic activity, multidisciplinary working, suicide prevention, behavioural formulation, and rehabilitative provision integrated between healthcare and prison operational staff.

The aim should be to reduce unwarranted variation. Standards should be measurable, clinically meaningful and linked to workforce planning. England might not simply copy California's 20-hour inpatient programming requirement, but there should be a definition of an evidence-informed minimum therapeutic offer, so that clinically meaningful contact is protected rather than becoming whatever remains after operational pressures have been absorbed.

10.2 Introduce Time-Bound Standards for Inpatient Care

> **Action: Make the 28-day transfer standard provided for in the Mental Health Act 2025 achievable through sufficient secure capacity, transparent escalation for breaches, and carefully governed in-estate alternatives for appropriate patients.**

The Mental Health Act 2025 will provide for a 28-day prison-to-hospital transfer period, subject to commencement. [4] The priority should be to make that standard achievable and meaningful where breaches should trigger escalation, review and transparent reporting. Performance should be measured from the earliest relevant referral point so that delays are not displaced into unmeasured parts of the pathway. Long waits should be treated as serious system failures rather than routine operational difficulties.

England should also consider whether some forms of enhanced or inpatient care could be developed within the prison estate where clinically, legally and ethically appropriate. The Californian model demonstrates that in-estate acute and intermediate psychiatric care can reduce reliance on external transfer pathways, improving access to care and avoiding the boundary, commissioning and operational problems that can slow treatment.

Any in-estate inpatient model should only proceed where it can provide clinical standards, legal protections and patient rights equivalent to those expected in an appropriate hospital setting. This would require an explicit legal basis, independent clinical governance, robust consent and capacity safeguards, access to advocacy and statutory review where applicable, and an unhindered route to external hospital transfer whenever prison-based treatment is no longer clinically appropriate. It must not become a mechanism for retaining in custody people who require hospital care. Consistent with the wider recommendations in this report, any such service should form part of the NHS mental-health system rather than becoming a separate custodial healthcare silo.

Transparency and public accountability were key drivers of positive change in the California system. Thus, while long waits do exist as part of the English system, there should be greater curiosity and transparency about the impacts of such waits, with the monitoring of adverse health outcomes such as clinical

deterioration, the patient experience of long waits, and the impact on staff of feeling therapeutically constrained.

10.3 Strengthen Centralised Oversight and Planning

> **Action: Establish a stronger national coordinating function with visibility of demand, workforce, specialist capacity, serious incidents, outcomes and therapeutic provision across the prison estate.**

Prison mental healthcare in England would benefit from a stronger national coordinating function. This should provide visibility of demand, workforce, transfer delays, serious incidents, therapeutic provision, rehabilitative opportunities and outcomes across the estate. Central oversight should support rather than micromanage local services, identifying recurrent problems, matching specialist capacity to demand, convening expertise across institutions and ensuring that effective practice spreads beyond the provider or prison in which it originated.

10.4 Expand and Sustain the Prison Mental Health Workforce

> **Action: Plan and fund multidisciplinary prison mental-health staffing against clinical need and the intended therapeutic model, with retention, supervision and staff wellbeing treated as core safety priorities.**

Workforce expansion should be treated as a core quality and safety intervention. Psychiatric staffing, nursing, psychology, occupational therapy, social work, peer support and allied professional roles should be planned against the complexity of need and the intended therapeutic model, not simply historical staffing patterns. National workforce mapping would make unwarranted variation visible and allow staffing expectations to be linked to service standards.

Retention should be prioritised through supervision, reflective practice, manageable caseloads, professional development and recognition of prison mental healthcare as skilled, specialist and socially valuable work. Services should actively address burnout and moral injury as risks to both staff wellbeing and patient safety.

10.5 Develop Prisons as Training Environments

> **Action: Embed high-quality prison placements within mainstream professional training pathways to build recruitment, forensic awareness, risk-formulation skills and confidence in complex multi-agency work.**

The role of prisons as training environments for healthcare professionals should be maximised. Structured placements would build familiarity, reduce stigma, improve recruitment and develop skills in risk formulation, complexity and multi-agency working.

This would also strengthen forensic awareness across the wider mental health workforce. Considering national concern about risk management, serious incidents and the themes being considered by high-profile inquiries into healthcare delivery in parts of England, greater exposure to custodial settings would help clinicians develop confidence in managing complex risk while maintaining therapeutic engagement.

