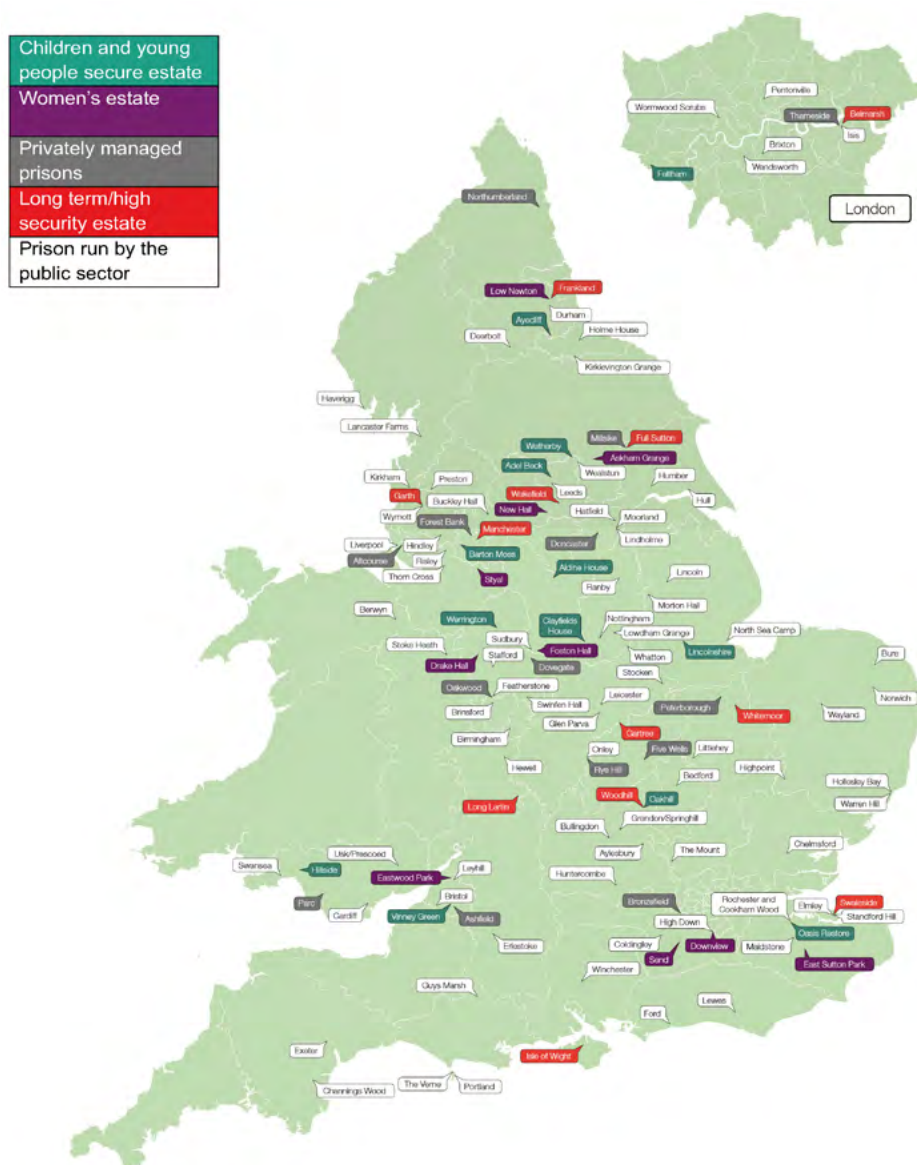


A report commissioned by the Lord Chancellor
and Secretary of State for Justice and the
Secretary of State for Health and Social Care
from the Chief Medical Officer



Foreword

For centuries it has been recognised that the health of people in prison is less good, and often much less good, than the general population. In part this is because those in prison or on probation are more likely to come from more deprived parts of the population where risk factors for disease are highest. It also occurs because the conditions in prison make the prevention and treatment of disease more difficult. Considerable strides have been made in improving healthcare in prisons and for those on probation in England over the last 3 decades but significant disparities and issues remain.

The Secretary of State for Health and the Social Care and the Lord Chancellor jointly commissioned me to write a report on health and healthcare for those in prisons, on probation and in secure NHS estates like Broadmoor. The NHS and HM Prison and Probation Service (HMPPS) are jointly responsible for ensuring that men and women in prison and children held in youth custody secure settings, on probation, and in the wider secure estate have healthcare comparable to the general population. In some cases offending and reoffending on leaving prison or probation are linked to health. For example, access to treatment for drug and alcohol misuse and mental health in the community can help reduce offending behaviour. There are also benefits to the health of those in prison, prison and probation staff and wider society from addressing communicable diseases that might otherwise be passed on. The prison population in England is ageing with the number of people in prison over 50 increasing from 10% in 2011 to 24% in 2024. As a result diseases associated with older age, previously relatively rare in prison, will inevitably increase significantly in the coming decades and we must plan for this, and prevent it where we can.

Throughout the work leading up to this report we have come across many prison doctors and nurses, prison and probation staff, governors and public health experts who are showing great leadership to improve the health of those in prisons, on probation and the NHS secure estate. There is much to learn from the best examples of prevention and healthcare across prison and probation services across the country. Many things that look impossible in one part of the country are being achieved in others.

There are of course many structural barriers. Some are difficult to overcome such as the ageing prison estate. There will always be a tension between optimising security and safety (HMPPS priority) and health (NHS priority). Many areas can be improved however, ranging from better medicine delivery through to improved integration of health data between NHS and prison and probation health services. Some of the greatest health risks predictably occur during and just after transitions: on arrival in prison; after transfer between prisons and just after release from prison or probation. These are exacerbated by poor data flows between prison health and wider NHS services. This report concentrates in particular on the areas where we consider improvements are practically possible and likely to have an impact in improved health for those in prison or on probation. I would like to thank the many people who have contributed to this report, and in particular Dr Nicola Vousden and Danny Duffield.

Professor Chris Whitty, Chief Medical Officer for England.

Report structure

The aim of this report is to explore the health and healthcare of people in prison and on probation in England and make recommendations to improve these. It combines insights from, and individual chapters authored by: front line professionals working in prisons and the secure estate and in probation; public health professionals; commissioners and policy makers in health and justice; third sector organisations; academics and lived experience experts.

These insights were gathered by extensive evidence gathering and stakeholder engagement, albeit by a small team within a defined time frame from September 2024 to July 2025. Regional health and justice teams across prison and probation were invited to share their written experiences and attend roundtables. Additional roundtables and workshops were conducted to explore specific themes such as the health needs and healthcare challenges of people on probation, health workforce and long-term conditions. We are very grateful for the time, enthusiasm and knowledgeable response from prison, probation, NHS and public health staff.

Building on previous CMO visits looking at health to the secure estate (including secure mental health hospitals) we visited a further: 15 male and female prisons; 1 young offenders' institution, 1 secure school and 1 secure children's home; 1 secure NHS hospital and 4 probation delivery units. These covered all regions of England. During visits we discussed with frontline clinical and operational staff as well as people in prison, prison and probation officers, governors and healthcare leaders and we are very grateful for their time and expertise.

In addition to lived experience identified by chapter authors and from group discussions during visits, we worked with the NHS Health and Justice Lived Experience Network and Empowering People: Inspiring Change (EP:IC) lived experience consultancy to bring together themes from existing lived experience engagement relevant to the chapters of this report, including engagement held for the 10 Year Health Plan. This was supplemented with additional lived experience focus groups held with pregnant women currently in prison, with people on probation and recently in prison on topics including the health and care needs of older adults in prison and health improvement in prison. One person with lived experience of the criminal justice system was a member of our steering group and contributed and reviewed all chapters. Lived experience contributions are incorporated throughout chapters in blue panels, practice examples (orange) and case studies (lilac) gathered from engagement are also included to illustrate findings.

The development of the report was guided by 2 groups:

- a stakeholder steering group with representation from UK Health Security Agency, Department of Health and Social Care, HM Prison and Probation Service, Ministry of Justice, NHS England and EP:IC lived experience consultancy
- a clinical task and finish group chaired by the Royal College of General Practitioners: Secure Environments Group. Attended by front line clinicians and clinical leaders (GPs, nurses, pharmacists, psychologists, psychiatrists, midwives, obstetricians and peer support workers) working in, or with recent experience of, prisons, probation and the secure estate

The 'children and young people' chapter was guided by its own steering group with representation from NHS England, Youth Justice Board, Youth Custody Service and clinical advisers.

The important challenges of substance misuse in prisons have been extensively explored in the recent independent review by Dame Carol Black published in 2024. For this reason we have not concentrated on this issue in this report and would point people to Dame Carol's recommendations¹. Sentencing policy is obviously outside the remit of this report on health, although the implications of long and short sentences on health and healthcare is considered. Any response to the Sentencing Review by the Rt Hon David Gauke 2025 is likely to have an effect on prison and probation health and healthcare². While important to this population, it was outside the scope of this review to do an in depth review of social care in prisons. The ongoing independent commission into adult social care should consider the justice population.

Summary of the chapters

The full report can be accessed on the [Chief Medical Officer \(CMO\): annual reports](#) page on GOV.UK. The chapters included in the full report are outlined below. This extended executive summary and recommendations highlights the main findings from the chapters on the current situation (largely descriptive), then identifies overarching themes. This is followed by the main high level and more detailed recommendations.

The full report contains 18 detailed chapters, which can be read together but, for those interested in specific aspects of prison and probation health, are each designed to stand alone, and include some more specific or detailed recommendations. Each of the chapters of this report include positive practice examples that we want to highlight, in addition to the many more good examples that were submitted to us. We recommend increased sharing of regional best practice and evaluation of interventions to increase the evidence base for these programmes and activities.

Summary of chapters:

Chapter 1 – Setting the scene on prison and probation health and healthcare

Chapter 2 – Pregnancy, birth and the postnatal period in prison and on probation

Chapter 3 – Children and young people in custody or at risk of custody

Chapter 4 – Women in prison and on probation in England

Chapter 5 – Older people in prison

Chapter 6 – Palliative care and end of life in prisons

Chapter 7 – Data and information sharing

Chapter 8 – Mental health of people in prison and in contact with the criminal justice system in the community

Chapter 9 – Supporting neurodivergent people and those with neurodevelopmental conditions within prison and on probation

Chapter 10 – Self-harm and suicide in prison

Chapter 11 – Complex care in the criminal justice system

Chapter 12 – Health protection in prisons and probation

Chapter 13 – National screening programmes in prisons

Chapter 14 – Health promotion and improvement in prisons

Chapter 15 – Health needs on release from prison

Chapter 16 – The health needs and barriers experienced by people on probation

Chapter 17 – A health and care workforce for the future criminal justice population

Chapter 18 – Health research with people in prison and on probation in England

Pregnancy, birth and the postnatal period in prison and on probation



Source: HMP Bronzefield

Each month in England an average of 47 pregnant women are in prison³. In the year prior to March 2024, 54 women applied and were approved to live in a specialist mother and baby unit (MBU) within the prison, with their baby⁴. The number and needs of pregnant and postnatal women on probation is not known.

A higher proportion of women in prison have social circumstances and factors that increase risk to the mothers' and babies' physical and mental health during pregnancy and the postnatal period than in the general population. In the pregnant and postnatal population in the general population, 1 in 5 women experience mental health difficulties⁵ but women in prison have a high prevalence of circumstances such as previous trauma and domestic abuse, alongside the stress of potential separation from their baby or other children, which can all increase the risk of poor mental health⁶. The prison environment can also add additional risk through its impact on access and quality of healthcare. For example, women are locked in cells at night and maternity care is generally not available 24 hours a day, 7 days a week while medical emergencies in pregnancy can occur at any time. All women experience symptoms and health changes during pregnancy. Being in prison can have an impact on these, for example women with sickness in pregnancy (which can be severe) may be affected by restricted choice of foods.

There have been significant advances in the co-ordination of care for this group, described in this chapter, and which could be replicated for other vulnerable groups. Despite these, excess risks to both mother and baby inevitably remain and it is medically responsible to avoid

imprisonment of pregnant and postnatal women where possible, in concordance with the mitigating factor introduced by the Sentencing Council in 2024⁷.

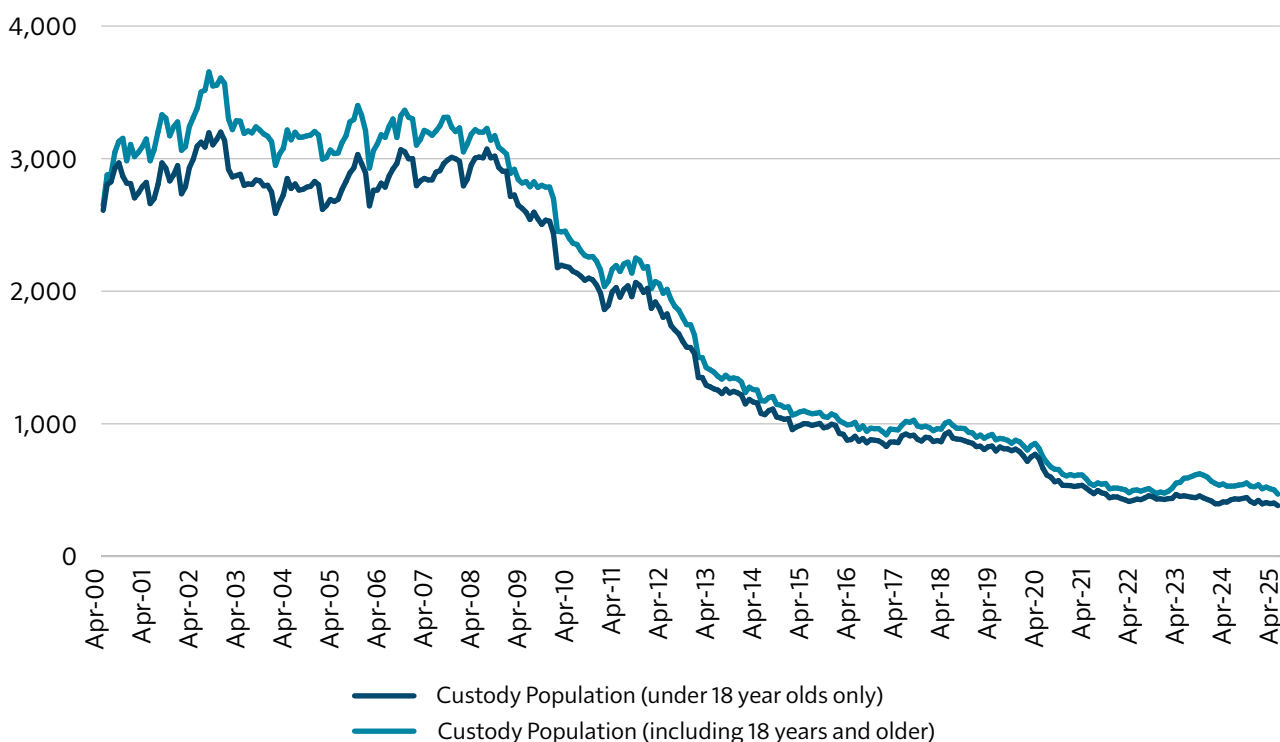
Three main challenges we identified which can be improved are:

- assessment of need on reception to prison: maternity records from the general population are often not accessible, assessment screening templates are not specific to pregnancy and maternity staff are not always available
- transitions back into the general population: the risk of deteriorations in perinatal mental health are increased during transitions, clinical handover may be dependent on the woman self-referring her pregnancy and joint working between maternity and probation is not specifically supported by policy
- significant variations in care in prison: this includes pathways to access early pregnancy care, support following pregnancy loss (miscarriage, stillbirth or separation), post-birth care, access to perinatal mental health pathways and midwifery cover that takes account of the complexity of the caseload

Children and young people in custody or at risk of custody

The population of children and young people in the secure estate has decreased substantially since 2008.

Figure 1: population of the children and young people in custody from 2000 to 2025



Note: includes children held for justice reasons, not welfare, includes Wales. Includes Hillside, Parc Youth Offenders' Institution (YOI) and Oakhill Secure Training Centre (STC). Source: youth custody data⁸

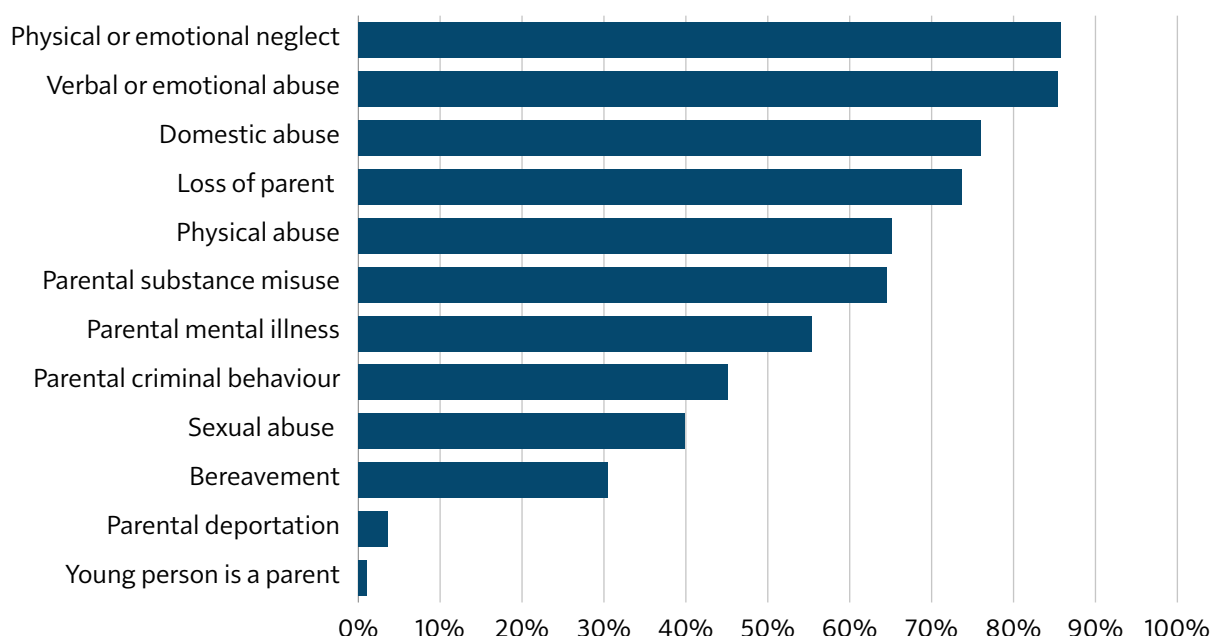
As figure 1 shows, 383 children aged under 18 were accommodated in April 2025, down from a peak of 3,145 children in July 2002⁹.

Children and young people can be placed in the secure estate on youth justice grounds or held for their own protection or for the safety of others on welfare grounds. The commissioning and governance structures are complex and separate. This division of the estate results in a government policy focus on ‘young offenders’ and separately on children in need of secure accommodation for their own welfare. A third group, which overlaps with both these cohorts, consists of children referred to secure mental health hospitals. In reality, these groups of children and young people frequently have parallel very complex health needs relative to the general population of children and young people, including:

- high levels of childhood adversity
- mental health difficulties
- neurodevelopmental difficulties
- emotional difficulties

There are also children at risk of entering the secure estate with similar complexity.

Figure 2: adverse childhood experiences of young people placed for welfare reasons in England between 2021 to 2024



Source: Secure Children Welfare Unit

Figure 2 shows the very high levels of adverse childhood experiences (ACEs) of children and young people placed for welfare reasons in England, including 86% experiencing physical or emotional neglect, 85% verbal or emotional abuse and 76% domestic abuse.

From the limited available evidence, physical long-term conditions do not appear to be more prevalent in children and young people in the secure estate compared to the general population

of children and young people, with the exception of epilepsy. Neurodivergence, speech and language needs and mental health needs are however considerable and higher than the general population of the same age.

Children can often come into contact with the youth justice system when earlier intervention, including health or mental health intervention, could have avoided it. Effective prevention and diversion work relies on multi-agency collaboration. The NHS England Framework for Integrated Care includes community vanguards. These are community pathways of care that target children that have experienced trauma or adversity and are at risk of encountering a secure setting, either on welfare, youth justice or mental health grounds¹⁰. Community vanguards currently target 19% of the possible cohort of children that could benefit.

Currently there is no single or integrated approach across government to programmes for vulnerable children and young people and no shared narrative at a cross-government level for vulnerable children and young people, which risks siloed systems and a lack of shared understanding. Unless these needs are addressed, children and young people are at significantly increased risk of negative social, physical and mental health trajectories across their life.

Women and families in prison and on probation

Across England and Wales, there are currently 12 female prisons, all of which are in England. Females make up 4% of the overall prison population and 12% of the population under the supervision of probation. In 2023 there was an extensive national independent review of health and social care for women in prison and leaving prison¹¹. This identified 8 main findings and associated strategic recommendations, which are still current national priorities. Women are more likely to have short prison sentences and in 2024 the government announced plans to reduce the number of women in prison by diverting them to sanction and support in the community.

Most women in prison and under the supervision of probation have experienced trauma at some point in their lives, including 2 in 3 identified as victims of domestic abuse¹² and over half experiencing emotional, physical or sexual abuse as a child¹³. This can be associated with a complex and cyclical pathway of poor mental health and substance use, both of which are more prevalent in women than men in prison^{14 15}, and significantly higher than the general female population. Although data on wider health needs of this group is very limited, these factors directly impact on health, as well as engagement, access and experience of healthcare. There are many positive practice examples where services identify and respond to these holistic needs, including women's centres and women's health or primary health services working within probation. However, access to these services is very variable between areas, dependent on local commissioning arrangements.

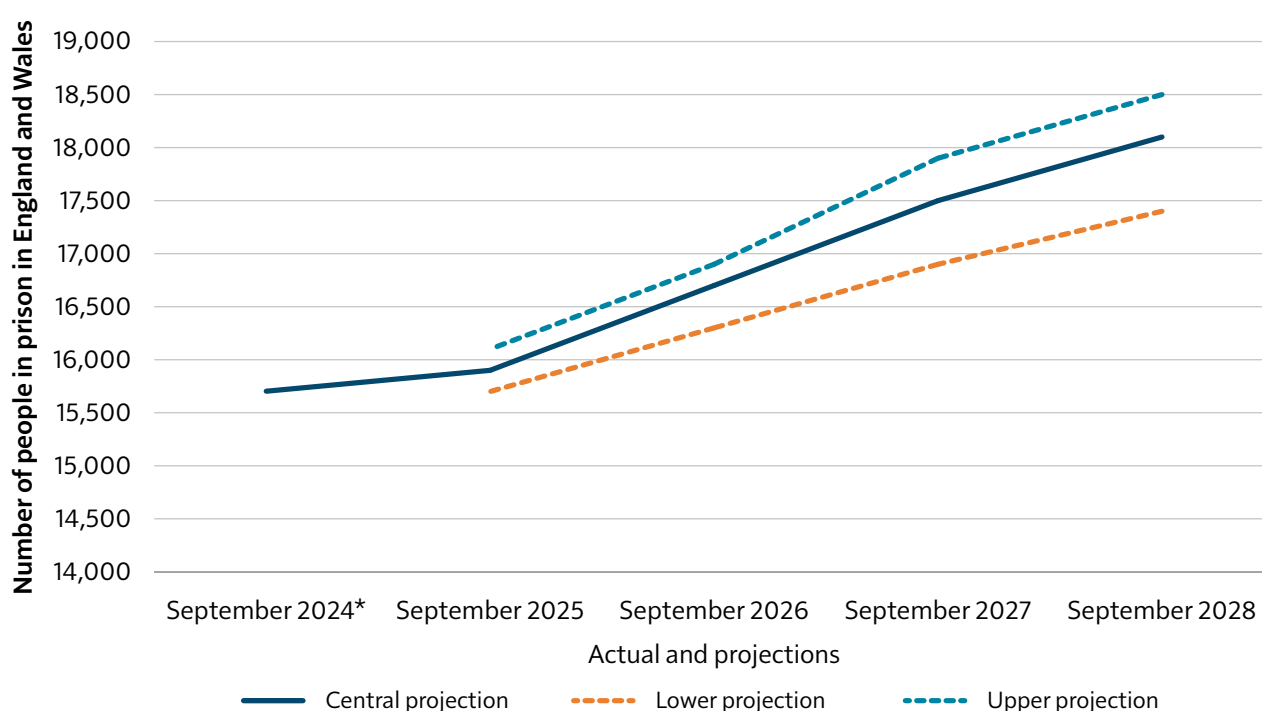
There are further opportunities to ensure this good practice is shared and supported at a regional and national level, building upon the integrated pathways of care that have been developed for women's health hubs. The 2025 government commitment to neighbourhood

health services provides an opportunity to include the justice system and wider partners to ensure the needs of women with criminal justice system involvement are met.

Older people in prison – an increasing health issue

The criminal justice system defines individuals aged 50 to 60 as ‘older’, noting that age-related illnesses, dependency and frailty can begin at an earlier age than people of the same age in the general population. The prison population is ageing. The number of people in prison over 50 has increased from 10% in 2011 to 24% in 2024¹⁶.

Figure 3: actual number of people aged 50 and over in prison in September 2024 and projected number of people between 2026 to 2028 (upper and lower projections)



Source: Ministry of Justice, prison population projections 2024 to 2029, *actual prison population values taken from 30th September 2024¹⁷

Figure 3 shows that a further 15% rise in the older prison population is projected by 2028¹⁸. This has implications for future healthcare needs given the generally higher health needs of older people.

Older people in prison have on average worse physical and mental health than older men of the same age in the general population^{19 20 21 22}. While individual conditions pose challenges, their combination (multimorbidity, or multiple long-term conditions) is significantly more problematic. In prison populations frailty often begins earlier – more than 40% of men from prisons over 50 who were admitted to hospital in an emergency showed signs of frailty²³, much higher than the general population. Frailty can affect ability to climb stairs, wash independently and walk unaided²⁴. This is important in the prison environment, where there may be overcrowding, shared cells and in-cell sanitation, and because employment and activities are often aimed at the predominantly younger population. The prison estate is also ageing and was

designed for a young male population and generally not designed for the needs of elderly or disabled prisoners.

Older people in prisons may underreport early symptoms of disease, reducing the time for more effective intervention to head off major disease. In 2008 the Department of Health recommended that assessments to identify the health and social care needs in prison should automatically begin at 60 years of age and be repeated, as a minimum, at 6-monthly intervals²⁵. While the screening tool on arrival at prisons asks combined question about disability and personal care needs, it does not include standardised questions about age-related needs such as frailty or cognition and is not systematically repeated.