10.6 Embed Rehabilitation and Purposeful Activity

> **Action: Make meaningful rehabilitative activity a core outcome of imprisonment and mental-health care, with programmes judged by their contribution to identity, capability, recovery and successful reintegration.**

Prison mental healthcare should not be reduced to assessment, medication and crisis management. Across the Californian sites visited, meaningful activity was treated as a central component of recovery and

rehabilitation. The partnership observed between healthcare and custodial staff around rehabilitation as a core purpose of imprisonment was particularly striking.

England should look to expand access to structured programmes that provide skill development, responsibility, purpose and contribution. This should include educational, vocational, creative, peer, animal-assisted and socially useful programmes. The key test should be whether activity supports identity, capability and future reintegration, rather than merely occupying time.

10.7 Embed Health Inequalities in Prison Healthcare Reform

> **Action: Treat prison mental healthcare as a health inequalities priority and assess equity through access, treatment intensity, continuity and outcomes rather than nominal availability of the same service.**

Prison mental healthcare should be recognised explicitly as a health inequalities priority. Data should be used to monitor access, waiting times, treatment intensity and outcomes across relevant groups, including ethnicity, age, diagnosis, disability and care pathway. Equity should be built into standards and commissioning to drive progression in culturally competent care delivery.

Developments should prioritise those with the greatest need, recognising that delayed, inconsistent or under-resourced care compounds disadvantage. Equity should be assessed by outcomes and opportunity for recovery. This means asking whether people with the greatest morbidity receive the intensity, continuity and specialist input necessary to benefit.

10.8 Measure Outcomes That Matter

> **Action: Establish a core national prison mental-health outcomes dataset that measures clinical outcomes, continuity, rehabilitation, restrictive practice, patient experience, workforce sustainability and equity - not simply contract activity.**

National oversight should measure more than activity and contract compliance. A core prison mental health dataset should include transfer waiting times, treatment intensity, time out of cell for people on healthcare units, restrictive practices, serious incidents, continuity at prison transfer and release, post-release linkage to services, patient-reported experience, staff vacancies and retention, and meaningful rehabilitative participation. These measures should be stratified by relevant inequality dimensions so that variation can be identified rather than averaged away.

Commissioning should also assess whole system value. A cheaper prison contract may represent poor value if fragmentation contributes to repeated crisis, delayed hospital transfer, staff sickness, avoidable use of segregation, failed rehabilitation or loss to follow-up after release. The relevant economic question is the cost and outcome of the whole pathway, not the price of one organisational segment.

10.9 Integrate Prison Healthcare within Local Health Systems

> **Action: Commission for continuity, not custody: design care around the patient pathway between community, prison and hospital rather than around organisational boundaries or the prison wall.**

Reception into custody, movement between prisons and release back to the community are among the highest risk transitions for people with mental illness. Systems that fail to preserve information, therapeutic relationships and responsibility across these points risk undoing gains made before the transition and amplifying existing inequality.

Prison healthcare should therefore be aligned with local NHS systems wherever practicable, recognising prisons as part of the healthcare ecosystem of their geographical footprint.

Commissioners should explore models in which the same NHS provider, or a formally integrated partnership, spans prison, community and local inpatient services. The long-term direction should be away from siloed prison-only arrangements that create additional boundaries without demonstrable clinical benefit. Where separate or independent providers remain, contracts should require interoperable information, shared governance, training links and jointly owned transition pathways.

11. Implementation Considerations

The recommendations in this report are ambitious, and implementation would require political will, investment and sustained leadership. Workforce shortages are likely to be a significant barrier. Without a credible workforce strategy, new standards risk becoming unfunded aspirations that increase pressure on already stretched services.

Funding is another barrier. The recommendations in this report imply increased investment in prison mental healthcare, which may initially appear difficult in a constrained public-finance environment. Yet the cost of poor care is also substantial: untreated illness, self-harm, suicide risk, staff sickness, failed rehabilitation, delayed transfers, repeated crises, litigation, inspection failure and loss of public confidence all generate cost elsewhere in the system. Investment should therefore be assessed in terms of whole-pathway value, safety and long-term outcomes rather than prison-healthcare spend in isolation.