Data on prevalence of health and social care needs in older people in prison are not used nationally to plan operational or healthcare responses. Given the significant increase in older prisoners is recent, even experienced prison officers may have limited experience or understanding of age-related health conditions. There are local examples of excellent practice and innovation to support the needs of older people in prison, including peer support 'buddy' models and dedicated provision for age-related concerns. It is important that there is adequate accessible provision across the entire prison estate and an operational and health workforce to meet the needs of older people in prison.

Palliative care and end of life in prisons

Palliative and end of life care is a relatively small but increasing need for prisons. Dying well wherever you are and whatever your background or circumstances are fundamental aspects of human dignity. Despite multiple recent reports on palliative and end of life care^{26 27 28 29} and individual examples of good practice, to date action is voluntary and not necessarily supported by commissioning by health and social care. In 2018 the unique challenges of providing equality in end of life care in prisons was recognised and the dying well in custody charter and self-assessment tool produced, which was updated in 2024. However, the charter remained for local implementation in individual prisons, which has varied.

This chapter uses case studies to describe challenges. These include:

- systematic identification of end of life and care planning in prison, especially in individuals with advanced chronic disease compared to those with malignancy
- rare approval for compassionate early release on the grounds of health or social care needs
- complexity of the multi-organisational process, with the prison service and probation needs in addition to patients, family and friends, primary care, hospital teams, physiotherapy, occupational health, social care and specialist palliative care

The ageing prison estate can lack essential resource for end of life care such as hospital beds. There are also barriers to accessing medication which is part of normal care for end of life in prison, including opiates. There is a need to ensure prison officers, who may have no prior experience of death and dying, know where to call for help overnight and that there are policies in place for additional support for prison officers and fellow people in prison. Release planning

when there are complex health and social care needs in the last months of life can be complicated.

Caring for people who are dying is a normal part of medicine. In common with the general population most people who die in prison will need general medical care rather than specialist palliative care. Most will have no greater complex medical needs than those usually seen by a specialist palliative care team in the community – it is the prison setting that adds complexity to their care.

Data and information sharing

Health data is essential for safe, high-quality care, research, surveillance and planning of health services. Sharing health data between the NHS and prison and probation service makes services both safer and more efficient for individuals and overall. The criminal justice landscape is a complex system of numerous geographical, commercial and legal boundaries and responsibilities. There are many IT systems that sit across multiple government departments and organisations, including: DHSC; MoJ; Home Office; NHS and UK Health Security Agency (UKHSA).

Many of these systems cannot communicate with one another. There has been considerable progress toward improving the transfer of records between community primary care and the prison healthcare record system, but there remains some way to go. Since 2022 in the male estate and 2024 in the female estate, those arriving in prison are able to choose whether to fully register with the prison healthcare system and transfer their lifelong community health record to the prison GP service. Approximately 1 in 3 people in prison do not choose this and their full electronic health record is not available to prison healthcare staff.

The issue around opting in is that people in prison are then de-registered with their community GP. Therefore, those on remand or with short sentences are less inclined, or not encouraged, to opt in, as it will appear on their health records and may lead to a potential break in service provision when they leave prison. There are more challenges on leaving prison:

- there is currently no mechanism by which prison healthcare providers can electronically or automatically pre-register a patient with a community GP practice prior to their release from a prison to ensure that the record is transferred back to the community on the day of release
- following release, a person must register with primary care in the community so the full care record, including episodes from within the prison, transfer back to the community GP practice
- pre-release clinics can support by prescribing medication and identifying a community GP practice to register with, but not everyone is eligible, often release can be unexpected, or community practices opt to wait until the patient makes contact to be sure they are released
- if a person does not have primary care registration with a community GP on release the electronic record remains 'siloes' in the prison system

There is currently no mechanism by which the relevant essential individual data in the person's clinical record can be routinely or directly shared with other relevant health or justice providers. This includes community mental health teams, substance misuse services or social care providers, as well as justice organisations including probation services. This has implications for supporting continuity of healthcare. For example, if an individual has started a course of treatment for Hepatitis C, probation may be unaware and therefore unable to support the person with the continuity of this following release from prison, posing a risk to the person on probation and others.

Aggregate, anonymised health-related and criminal justice data has been largely excluded from the large aggregate data projects, despite this being a population with a particularly high prevalence of many mental and physical health needs. Health data from prisons or people on probation is not currently routinely included or visible, or is of poor quality, in the national extracts such as the Mental Health Services Dataset, or regional extracts available to integrated care boards (ICBs). This inhibits research necessary and beneficial for understanding trends and informing patient care as well as:

- population surveillance, for example monitoring progress towards elimination of Hepatitis C
- procurement processes for prison healthcare
- service planning by ICBs and local authorities

Health data and justice data are also not linked, which limits understanding of care pathways, risk factors, the impact of interventions and health inequalities. Accurate data linkage requires 2 or more datasets to have the same information relating to the same person. Agreement on the use of the NHS number as an appropriate unique identifier would be a pragmatic approach. Ensuring that health and justice data are included in the growing number of cross-government data linkage projects will further enhance our understanding of population needs.

Changes in this field need cross-departmental leadership, resource and a team with appropriate enablement and permission to oversee data governance, data controllership, data-sharing, data linkage and data analysis, in conjunction with developing interoperability of the systems and data quality improvement. It is important to include representatives with lived experiences in this team, for example, to explore principles of consent and the extent and timing of information sharing.

Mental health of people in prison and in contact with the criminal justice system in the community

Mental ill health is very common across the criminal justice system pathway compared to the general population³⁰. The relationship between mental health and crime is complex but evidence suggests that the better mental health is in prison, the lower the probability of reoffending on release³¹. Similarly, improving mental health after release from prison reduces reoffending³².

Liaison and Diversion services exist to:

- identify people who have vulnerabilities
- support people through the early stages of criminal justice system pathway
- refer people for appropriate health or social care
- divert people away from prison and other justice settings if required

Avoiding offending and custody through earlier intervention is essential.

Of people in prison, around 1 in 7 are identified as having a treatable mental disorder. For people with an established diagnosis there is a pathway and treatment, although not all prisons have specialist mental health services sufficient to respond to need.

The acute pressures of the NHS mental health service for the general population have implications for people in the justice system. The criminal justice environment is often not a suitable place for managing someone with acute mental health needs. Currently, people can be remanded (detained) in prison for their 'own protection' solely on mental health grounds. The Mental Health Bill 2025 (going through Parliament at the time of publication) is removing powers to do this, but to make this effective alternative community provisions need to be found to keep people safe and give them access to appropriate treatment and care.

Currently, individuals with severe mental illness in prison can also be detained temporarily in prison as a 'place of safety' while awaiting a hospital bed for treatment or assessment under the Mental Health Act. The Mental Health Bill is also removing the power to use prison as a 'place of safety'. Instead, a defendant or convicted person who meets the criteria for detention must be transferred directly to hospital on the day of their court hearing, ensuring swifter access to the care they need. This however depends on a suitable bed being available.

Some people in prison with acute mental illness may need to be transferred to secure NHS hospitals during a custodial sentence. This is complex and while guidance states referral to transfer should not exceed 28 days, the average wait in 2024 was 85 days³³. The Mental Health Bill aims to address this, but there remain significant practical and structural issues across mental health inpatient provision that must be addressed to meet the 28-day limit.

The current pressures on secure NHS beds creates significant challenge. In some circumstances when an individual with acute mental illness is deemed appropriate to be detained under the Mental Health Act is due for release at very short notice, there is a critical need to find an appropriate bed in a secure mental health setting. This is often difficult.

A large number of people in prison also have risk factors for poor mental health such as experience of childhood trauma, domestic violence and concurrent substance use disorder. In addition, the prison environment, regime and sentence type can inevitably have a negative impact on mental health and access to services. Together this means there is a need to identify and support the mental health needs for the whole prison population, but this is not easy. There is a variable range of non-clinical services and supports available, but often health-related activities, including ones aimed at mental health, are not incentivised and prioritised in the same way as education and employment, and so are not always well used.

There is insufficient capacity in NHS community mental health, crisis and inpatient services to meet needs of this population on release, or for those on probation that do not go to prison. As for the general population, there is a significant treatment gap, which means that there are high thresholds to access mental health support and only the most unwell receive specialist care, with many experiencing long waits. Mental Health Treatment Requirements (MHTR) are a type of community sentence treatment requirement commissioned by NHS England. Completion of primary MHTR improves mental health and reduces re-offending³⁴. There is variation in implementation and access to MHTR, including for people with concurrent substance use disorders. People with complex mental health needs will not be eligible for primary MHTR and can face barriers to accessing community mental health teams. This can contribute to an ongoing cycle of offending and imprisonment.

Supporting neurodivergent people and those with neurodevelopmental conditions in prison and on probation

The proportion of neurodivergent people and prevalence of diagnosable neurodevelopmental conditions in the adult prison population and the population on probation is estimated to be higher than in the general population^{35 36 37}.

The prison environment can be difficult and stressful to navigate, especially during transitions into, out of and between prisons and can often exacerbate the difficulties experienced by a neurodivergent person or someone with a neurodevelopmental condition. There has been an overarching improvement in organisational and staff awareness of the high number and potential needs and support requirements of neurodivergent people in prison.

Prison healthcare staff have an important role in clinical screening, further assessment or recommendations. Specialist secondary care clinicians can support with many tasks including:

- clinical risk assessments
- medication management
- care co-ordination and care plans
- medications for some neurodevelopmental conditions

Not all neurodivergent people arriving into prison will have a prior confirmed diagnosis.

The national shortage of staff trained to undertake diagnostic assessments for neurodevelopmental disorders has an impact on prison healthcare, as it does in the general population and those on probation. Neurodevelopmental diagnostic assessment is not part of the standard prison healthcare contract or commissioning framework. Therefore, if a prison healthcare team does not have access to this expertise (as is common), then the decision to undertake an assessment is dependent upon the judgement of the lead clinician and also the discretion of the local commissioner. Prison health primary care services can in theory refer to community secondary care services or waiting lists, but this does not appear to be happening or

possible within most prisons. This means that the majority of individuals who screen positive for certain conditions do not receive a diagnostic assessment when in prison. They then join the community waiting lists of assessment on leaving prison, therefore prolonging their waiting times. There are also reports of individuals being removed from community neurodevelopmental waiting lists when they enter prison, possibly as record changes are taken to mean they have permanently moved out of the area.

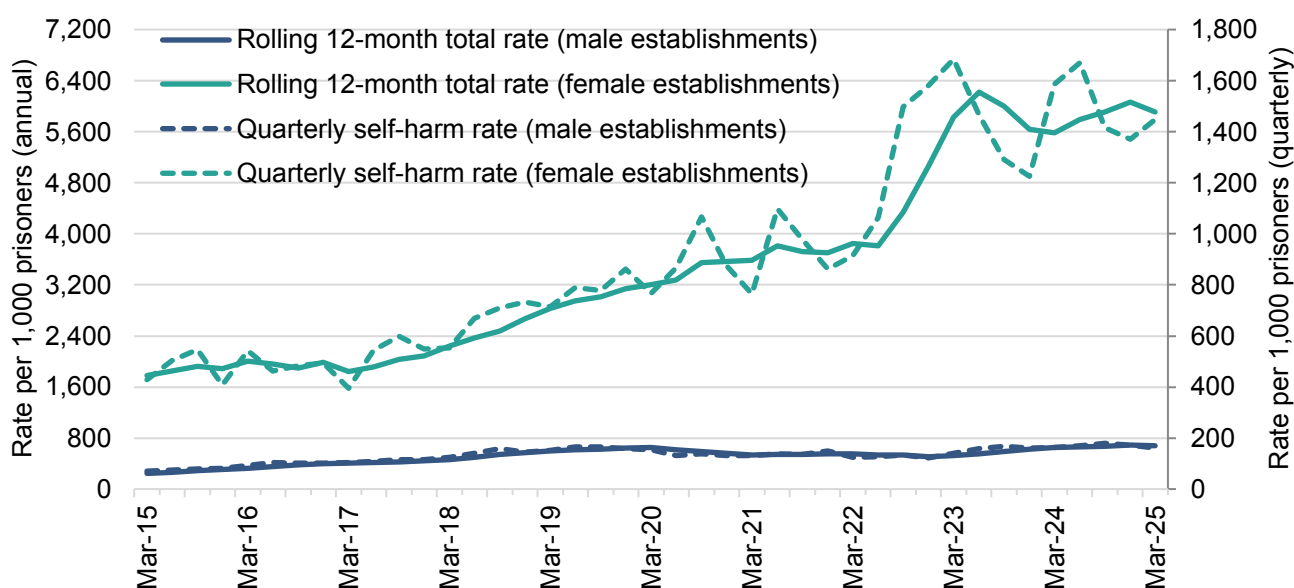
For many, where the appropriate awareness and needs-based support is provided by all agencies within a prison, or reasonable adjustments for people on probation, this lack of diagnosis does not significantly reduce their ability to engage with justice and healthcare systems. However, for others, this can be an obvious barrier to accessing interventions, such as medications, that could have a significant impact upon their health, well-being and ability to cope and engage with these systems. It also presents challenges on release, a time of considerable change but long community waiting lists.

A further specific example of the impact of prison on the care pathway is interruptions to access to ADHD medication as people move in and out of, and between prisons. This can occur for a variety of reasons including confidence in the credibility of the diagnosis or lack of specialists to carry out the National Institute for Health and Care Excellence (NICE) recommended 12-month medication review.

Self-harm and suicide in prison

Rates of self-harm in prison are now at the highest level since records began in 2012 (figure 4). The rates are almost 9 times higher in the female compared to the male estate, and highest for people on remand compared to those sentenced.

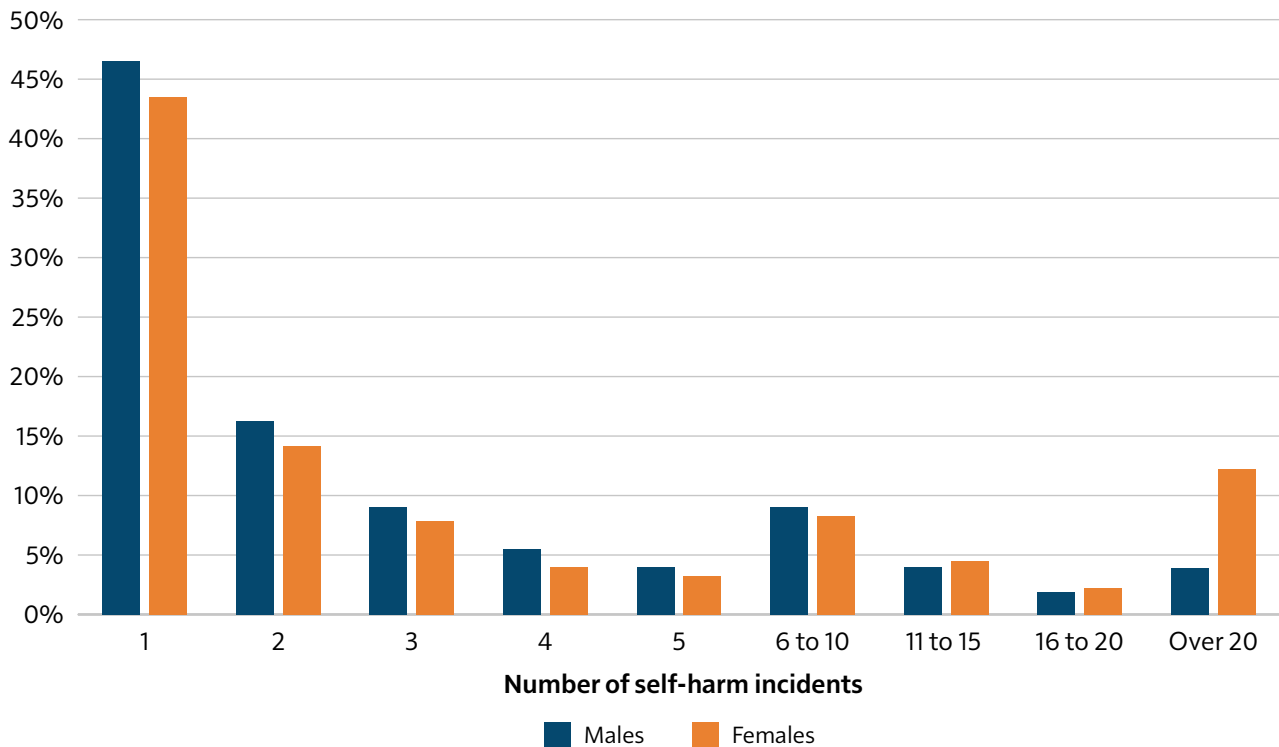
Figure 4: quarterly 12-month rolling rate of self-harm incidents per 1,000 people in prison by gender of establishment, 12 months ending March 2015 to 12 months ending March 2025



Source: Ministry of Justice³⁸

Figure 4 shows that the rate of self-harm incidents in the male estate in the 12 months to March 2025 was 684 incidents per 1,000 people in prison, compared to 5,906 per 1,000 people in the female prison estate. Most people in prison who self-harm do so more than once and multiple self-harm attempts are more common in the female estate (figure 5).

Figure 5: proportion of individuals self-harming by frequency of self-harm incidents in 12 months ending December 2024



Source: Ministry of Justice³⁹

Figure 5 shows that of individuals that self-harmed in prison in 2024, 53% of males and 56% of females had more than one self-harm incident and 4% of males and 12% of females had over 20 self-harm incidents. Some incidents of self-harm in custody can be very serious and complex to manage.

Clinical risk factors such as major depression and psychotic disorders are strong risk factors for self-harm in prison⁴⁰. Therefore, identification and treatment of clinical depression, psychotic disorders, personality disorders and other disorders is central to preventing and reducing self-harm.

Prison factors that are associated with increased risk of self-harm⁴¹ include:

- separation from other prisoners
- disciplinary infractions
- experiencing sexual or violent victimisation
- being threatened with violence

In England and Wales, the rate of self-inflicted deaths (suicide) per year on average has remained fairly stable at around one death per 1,000 people in prison⁴². People in prison on remand have higher rates of self-inflicted deaths than those sentenced⁴³.

Some of the risks of self-inflicted deaths are modifiable, within the control of HMPPS and can be targeted. A primary way to prevent suicide is reducing access to means. In 2024, 80% of self-inflicted deaths used ligatures⁴⁴. New prisons largely have ligature resistant cells but the number of existing cells per prison that are ligature resistant is insufficient compared to the population at risk.

Recognising the joint potential impact of the environment, psychosocial treatments and clinical treatment is essential to reducing the incidence of self-harm and this requires multidisciplinary management.

Complex care in the criminal justice system

People in contact with the criminal justice system experience disproportionately high levels of physical and mental ill-health, often compounded by social exclusion, trauma and systemic barriers to care. The prison environment presents both challenges and opportunities for addressing complex health needs, particularly for people living with long-term conditions (LTCs), multimorbidity (more than one health condition at once) and multiple disadvantage. Some of the additional challenges for caring for people with complex healthcare needs in prison include that:

- there is poor coding of long-term conditions in prison electronic health records
- digital advances in providing care being developed for the general population that could support efficiencies are not available in prison
- staffing capacity with high patient volume and complexity mean that long-term condition management is not prioritised
- the prison population can rapidly change when the function of the prison changes, therefore healthcare provision has to adapt
- enablement challenges that exist for everyone, such as sufficient escorts to attend external hospital appointments, are heightened in those with greater need for healthcare or repeated visits due to complex or multiple (multimorbid) conditions

Increasing use of telemedicine is one potential solution to at least some of the need and can improve care when barriers such as secure WiFi and consistent engagement from NHS hospitals are overcome. We consider expanding this a priority.

For the probation population, maximising opportunities for health for people with long-term conditions includes earlier detection of disease which would otherwise progress and supporting people to overcome barriers to care.

Health protection in prisons and probation

Minimising the prevalence and transmission of major infectious diseases in prisons improves the health of prisoners with infections, protects staff and other prisoners and reduces risk to the general population after someone leaves prison. It should therefore be seen as a priority. Prisons populations experience a higher burden of major infectious diseases compared to the general population including HIV, syphilis, Hepatitis B and C viruses (HBV, HCV) and tuberculosis (TB).

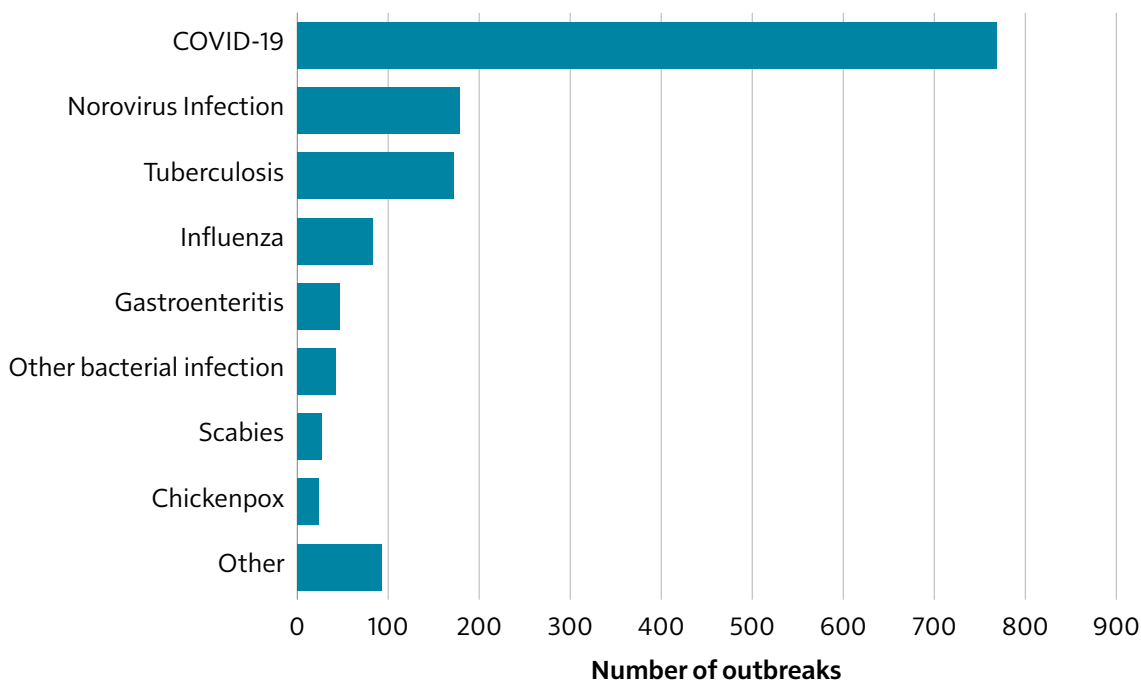
Prisons can present an opportunity to improve future health outcomes, such as:

- testing for infectious diseases
- increasing vaccination rates
- providing access to definitive treatments for diseases such as Hepatitis C in a prison population where uptake is often lower than the general population

Outbreaks of infections in the general population can also be introduced into prison settings by staff and visitors and may be hard to control in the relatively crowded prison environment once present. This can disrupt operations. Standard infection prevention and control (IPC) measures are harder to apply in prisons. For example, providing liquid soap or alcohol hand rubs is difficult because the equipment or the contents might be misused. Personal protective equipment (PPE) use is also inconsistent, as staff and people in prison have different levels of training and perceptions of risk. Implementation of basic IPC principles such as cleaning, laundry and waste management is also challenging.

Between 2011 and 2024 1,435 outbreaks in English prisons were notified and managed (figure 6).

Figure 6: number of outbreaks in prisons in England by pathogen, 2011 to 2024



Source: HPZone health protection case management system

As Figure 6 shows, the largest burden numerically, excluding COVID-19, was from norovirus infection (a highly infectious cause of diarrhoea and vomiting) and TB.

TB is a serious infection. It is easily transmitted and poses significant operational and resource challenges, but it is treatable making it a high priority. Measures are in place to identify, test and treat TB in prisons but they are insufficient, potentially leading to delayed case detection, loss to follow-up of contacts and further transmission.

There have been improvements in blood-borne virus screening on entering prisons – this is mainly for Hepatitis B, Hepatitis C and HIV. The proportion of people who test positive for Hepatitis C, which is now treatable, has declined, although reinfection rates and continuity of care for Hepatitis C treatment on release remain challenging. Less is known about the care pathways of Hepatitis B in prisons due to the lack of linked data. Hepatitis B is less easy to treat but there is a highly effective vaccine available to prevent transmission. Despite vaccination being recommended for everyone in prison since 2003, only 48% of people have at least one dose. Pre-exposure prophylaxis for HIV is also available in prison but awareness and access may require improvement. The extent of blood-borne virus transmission in English prisons remains unknown and this makes it more difficult to optimise policies to prevent and test. Enhancing harm reduction efforts, such as supporting safer injecting practices will reduce avoidable infections.

Overall, vaccine coverage in people in prison is low compared to the general population, often due to poor engagement with health services prior to imprisonment and higher levels of vaccine hesitancy. As well as proactive delivery of preventative vaccinations, there are occasions when reactive vaccination is required in response to an outbreak. Currently HMPPS occupational health services lack the capacity to provide staff vaccination in response to an outbreak or to offer catch up immunisations identified in pre-employment checks.

Environmental hazards, including extreme heat and air quality issues, pose increasing threats to health for more vulnerable people such as older people and pregnant women in prison settings^{45 46}. Temperature fluctuations are more extreme in some prison environments than most public buildings. Factors such as building quality, design and variation between prisons must be considered in mitigating these threats as very hot days become more common.

Most people leave prison. Reducing levels of infection among people in prison, for example infectious Hepatitis, can therefore also reduce the risk of the public contracting infectious disease. People cannot be detained past the end of their prison sentence even if they are currently receiving treatment for a transmissible infectious disease, therefore it is important that local healthcare systems work in partnership with their prison establishments to hand over and achieve continuity of care.