A further implementation challenge is governance. England's fragmented model makes change harder. Stronger central oversight would need to work constructively with commissioners, providers, prison leaders, clinicians, regulators, patients and families. Future developments should avoid creating a purely compliance-driven culture. The aim should be learning, consistency and improvement.

There are also important ethical considerations in any discussion of in-estate inpatient care. Prison is not a hospital, and deprivation of liberty creates inherent risks. Any enhanced prison-based treatment model in England would need robust legal safeguards, independent scrutiny, clear clinical governance, patient rights protections and routes to hospital transfer where required.

Despite these challenges, the Fellowship suggests that change is possible. California's current system emerged from serious failure, sustained external challenge, the definition of standards and repeated attempts to build the capacity needed to meet them. England does not need to reproduce that history to learn from it. A deliberate reform programme can combine national direction with local clinical ownership and sequence change so that expectations rise alongside capability.

A pragmatic sequence for reform

Time horizon	Priority actions
Immediate / 0-2 years	Implement and transparently monitor the 28-day transfer framework; establish national workforce and outcome baselines; protect reflective practice; define minimum therapeutic standards; strengthen escalation for people awaiting hospital.
Medium term / 2-5 years	Expand prison mental health training placements; develop regional specialist capacity and enhanced in-estate care

Time horizon	Priority actions
	pilots; align commissioning with local NHS pathways; build interoperable transition processes and common outcome measures.
Longer term / 5+ years	Move toward an integrated national model with NHS-led local provision, specialist hubs that serve multiple prisons, and commissioning based on rehabilitation, continuity, equity and whole-system value.

12. What next: translating Fellowship learning into change

This report is intended as a starting point. The next step is to test its proposals with people with lived experience of prison mental healthcare, prison governors and custodial staff, frontline clinicians, NHS England, HMPPS, secure mental-health providers, commissioners and regulators. In particular, the proposed shift from prison-by-prison contracting towards continuity-focused local health-system integration needs to be examined against operational, legal and financial realities.

A practical early objective would be to develop a small national set of measures that make the current system visible, such as psychiatric and multidisciplinary staffing, therapeutic activity, transfer delays, restrictive practices, continuity at release, patient experience and rehabilitative access. Alongside this, pilot areas could test whether closer alignment between prison healthcare and local NHS providers improves information flow, access to specialist advice, workforce development and through-the-gate continuity.

The wider purpose of the Fellowship is to promote a conversation about ambition. Prison mental healthcare should not be judged by whether a basic service can keep going in a difficult environment, but I would hope that the ambition would be to develop a system that enables people to stabilise, recover, develop capability and return to their communities safer and healthier.

13. Conclusion

This Fellowship demonstrates that the challenges facing prison mental healthcare in England are not inevitable. They are shaped by choices about system design, commissioning, workforce, accountability and the value placed on rehabilitation. California is a challenging rather than comfortable comparator. Its stronger structures were built in response to identified challenges and remain under legal oversight. However, that history shows what becomes possible when a large prison system is required to define standards, build capacity, create multiple levels of care and account for delivery.

The strongest lesson is that quality cannot depend on individual clinicians working ever harder within constrained systems. Good care requires architecture that includes clear standards, sufficient staffing, appropriate facilities, timely pathways, continuity across transitions, meaningful activity, data, oversight and learning. Without these, even highly committed staff are left trying to provide care that the system is not designed to support. A system that normalises workforce overextension also risks normalising reactive care, blind spots, moral injury and diminished rehabilitation.

For England, the opportunity is to move from fragmented and reactive provision towards a more integrated, proactive and equitable model. Prisons should be understood simultaneously as healthcare settings, rehabilitation environments, training grounds for skilled professionals and temporary stages in a person's wider life and care pathway.

Most incarcerated people will return to the community. As staff across the Californian prisons repeatedly reminded me, they are our future neighbours. The relevant question is therefore not simply how safely people can be contained today, but in what condition they will return to our communities tomorrow.

Commissioning for continuity, building adequate clinical capacity and treating rehabilitation as a measurable outcome would serve patients, staff, communities and public safety alike.

14. Appendix: Fellowship sites and engagements

Visits to Folsom State Prison, San Quentin State Prison and the California Medical Facility. This was in addition to discussions and meetings with a range of CDCR staff.

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