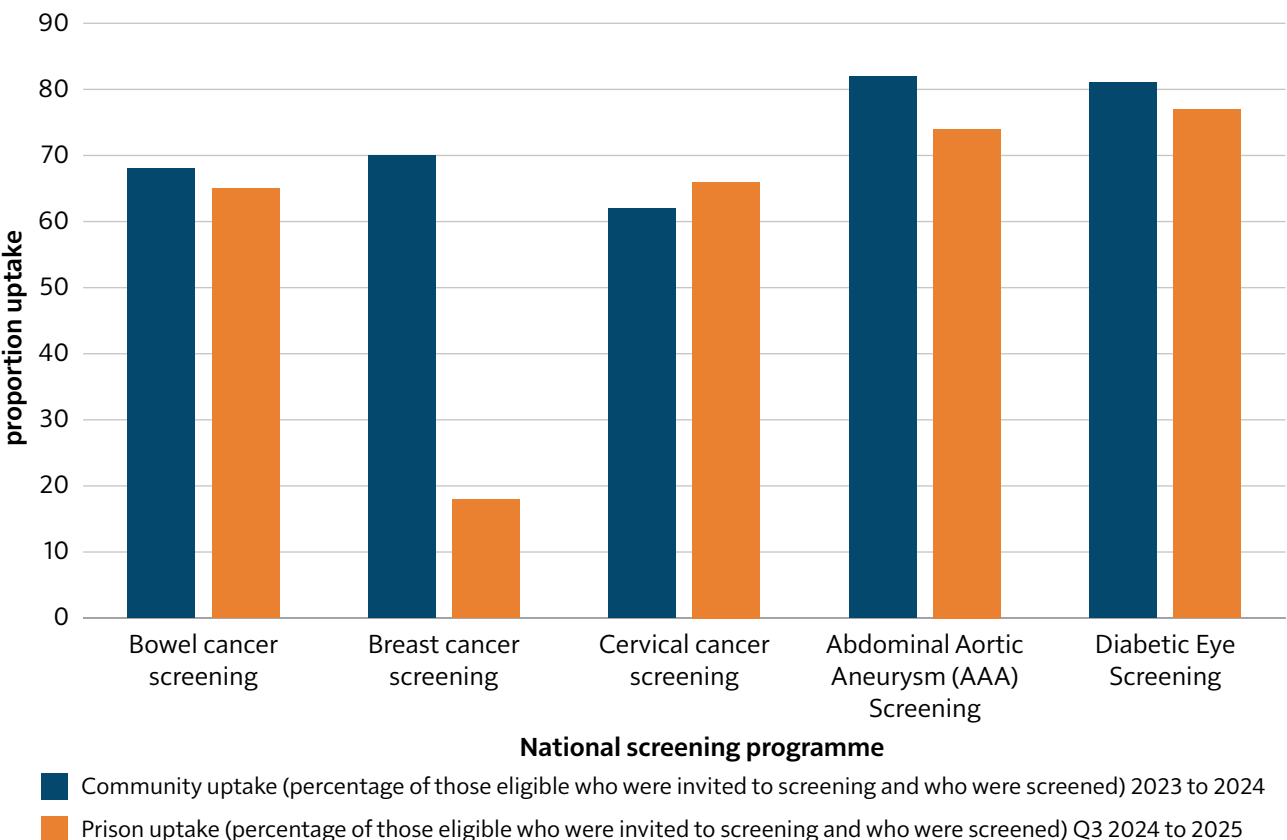
The role of probation settings in supporting health protection initiatives is currently less well defined. There are some examples of good practice such as bloodborne virus testing in some probation services but probation staff⁴⁷ report there are limited routine procedures for managing infectious diseases on probation, and that staff did not see infectious disease guidance as part of their role.

National screening programmes in prisons

National screening programmes help with disease prevention, early detection, timely (and often cheaper) treatment and better health outcomes. Ensuring everyone has access to these programmes is important for reducing health inequalities. This is important for individuals in the criminal justice system, who often have higher rates of disease and challenges with accessing healthcare and prison could be an opportunity to catch up with screening. Data suggests people in prison are less likely to receive curative treatments and have lower overall survival for cancer than the general population⁴⁸. Prison healthcare providers are responsible for ensuring that adult cancer and non-cancer screening programmes are offered and accessible.

Data on prison screening is subject to significant caveats for the reasons described in this chapter. This limits our ability to understand screening performance in prisons and to compare national screening programme coverage in the prison population against coverage in the general population (proportion of those eligible who are up to date with screening).

Figure 7: uptake of national screening programmes in prison and immigration removal centres compared to the general population



Source for general population data: NHS England^{49,50,51,52,53}. Immigration removal centres are out of scope for this report but it is currently not possible to disaggregate the data. Diabetic eye screening includes a small number of children in the children and young people secure estate.

Figure 7 compares the uptake of national screening programmes in the general population in 2023 to 2024 to that in English prisons in quarter 3 of the 2024 to 2025 financial year. While bowel, abdominal aortic aneurysm and diabetic eye screening uptake is only slightly lower in

the secure estate compared to the general population, breast cancer screening uptake in women is notably lower in prisons.

Most national screening programmes' specifications, guidance, protocols and information sources have not been translated nationally to consider the unique environment of prisons. This causes variation in delivery between sites and inequity in access compared to the general population, despite many excellent regionally developed pathways and local models. For example, targeted lung cancer screening is being rolled out in the general population with a range of models. Some models of delivery, for example mobile CT scanners, will be unable to access prisons with narrow entry gates, or unable to be accommodated due to lack of usable physical space in the grounds. With 80% of the prison population having a history of smoking, there is an opportunity to develop prison-specific national guidance and minimum standards to avoid delay in lung cancer screening for the prison population.

Most of the prison population is highly transient. People may move through, in and out of prisons quicker than they can be identified as eligible and screened, meaning many are released or transferred before being engaged in screening. Current reporting systems cannot track individuals, so those who move between prisons may appear in multiple screening activity reports and continuity is challenged.

Prisons have physical restrictions from various buildings and locations and strict security measures. Gaining clearance and co-ordinating access for specialist community healthcare staff and large specialist equipment can be difficult. For example, cervical screening can be readily undertaken by trained prison healthcare staff, but breast screening is reliant on individuals to be escorted out of prison or for specialist mobile screening units to go into prison on an annual or biannual basis. However, women are often serving shorter sentences meaning they may miss the visit of the screening team.

Prison healthcare electronic systems and national screening data systems are not linked. For most national screening programmes, prison healthcare providers have to manually identify eligible populations, manually invite them to screening and record outcomes and manually report screening, which is time consuming and liable to error.

Individuals in prison have often experienced trauma and may have limited trust in health services. Some programmes cannot be delivered with the same privacy and dignity as they are in the community, for example being unable to shower due to insufficient notice of cervical screening, or being escorted and potentially cuffed to a prison officer during breast screening.

There is considerable effort nationally, regionally and locally to improve access, experience and outcomes for people in prison eligible for the national screening programmes. The structural and systemic challenges described are substantial and mean that, despite these efforts, people in prison do not consistently receive equivalent access, experience, or outcomes from national screening programmes in comparison to the general population.

Health promotion and improvement

People in prison and on probation are at higher risk of premature chronic illness and death compared to people in the general population. This is largely due to the presence of risk factors for disease; many of these are preventable or modifiable. Cardiovascular disease, stroke and chronic conditions such as heart failure and chronic obstructive pulmonary disease are among the leading causes of deaths for people in prison in England and Wales. Preventing or delaying disease is good for those in prison. It will also reduce the long-term pressure on prison medical services and the need for escorted trips to healthcare outside prisons to manage preventable conditions, which once established will require repeated health interventions and often multiple escorted trips to specialist NHS services outside prison.

People arriving into prison are over 4 times more likely to be smokers and addicted to nicotine in comparison to their peers in the general population, with a prevalence of around 80% to 83%⁵⁴, compared to less than 15% in the general adult population. All prisons have been 'smoke free' since September 2018. Smoking cessation support is variable and is not available in all prisons. The proportion of smokers who are identified on arrival to prison and who accept referral to smoking cessation services is low. For many, vaping has become the preferred option. There is currently support to stop vaping in prisons. International evidence suggests that most prior smokers return to smoking on leaving a smoke-free prison⁵⁵. Substance use in prisons is a significant challenge and explored in the recent report by Dame Carol Black.

Physical health checks (prison equivalent of NHS health checks) should be offered to people aged 35 to 74 in prison but there is a lack of data on offer and uptake. Research suggests uptake is actually higher than in the eligible general population and can identify significant new cardiovascular morbidity in around 12% of people in prison⁵⁶, increasing the opportunity to intervene early and avoid later significant health needs.

Some health promoting activities are the responsibility of HMPPS. There is a lack of good data on physical activity and other health promoting activities in prison, but it is likely that most people do not meet or even approach the level of physical activity that optimises health. Access to exercise and other health promoting activities has to fit into a structured prison regime and therefore often competes with other elements of the regime. Individuals may have to choose whether they are going to attend health activities or paid work or education, or between exercise and socialising, or calling friends and family. Reducing time spent in a cell has wide-reaching benefits for individuals and the environment.

Supporting health in prison requires a whole prison approach, recognising that health promotion is 'everybody's business', not just the responsibility of healthcare staff. There is growing evidence that a range of non-medical, low cost opportunities can have a positive impact on health, including whole system interventions such as Greener on the Outside for Prisons and social prescribing both in prison and for people on probation. All staff in prison and probation need to be confident and capable of health promoting conversations.

Prison leavers

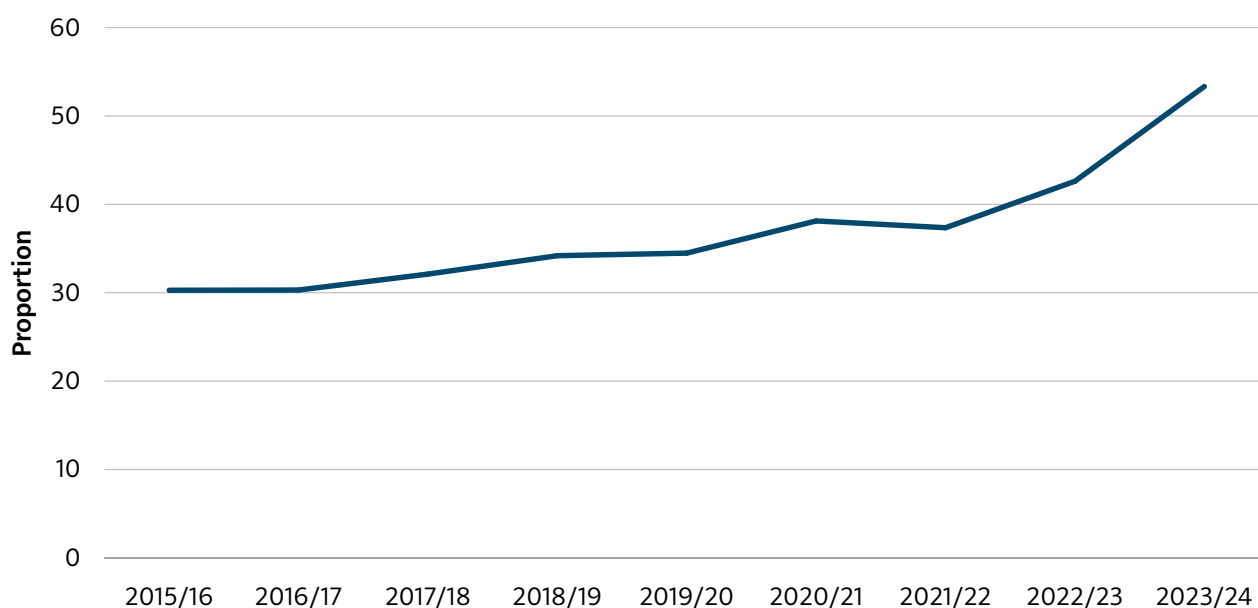
In 2024 57,277 people were released from custody⁵⁷. There are many factors that have an impact on subsequent health on release from prison, including:

- stable, safe accommodation
- employment
- reconnecting with family and children
- continuity of health services
- substance treatment services

In 2024, nearly 1 in 7 people were released without any accommodation, a proportion that has remained similar for the last 5 years⁵⁸. In the year to March 2024, less than 1 in 5 of people whose employment status was known were in employment 6 weeks after release from custody, increasing to roughly 1 in 3 at 6 months after release from custody. Both of these have improved significantly since 2020⁵⁹. Both housing and employment have a significant impact on mental and physical health, as well as the risk of reoffending.

Leaving prison can be an acutely vulnerable time for those with mental health issues and substance use, which often co-exist. One-third of adults leaving drug and alcohol treatment in prison were transferred for further treatment in the community.

Figure 8: proportion of adults with substance use treatment need who successfully engage in community based structured treatment following release from prison from 2015 to 2016 to 2023 to 2024⁶⁰



Source: Department of Health and Social Care (DHSC) Fingertips Public Health Profiles

Figure 8 shows that in 2023 to 2024 53% of people referred for ongoing treatment in the community successfully started on treatment, a significant improvement in recent years.

Unlike substance misuse, there is no key performance indicator (KPI) for continuity of mental health service provision on immediate release from prison. Access to community mental health services is a challenge, as described earlier. One of the potential contributors is that mental health teams will not accept referral until someone is released.

There is a range of ‘through the gate’ services to support access to healthcare, as well as other support and services, commissioned by HMPPS (for example, Creating Future Opportunities and the Commissioned Rehabilitative Service), joint between HMPPS and NHS (such as the Offender Personality Disorder pathway) and the NHS. One such programme commissioned by NHS and covering most prisons is RECONNECT, a liaison, advocacy and care co-ordination service. Most people are referred for mental health, substance use treatment, physical health needs or support to register with a GP. As the service becomes more established, referrals are increasing but it is likely they represent a small proportion of the eligible population leaving prison.

For people with health conditions managed by hospitals, release from prison, often to new areas, relies on transfer of care between hospitals. While there are mechanisms that hospital trusts can transfer specialist care between them, they are not frequently recognised by trusts or by prison or community primary healthcare providers⁶¹. Transfer of care usually relies on the patient proactively requesting or consenting to a re-referral to the local hospital from the community GP. Care can be disrupted at this point, or if the prison healthcare team cancels all outstanding appointments, once a patient de-registers on discharge. In addition, people are not allowed to access their appointment details until they are due to leave due to security requirements. If a person has a short sentence, an unplanned release or is moved by the prison a few days pre-release they may not be provided with the appointment details, leaving care interrupted. More efficient healthcare planning between Ministry of Justice (MoJ), HMPPS and healthcare partners is required. However, since continuity or attendance at healthcare is not a KPI for prisons and courts, it will be challenging to prioritise.

The independent review by Dame Carol Black concluded that the process for continuity of substance misuse treatment on release and resettlement is too complex⁶². Her review called for one HMPPS-designed, simple, streamlined process for release and resettlement supported by a single IT system, accessible to the right people at the right time without duplication of effort. This included recommendations that the ‘resettlement passport’ (now called prepare Someone for Release (PSfR)), should contain necessary information about all appointments⁶³. Even in the absence of substance misuse referral, preparation for release include multiple referrals with duplicated information and lack of clarity of responsibility between organisations. ‘Resettlement passports’ are not expected to provide health information in the foreseeable future, owing to significant data sharing constraints.

The health needs and barriers experienced by people on probation

Probation is when someone is serving some or all of their sentence in the community. On 31 March 2025, there were 226,826 people on probation supervised by the Probation Service in

England – around 3 times the number currently serving time in prisons⁶⁴ – the majority of whom will not go to prison. The probation population is also likely to increase.

People on probation experience worse health than the general population, with early onset of multi-morbidity, poor mental health, substance misuse and a high prevalence of risk factors such as smoking. While people on probation are included in primary care datasets, it is currently not practically possible for them to be identified in health records as on probation and therefore the specific needs of this group are often not identified in detail. Unlike in prison there is no systematic comprehensive health screening assessment on entry to probation, but some self-reported health needs are held in the probation dataset. This cohort can be underrepresented in local community needs assessments and health and care commissioning plans.

People on probation access the same NHS healthcare services and prevention activities, such as national screening and smoking cessation, as the rest of the general population. They are however more likely to have health needs and there are barriers to access, for example:

- numerous statutory and voluntary services to navigate (for example, mental health, addiction, family support) that mostly work in silos rather than as a single system
- long waiting lists for some specialist services such as mental health and neurodiversity services (as there is in the general population) that are more likely to be needed in the group
- barriers registering with general practice, such as local requests to provide an address or photo identification (which should not be required), or digital only registration processes

Probation staff and people on probation can find this provision complicated to navigate. People on probation have to disclose their needs and build trust repeatedly, when their trust in services may already be low. This can perpetuate inequalities.

There are also challenges with mental health community provision as described earlier. People with both mental health (MHTR) and drug or alcohol treatment (DRR/ATR) requirements are often required to engage with drug and alcohol treatment first, due to shorter waiting times and perception of readiness to engage with mental health services. This, however, fails to address the high proportion of drug and alcohol use because of trauma and poor mental health.

Integrated approaches that combine mental health care with support to housing, finances, social inclusion and wider social services are found to be useful by both people on probation and probation practitioners. Probation provides an opportunity to improve access to mainstream neighbourhood health services while people are engaged. The best model of integrated care for people on probation will depend on the local population and there are frameworks to set out good practice⁶⁵. Peer support mentors and health navigators, co-located health and probation services, social prescribing and reducing barriers to specialist or mainstream GPs may be beneficial.

A health and care workforce for the future criminal justice population

This report has identified a health and operational workforce that is passionate, skilled and resilient. Often, this is in the face of adversity, working with individuals with complex health and social care needs, in settings that are themselves acute environments and have not to date been designed with optimising health as a priority. This means unique challenges arise in ways of working both within, and between, professions and organisations.

Healthcare provision for prisons in England is commissioned by the NHS but delivered by private providers, community interest companies and NHS providers. On site provision usually consists of a 'team of teams' delivering primary care, public health, mental health, drug and alcohol services, dental and optometry services. This is under the leadership of the Head of Healthcare, who sits on the prison senior leadership team. They are responsible for ensuring the delivery of the healthcare contract against KPIs aligned with local interpretation of service specifications, set by regional NHS England commissioners. HMPPS is responsible for enabling healthcare. For example, at a local level, each prison governor or director of a privately managed prison is responsible for:

- vetting new staff
- ensuring the work environment is fit for purpose
- providing adequate numbers of rooms for healthcare delivery
- providing sufficient prison staff to escort patients to health appointments, both inside and outside the prison
- enabling attendance at health and wellbeing activities

Governors are therefore responsible for deciding the priority of health and social care within their prison estate and setting the regime that enables this priority. The primary concern of healthcare providers is provision of healthcare services, whereas for HMPPS it is security and safety. To ensure each organisational need is met, operational staff need a basic working knowledge of health, and health staff of security policy and practices. Multidisciplinary partnership working and collaborative clinical and professional leadership are essential. When working well, this can be a mutually beneficial opportunity to troubleshoot concerns, identify and work towards joint strategic priorities. When this doesn't work well, for example if there is an imbalance of authority combined with a lack of joint working or goals, then this can have a substantial impact on health and healthcare, and the ability to train and recruit a sustainable workforce.

Prisons can have a high turnover of patients with significant or previously unrecognised needs. There are concerns over the capacity of the healthcare workforce to deliver the expected range and quality of patient care to meet the principle of equivalence, within the context of escalating demand, rising violence and self-harm, and both health and operational staff shortages. Particularly but not exclusively in reception prisons, patient volume and throughput mean that

health prevention, planned primary care, and proactive mental health and substance misuse interventions are hard to achieve. Staff wellbeing is impacted by this acute work environment. Staff have described feeling unsafe or unable to provide the standard of care that they would like to contribute. The level and type of support and interprofessional training available to health and prison staff varies between prisons.

The health workforce in prison and on probation is complemented by:

- lived experience roles, recognised to be essential in the design of services, a core part of the workforce, and a valuable source of informal support for people in contact with the criminal justice system
- over 1,700 voluntary, community, faith and social enterprise organisations (VCSE), identifying and responding to unmet need and well placed to be part of the emerging social prescribing provision in prisons, and supporting re-integration in the community through local connections

The health and justice workforce is highly skilled in the complex needs of people with multiple disadvantages that may be excluded from society (known as 'inclusion health'). However, these skills and specialist experience are not formally recognised. The health and justice workforce within an integrated care system should be identifiable as a workforce with skills for inclusion health and included in workforce plans and people strategies, but this is rarely the case at present.

Health research with people in prison and on probation in England

Research underpins the remarkable improvements in health we have seen in the last 170 years. Conducting health research with people with complex health needs and multiple disadvantages (such as people in prison and on probation) is important to identify their unique health needs, barriers that stop them from accessing and benefitting from care and to test ways of overcoming these. For many, prison may be the only point at which their health needs could be systematically assessed and addressed, making it a critical window for prevention, early intervention and long-term health improvement in a population with high health needs.

Over a 10-year period, between 2015 and 2024, a total of 203 health research projects with people in prison and on probation received approval from the National Institute for Health and Care Research (NIHR), UK Research and Innovation (UKRI) and/or the Ministry of Justice (MoJ) and its agencies with relevant ethical approval. Most research was led by universities, conducted in prisons and was among males not females.

Figure 9: the health category of study of research projects conducted with people in prison and on probation in England between 2015 and 2024

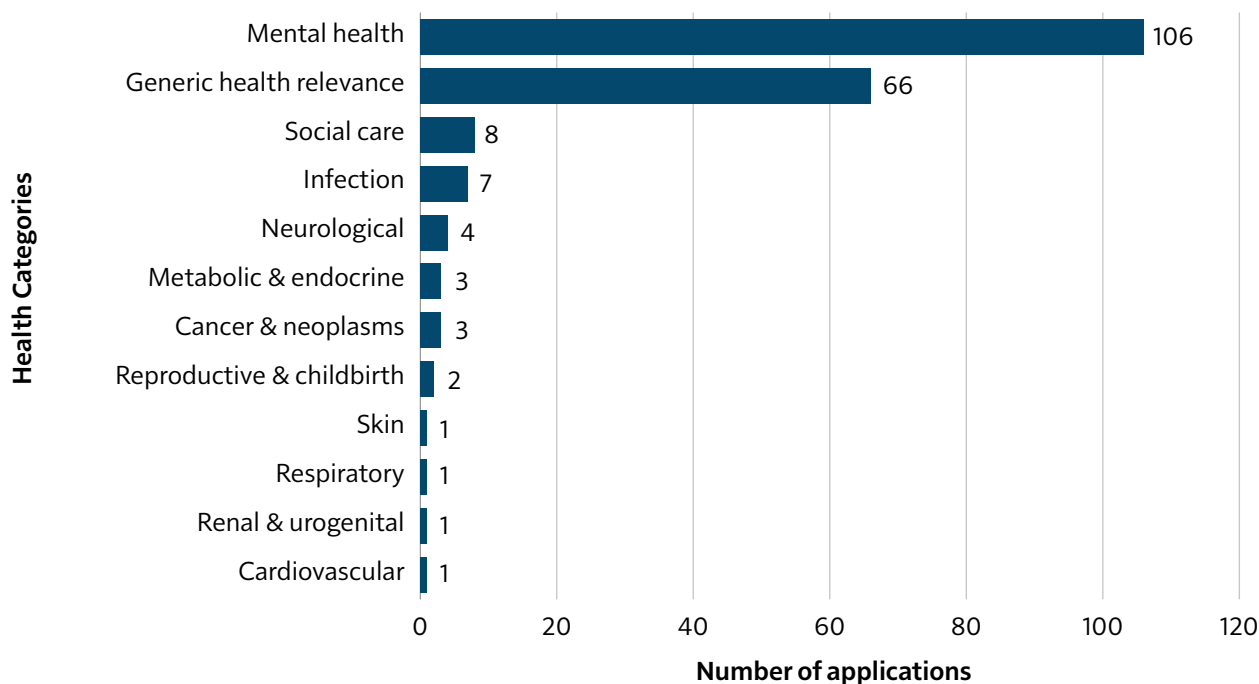


Figure 9 shows that 52% of research was on mental health topics. Other areas include generic health (33%), whereas research on social care (4%), and specific physical health topics like cancer and cardiovascular disease was rare (less than 2% each).

Of those where the funder could be identified (54%), NIHR (run out of and funded by DHSC) was the leading source of funding. NIHR expenditure on health research with people in prison and on probation in the financial year 2023 to 2024 was similar to people in the general population, but the costs of delivering research in this setting are higher and health needs are greater.

A survey of independent researchers planning or conducting research in people in prison and probation, and workshop findings with representatives of organisations who enable their research, is presented in this chapter. The results highlighted many challenges of research in this population or setting, including:

- navigating multiple research and ethical approval processes across organisations
- gaining access to health and justice data as it crosses organisational boundaries
- gaining access to the justice estate and working with justice staff to gain support for the research
- engaging with people in prison and on probation
- funding health research with people in prison

The chapter highlights existing guidance, support and processes to help with some of these challenges.

Summary of overarching themes

The following are important themes arising from this report, found in several chapters:

- previous systemic disadvantage and impact on health
- prison environment and health
- continuity of health across the criminal justice pathway including probation and transitions, especially into prison, between prisons and on release from prison
- organisation structures, governance and oversight
- limitations of data and research

Previous systemic disadvantage of people in the criminal justice system and the impact on health

This report highlights that many people in prison and on probation have previous experiences and circumstances that have an impact on their health and ability to access and engage with healthcare. Capturing these experiences accurately in data is challenging as they are dependent on reliable questioning, disclosure and recording.

The rate of imprisonment for people living in the most deprived areas of England is around 10 times greater than people living in the least deprived areas⁶⁶. Minority ethnic groups are statistically overrepresented at many stages through the criminal justice system compared to White ethnic groups. Since risk factors for poor health are heavily clustered in the most deprived areas this has inevitable implications for the health of those entering prison. The relationship with disadvantage is bidirectional, meaning people leaving prison can also have lower rates of employment and housing on release.

Substance use, mental ill health, domestic abuse and childhood trauma are much more common in people in prison and on probation than the general population. Often these factors can co-exist. Together these factors can have a significant impact on health, as well as the ability to access and engage with health and health systems. People in contact with the criminal justice system can face stigma and discrimination and further barriers such as poor health literacy, digital exclusion and lack of trust in health services. This results in a higher burden of preventable disease and premature death. The median age of death for people (mainly men) in prison is 67.5 years compared to 82.3 years for males and 85.8 years for females in the general population for the same time period (2018 to 2020)⁶⁷.

The core principle of prison healthcare is that of 'equivalence', with prisoners having a right to care that is considered to be at least consistent in range and quality as if they were not in prison⁶⁸. However, to achieve equitable health outcomes these must be delivered proportionate to need, which is greater than the general population who use the NHS. People on probation can in principle access the same NHS and preventive health services as the rest of the

population, but often complex disadvantages can create a barrier to engagement. To achieve equitable health outcomes, NHS and community health partners need to work with probation to deliver a service responsive to need.

Prison environment, regime and health

Healthcare in prisons is commissioned by NHS England at the time of writing. It is expected when the assimilation of NHS England into DHSC completes by April 2027 subject to the legislation passage through parliament, commissioning for healthcare in prisons will be done by integrated care systems (ICBs). This will likely be through offices for cross-ICB commissioning across regional footprints.

HMPPS is responsible for enabling health and healthcare. HMPPS and governors are also responsible for many factors that influence health, such as the food provision and time spent in meaningful activity and exercise compared to locked in a cell.

Several chapters of this report have highlighted the importance and challenge of this interdependency. The typical prison environment and regime restrict activities that promote health and wellbeing, such as exercise outside. Any prison cultures of violence and bullying, overcrowding and staff shortages can all affect personal safety and mental health, as well as directly and indirectly affecting physical health, for example, reducing the movement of people in prisons and therefore the ability to attend healthcare appointments or health-related activities. Overcrowding, the movement of residents, shared facilities, and the connection between staff and the general population make prisons particularly vulnerable to the spread of infectious diseases. Some prison estates are old, and healthcare is delivered in environments that would not be considered acceptable in the community. These environments also have an impact on healthcare and operational staff. For example, there has been transmission of TB from people in prison to staff.

The prison environment can have a particularly large impact on more vulnerable people in prison. In England, pregnant women can be sent to prison. Overnight, the cell doors in prison are locked, presenting physical barriers to getting help. Maternity staff are not in prison overnight or on weekends. However, there has been a cross-government response with policy changes that have been widely reported as positive. It may be possible to build on learning for others with unique needs such as older people in prison.

People of any age in prison that have an increased need for healthcare are dependent on the governor of the prison to facilitate escorts. The severity of the prison populations needs and the need for a secure, safe regime frequently competes with healthcare priorities, leading to cancelled or postponed appointments or reduced uptake due to choice. The availability of escorts is determined by governors based on their staffing. When this is insufficient, healthcare providers may need to choose which individuals can attend, having to prioritise acute needs over long-term conditions.

Continuity of health across the criminal justice pathway including probation

Despite the greater number of people on probation compared to prison, less is known about their health. Two-thirds of people on probation do not go to prison. Their health records are captured in routine health data but cannot be identified as being from someone on probation. It is possible to work with probation and local health providers to collate data, including self-reported data from the probation system to get a picture of needs and plan services, and some regions are already doing this. For others, probation staff report that they are not closely involved with ICBs and there is a need for greater clarity of responsibility of ICBs, including to the specialist inclusion health workforce.

Most people on probation do not go to prison but serve sentences in the community. There is an opportunity to involve probation staff to optimise health and intervene earlier to interrupt the cycle of offending and poor health. This should be in line with the offer for the general population but tailored to take account of the increased risk of premature non-communicable disease associated with behavioural risks such as smoking, and factors that influence access and engagement with healthcare, such as regular housing moves and reduced trust in statutory services. For example, there are opportunities to ensure that:

- screening and immunisations are up to date
- people are supported to engage with mental health and substance use treatment services as required
- people are signposted to community support and education to promote health and prevent infections

The prison population is not static and movements in and out and between prisons can interrupt healthcare. Nearly every chapter across this report highlight the challenges of movement into, between and out of prison.

Often large numbers of people can arrive in prison, requiring rapid assessment of risk of a population who may have poorly controlled or undiagnosed health conditions, complex social needs or previously limited engagement with healthcare. There is a comprehensive assessment of health over the first week, but it is not specialised, for example, by pregnancy or age and health is not systematically assessed again, despite acknowledgements that arrival to prison can be a period of acute distress where people may not self-report their needs.

Leaving prison, either to the community or a different prison, requires support for continuity of health, substance treatment services, housing, employment and more. Currently there are multiple pathways and processes to gain this support from this wide variety of organisations, with duplicated effort. The processes for continuity of secondary healthcare is less well supported.

People with mental health conditions requiring specialist input are especially at risk of interruptions to continuity at every level, from waiting lists for community mental health support, to waiting times to transfer to secure NHS estates.

Organisation structures, governance and oversight

There are partnership agreements in place, and many examples of excellent joint working between health and justice. However, from local to national and community to prison, the cultural divide is significant, despite the clear shared strategic agenda that:

- improving and preventing poor health reduces offending
- in the long run, reducing the operational burden of chronic and multimorbidly ill people requiring complex or repeated care in prison can benefit the service as well as the individuals

This is true for adult and child secure settings, where currently there is no single or integrated cross-government approach to programmes for vulnerable children and young people, and both the mental health and health improvement chapters of this report call for whole system responses to improve health outcomes. Health cannot be improved by healthcare alone.

For people on probation there is a need for greater clarity of responsibility and oversight into health needs. Directors of Public Health (DPH) have a lead role in addressing health inequalities of people on probation in their area. ICBs commission the majority of healthcare services in the community, including for people on probation with important additions such as substance use and sexual health services from local authorities. Local authorities also provide housing and financial advice and support as well as providing adult and children's social care. Many excellent third sector organisations provide valuable services that need to be engaged and integrated with statutory services.

Limitations of data and data integration

A thread through this whole report is the limitations of data integration. Health data are not linked with NHS or wider health or justice data. While there are improvements in data sharing, current processes do not support personalised care, or understanding of health, planning health services and responding to population change. While this is not easy to fix quickly, there are now potential solutions identified in the data chapter that are feasible with sufficient will, time and resource. Once achieved this will improve the effectiveness of healthcare provision.

Recommendations

The report has 3 sets of high level recommendations, and several more specific recommendations. Lead government departments and organisations are listed where appropriate, but this list is not exhaustive. This work needs a response from multiple government departments and agencies.

High level recommendations:

1. **There will be an increasing need to prioritise preventive health and healthcare for chronic diseases within prisons further as the prison population ages.**

Some prisons visited such as HMP Low Newton and HMP New Hall demonstrated joint leadership and innovative regimes to achieve this. This requires action by HMPPS with NHS England and/or DHSC and prison healthcare providers, including that:

- telemedicine should be expanded. It is a way specialist care can be provided for many people in prison with multiple chronic diseases while minimising the need for many complex escorted outpatient visits that may be delayed or not occur at all
- access to on-site healthcare appointments to treat chronic diseases should be prioritised equitably and remunerated equivalently to employment and education; like education this will have lifelong impacts and prevent trouble in the future
- many chronic diseases can be prevented. HMPPS, MoJ, NHS England and DHSC should create a list of approved health activities or interventions that should also be classified as meaningful and purposeful activity and prioritised equitably and paid equivalently to employment and education. This should include health interventions that may benefit a large proportion of the population such as smoking cessation and medical and psychosocial substance misuse interventions as well as health interventions that may be socially prescribed to a defined population
- the proportion of healthcare appointments and activities that are not attended for operational reasons (for example, lack of escorts) should be monitored and reported nationally, a point made previously by the Dame Carol Black report on substance misuse in prisons

2. **Health data are essential for safe, high-quality care, research, surveillance and planning of health services inside and outside prison. In particular it is important that NHS data from care outside of prison can be shared in and out of prison and other secure settings to allow continuity of care. There are also many IT systems that sit across multiple government departments and organisations relevant to healthcare and many of these systems cannot communicate with one another.**

The national partnership agreement for health and social care should prioritise improving data and data information sharing. Data should inform the strategic priorities of this group

and be used to report accurate oversight of progress. This should be reviewed at an annual high level accountability meeting, with appropriate external oversight. Further technical recommendations regarding data and information sharing are outlined below.

3. People on probation often have high health needs compared to the general population and this is often not recognised by the NHS, public health and other provider organisations.

Probation populations are going to grow and age so this problem is going to get larger over time. Some regions have established relationships between DPH, ICB, regional commissioners and probation services and work together to understand and share the available data and plan health services.

- ICB and DPH should work with probation services in their area to understand health needs and design local pathways
- the national partnership agreement includes not only prison healthcare but individuals under the statutory supervision of the probation service in the community. The partners should set priorities to improve the health of people on probation including within future healthcare initiatives such as neighbourhood health models

Detailed and specific recommendations

Improving opportunities for health for people with systemic disadvantage in prison

Recommendation	Organisations involved
1.1 Pregnant and postnatal women in prison are at high risk of poor mental health. All women who are identified as pregnant, postnatal or that experience separation up to 2 years after the end of pregnancy, including separation from infants on entry to prison, should have access to specialist perinatal mental health assessment and care equivalent to the general population and this needs to be planned for in the whole female estate.	NHS England, and NHS England Health and Justice/DHSC
1.2 The needs of the older population in prison are not systematically identified or met. A standardised approach to assessing need and planning health and prison services for older people in prison should be used to inform provision for suitable accommodation, regime, healthcare and activities for older people with health needs in prison. HMPPS and NHS England should initiate augmented standardised assessment of healthcare and environmental needs for people arriving in prison over 50 years of age, repeated on an annual basis.	HMPPS, and NHS England Health and Justice/DHSC

Recommendation	Organisations involved
1.3 Dying well wherever you are and whatever your background or circumstances are fundamental aspects of human dignity. The dying well in custody charter should be implemented consistently by all prisons and prison healthcare providers.	Prison healthcare providers and HMPPS
1.4 Mental health conditions are very common in prisons, and in some cases if untreated may contribute to reoffending. There is a need for access to assessment and mental health services that are equivalent to provision in the general population and commissioned with the same proportion of need as in the general population, which is not dependent on the type of prison or long length of stay. This requires comprehensive assessment of needs using a validated mental health screening tool by people who are trained in assessment of mental health, and who can refer to pathways to access support by trained mental health specialists, including urgent support when people are in crisis. While self-referral or primary care referral to evidence-based psychosocial treatments (NHS talking therapies) are already commissioned in prison, this should be adequately resourced by the NHS and access to these should be monitored in prison settings to ensure equivalence to community access and provision.	NHS England Health and Justice/DHSC

Overcoming challenges and using the opportunity of the prison regime and environment to improve health

Recommendation	Organisations involved
2.1 We recognise the challenges of ensuring safe access to analgesia, especially opioids, in a prison setting. For end of life and palliative care it is possible and necessary. Prison staff and prison healthcare staff must work together to ensure access to analgesia, including opioid analgesia, is provided for palliative care patients. Both the dying well in custody charter and this report provide examples of making this work in practice.	Prison healthcare providers and HMPPS

Recommendation	Organisations involved
2.2 In 2024, 80% of self-inflicted deaths in prison used ligatures. New prisons largely have ligature resistant cells but the number of existing cells per prison that are ligature resistant is insufficient, compared to the population at risk. HMPPS should develop a national approach to more rapidly increase the availability of ligature free cells, starting in prisons with the highest rates of ligature related self-harm and self-inflicted deaths.	HMPPS and MoJ
2.3 People in prisons experience a burden of TB approximately 4 times higher than the general population. Improving detection and treatment of TB reduces the risk to the wider prison population and to staff. Partners should work together to improve the detection, management and treatment of TB in prisons including improving detection on entry, considering introduction of routine targeted latent tuberculosis screening and increasing access to TB care through in-reach diagnostics and telemedicine.	UKHSA, HMPPS and NHS England/ DHSC
2.4 There is evidence that uptake of blood-borne virus (HIV, Hepatitis B (HBV) and Hepatitis C (HCV) testing remains lower than the national target in prisons and HBV vaccination uptake also appears poor. This is an opportunity missed. NHS England providers and commissioners should support initiatives that increase awareness of HCV and HBV to people in prison and staff, and proactively promote HBV vaccination, testing and HCV treatment. This should include implementation of sex-specific service improvements to encourage uptake, including learning from successes in some regions such as peer champions, education campaigns and timing of testing. There should be a clear target for prison HBV vaccination to support providers and commissioners.	NHS England/ DHSC

Recommendation	Organisations involved
2.5 HIV, Hepatitis B and Hepatitis C have relatively high prevalence among people in prison. Preventing spread of blood-borne viruses in prison benefits individuals in prison and the general population as most people in prison will be released. Evidence outside of prison shows that needle exchange reduces transmission of blood-borne viruses better than sterilisation of needles. Health services and justice partners should work on the assumption that needle exchange is the preferable method, unless there is new evidence of unintended consequences or new evidence that other methods are more effective. HIV pre-exposure prophylaxis (PrEP) medicine has been proven to be highly effective at preventing HIV transmission. Regional audits on prison sexual health services showed variation in provision and access to PrEP and engagement with people in prison suggested limited awareness of PrEP. People in prison should be able to access PrEP if appropriate. Health and justice partners should improve pathways for PrEP and post exposure prophylaxis.	NHS England Health and Justice/DHSC, HMPPS
2.6 Data on vaccination coverage in prisons is sparse and uptake is thought to be low and vary between prisons, although some prisons have managed to achieve high uptake levels. Every effort should be made to catch people up on vaccines while in prison. This is beneficial for preventing the spread of diseases in prisons, for the general population and for the individual. Nationally prison health staff should learn from best practice, especially those prisons that achieve impressive vaccine coverage. NHS England/DHSC should develop a standardised national reporting process to record the offer and uptake of vaccination in prisons to improve information on vaccination coverage.	NHS England/ DHSC, prison healthcare teams and UKHSA

Recommendation	Organisations involved
2.7 Some prisons can experience extremes of temperature. While high and low temperatures can be unpleasant for all, including staff, there are some specific population groups where they increase the risk of serious physical harm, especially: ■ older people ■ people with major pre-existing health conditions such as significant cardiovascular disease ■ pregnant women ■ infants All prisons should have localised plans to mitigate the impact of extreme heat for these groups.	HMPPS and prison healthcare providers
2.8 There are several technical recommendations in the screening chapter that should be implemented. This requires joint working and resourcing from NHS England to deliver this. This includes the need for: ■ nationally standardised prison-specific screening resources and templates ■ improved coding, reporting, governance and oversight	NHS England Health and Justice/DHSC and HMPPS
2.9 There are positive examples of health-promoting interventions and activities across the prison estate but they vary widely and are often initiated and monitored by either healthcare providers or justice services, rather than a co-ordinated approach between both. Together healthcare commissioners and providers with justice services should: ■ establish consistent and complete data recording across the secure estate on risk factors and prevalence of chronic diseases ■ trial and evaluate the development of specialist prison staff training or peer health champion training on how and when to intervene to promote health, including health promotion messaging and the health services available to people in prison and pathways to access and referral to services ■ ensure every prison has a stop smoking service with counselling and nicotine replacement therapy with offers of provision on entry to prison, as well as leaving prison ■ NHS England and DHSC should update guidance on the implementation and reporting of physical health checks in prison and ensure the target of screening is met	NHS England Health and Justice/DHSC and HMPPS

Supporting health needs through transitions in the criminal justice system, including the probation population who do not go to prison

Recommendation	Organisations involved
3.1 There is a need for improved links between health and probation in the community, and greater understanding of health of people on probation. DPHs, ICBs and HMPPS should identify the health needs of the justice systems transient and substantive populations. This may involve collating local knowledge from a wide range of organisations. This will also link with the current national work on Probation Health Needs Assessment led by the NHS Strategy Unit. Health and Wellbeing boards (HWBBs) should have oversight of the health needs of the population of people on probation, within their responsibilities for Joint Strategic Needs Assessment. They should work with ICBs and probation services to ensure the enactment of any advice. There should be explicit relationships with local probation service leads, DPHs and NHS commissioners, this could be through HWBBs or Community Safety Partnerships.	ICBs, Directors of Public Health and probation delivery unit teams
3.2 ICBs should support continuity of care for patients who are referred to or receiving specialist care if they are required to move areas as part of their journey through the justice system. This should be done by: ■ ensuring patients are transferred between and retain their position on new local waiting lists ■ direct transfer of care between specialist providers where treatment is in progress This is true for neurodevelopmental diagnostic assessments, as well as all other areas of healthcare.	ICBs

Recommendation	Organisations involved
3.3 There are challenges with identifying the needs and safety of pregnant and postnatal women as they arrive at prison. HMP Bronzefield is piloting a process of immediate hospital assessment of women in the third trimester of pregnancy, which is proving feasible. Reception teams should have access to community maternity records on arrival to prison. Where these are available, and the pregnancy to date was deemed low risk, then maternity assessment should be provided within 24 hours, or earlier if required based on clinical signs and symptoms. In the absence of maternity records demonstrating engagement with care and a low-risk pregnancy, then women in the third trimester require early assessment by a midwife or obstetrician at the local maternity NHS trust to the prison or court. This needs to be resolved at a local level depending on resource, to ensure that every woman is safe to be received in custody.	HMPPS, NHS England Health and Justice/DHSC, NHS trusts providing maternity care in prisons and courts
3.4 The addition of pregnancy and the postnatal period as a mitigating factor for sentencing in 2024 means that more women should be receiving community or suspended sentences instead of prison sentences. Less is known about the needs and models of multiagency care for these pregnant and postnatal women, including those separated from infants, under the supervision of probation. There should be work to identify the health needs of this cohort from conception to 2 years after birth, and improve integration between NHS health providers and probation services to provide holistic support.	NHS England/ DHSC and HMPPS

Recommendation	Organisations involved
3.5 People on probation also may have higher prevalence of mental health needs than people in the general population. There is a need for improved provision of immediate access to mental health support (including primary, community and secondary services) to provide continuity and support for people whose mental health may deteriorate on release from prison, and for people on probation who may not go to prison. This should include: ■ removing barriers to this cohort accessing community mental health services available to the general population such as NHS talking therapies, for example, barriers related to digital exclusion and GP registration ■ supporting equitable access to new and arising mental health service models, such as 24/7 neighbourhood health centres ■ continuing to improve access to Mental Health Treatment Requirements, including for those with concurrent substance misuse needs. Where there are not pre-existing joint Community Sentence Treatment Requirements (CSTRs) for people with combined mental health and drug and alcohol treatment needs, these pathways will need to be created. Dual-diagnosis and/or dual-needs pathways, should also be available to people on probation who are not on CSTRs and following the end of CSTRs, where there are unmet needs	ICB, Directors of Public Health, Probation services, NHS England/ DHSC
3.6 Leaving prison is a high-risk time for deterioration in mental health. There is a need to agree local processes to ensure continuity of mental health services on release from prison and improve provision, timely access to mental health support and both primary and secondary mental health services. The NHS RECONNECT service can support continuity of mental (and physical) health services when they are engaged with sufficient time. This requires: ■ joint efforts by all partners to mobilise the service ■ NHS RECONNECT to work in partnership with both prison and health partners to ensure a comprehensive plan for continuity of care for prison leavers	ICBs, Directors of Public Health, Probation and NHS England/ DHSC

Recommendation	Organisations involved
3.7 The independent review by Dame Carol Black concluded that the process for continuity of substance misuse treatment on release and resettlement is too complex. The review called for a streamlined process for release and resettlement, supported by one HMPPS-designed simple, streamlined process for release and resettlement, supported by a single IT system accessible to the right people at the right time with no duplication of effort. This included recommendations that the 'resettlement passport' (now called Prepare Someone for Release (PSfR)), should contain necessary information about all substance misuse treatment appointments. We agree and recommend that there is one simple streamlined process that is designed by HMPPS and NHS England, which also needs to include continuity of primary care and secondary healthcare appointments.	HMPPS and NHS England/DHSC

Facilitating organisations to support this population

Recommendation	Organisations involved
4.1 There are challenges with recruitment and retention of the healthcare workforce in prison and current approaches have separated out this workforce from the healthcare workforce in the community. There are several examples of good practice that could be replicated in more areas or expanded, including: ■ flexible training placements for GPs, medical students and pharmacists in prison and specialist 'inclusion' health settings in the community ■ the Royal College of General Practitioners (RCGP) provides substance misuse qualifications -and these could be broadened to include a wider curriculum relevant to a workforce working across prison and the community ■ wider engagement with health education institutions to increase the number of student nursing placements available within prisons and community justice settings and increase availability of masters-level specialist qualifications in health and justice nursing	RCGP and higher academic institutions

Recommendation	Organisations involved
4.2 All prison healthcare should establish links with their local specialist palliative care providers.	Prison healthcare providers and NHS specialist palliative care providers
4.3 There is no robust pathway to provide proactive and reactive screening and vaccination to prison staff, leaving them at risk of developing disease from exposure to infections in prison. HMPPS and MoJ should ensure staff can access TB screening, and vaccinations in response to a prison outbreak, including during working hours, and review the role of HMPPS-commissioned occupational health to ensure that staff can be vaccinated reactively if exposed to infectious diseases in the prison setting.	HMPPS and MoJ

Addressing the limitations of data and facilitating research

Recommendation	Organisations involved
5.1 Sharing of individual health data is essential for safe, high quality care for individuals, while linkage of anonymised, grouped (aggregate) data is essential for research, surveillance and planning of health services. There are many IT systems that sit across multiple government departments and organisations with numerous commercial and legal boundaries and responsibilities. Therefore, there is a need to create a centralised, cross-departmental team that is enabled with the appropriate permissions and responsibility for overseeing data governance, data controllership, data-sharing, data linkage and data analysis for the criminal justice population. This team should be led by DHSC and use existing cross-government capability in data linkage. Objectives of the team should include: ■ mapping the common needs for data sharing and data linkage between organisations, and the roles and responsibilities of each partner organisation (data protection impact assessments and data flow mapping) ■ increasing data linkage between organisations (such as Better Outcomes through Linked Data (BOLD) and Data First) ■ analysing and determining the approaches needed to improve data quality and data capture ■ exploring and agreeing on the mechanisms by which a unique identifier (potentially the NHS number) could be appropriately used to support information-sharing between organisations to support individuals' care and to aggregate data analysis ■ promoting inclusion of health and justice data in data repositories for research purposes such as OpenSAFELY, and potentially the UK National Data Library ■ ensuring that health-related data is included in wider screening and surveillance programmes. We support the inclusion of health and justice data within all relevant data initiatives, such as local federated data platforms, General Practice Extraction Service and UKHSA surveillance platforms that are currently available from community general practices ■ the recommendations of the Sudlow Review on health data should apply to the prison estate as well as to the NHS and wider health system Further technical components are described in the chapter. We consider linking data between the NHS and prison systems to be a major priority.	NHS England/ DHSC, HMPPS, MoJ, UK Health Security Agency

Recommendation	Organisations involved
5.2 There are several technical recommendations in the research chapter with which we agree. This includes the need for: ■ a joined-up approach to agreeing and promoting shared health research priorities ■ research infrastructure such as networks and simplification of approval processes and guidance on approval processes	

Editor and authors

Editor-in-Chief – Nicola Vousden

Editor – Danny Duffield

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1. Setting the scene on prison and probation health and healthcare

Dr Nicola Vousden (DHSC), Danny Duffield (DHSC), Professor Chris Whitty (DHSC)

2. Health and care of women through pregnancy, birth and the postnatal period in prison and on probation

Dr Nicola Vousden (DHSC), Fiona Grossick (NHS England), Nikki Luffingham (NHS England), Dr Lucy Wainright (EP:IC Consultants), Dr Christy Pitfield (Central and North West London NHS Foundation Trust), Dr Laura Abbott (University of Hertfordshire)

3. Children and young people in custody or at risk of custody

Emily Nicol (NHS England), Dr Nick Hindley (Oxford Health NHS Foundation Trust), Dr Lucy Thomas (UKHSA), Dr Nicola Vousden (DHSC)

4. Women in prison and on probation in England

Dr Nicola Vousden (DHSC)

5. Older people in prison

Dr Mary Piper

6. Palliative care and end of life in prisons

Dr Annelise Matthews (Northamptonshire Healthcare NHS Foundation Trust), Maria O'Neil (Northamptonshire Healthcare NHS Foundation Trust)

7. Data and information sharing for health in the criminal justice system

Dr Jake Hard (Oxleas NHS Foundation Trust and Independent Advisory Panel on Deaths on Custody), Donna Gipson (EP:IC Consultants), Angelique Whitfield (NHS England)

8. Mental health of people in prison and in contact with the criminal justice system in the community

Dr Sunil Lad (NHS England and Northamptonshire Healthcare NHS Foundation Trust) and Dr Matthew Tovey (HMP Long Lartin and HMP/YOI Swinfen Hall)

9. Supporting neurodivergent people and those with neurodevelopmental conditions within prison and on probation

Neisha Betts (NHS England)

10. Self-harm and suicide in prison

Professor Seena Fazel (University of Oxford)

11. Complex care in the criminal justice system

Dr Caroline Watson (Northamptonshire Healthcare NHS Foundation Trust)

12. Health protection in prisons and probation

Dr Chantal Edge (UKHSA), Dr Nicola Dennis (UKHSA), Steve Willner (UKHSA), Holly Goss (UKHSA), Dr Lucy Thomas (UKHSA)

13. National screening programmes in prisons

Elliot Graves (NHS England – North West), Elizabeth Taylor-Diparno (NHS England)

14. Health promotion and improvement

Professor Michelle Baybutt (The University of Cumbria), Dr Alan Farrier (The University of Lancashire), Rachel Campbell (OHID Public Health South West, NHS England)

15. Health needs on release from prison

Elizabeth Taylor-Diparno (NHS England), Dr Caroline Watson (Northamptonshire Healthcare NHS Foundation Trust), Danny Duffield (DHSC)

16. The health needs and barriers experienced by people on probation

Chandreaa Bhattacharya (HMPPS and NHS England), Dr Simon Marshall (HMPPS), Darren Redgwell (HMPPS), Lucy Smith (HMPPS), Dr Coral Sirdifield (University of Lincoln), Jonathan Bartram (NHS Cambridgeshire & Peterborough Integrated Care System (ICS), Andrea Solomou (MoJ), Dr Caroline Watson (Northamptonshire Healthcare NHS Foundation Trust), Professor Bola Owolabi (NHS England) and Dr Mary Hill (NHS England)

17. A health and care workforce for the future criminal justice population

Dr Caroline Watson (Northamptonshire Healthcare NHS Foundation Trust)

18. Health research with people in prison and on probation in England

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Prisons

Name	Location	Primary people
HMP Wandsworth	London	Kirsten Ross, Head of Healthcare
HMP Brixton	London	Amanda Darville, Head of Healthcare
HMP Hewell	Worcestershire	Alice Heward, Deputy Head of Healthcare Practice Plus Group
HMP Oakwood	West Midlands	Harriet Tunstall, Head of Healthcare and Care Quality Commission (CQC) Registered Manager
HMP Belmarsh	London	Jenny Louis, Governor HMP Belmarsh Dr Sarah Bromley, Practice Plus Director

Name	Location	Primary people
HMP Low Newton	Brasside, near Durham	Lynsey Edmondson, Acting Head of Womens Health, Perinatal Pathway and CSU
HMP Durham	Durham	Nat Marley, Deputy Governor HMP Durham Karla Treddenick, Head of Healthcare Spectrum Community Health
HMP East Sutton Park	Maidstone, Kent	Amy Dixon, Governor HMP East Sutton Park Vishal Bheenick, Head of Healthcare
HMP Chelmsford	Essex	James Bennett: Head of Drug Strategy and Healthcare Paula Unwin, Head of Healthcare
HMP Long Lartin	Worcestershire	Alice Heward, Deputy Head of Healthcare
HMP Bronzefield	Ashford, Middlesex.	Charlotte Wilson, Director Lorna Cox, Senior Commissioning Manager (Surrey Prisons), Health and Justice (South East)
HMP Channings Wood	Devon	Dave Crawford Janet Swift, Clinical lead for OPD Services
HMP Feltham A	Middlesex	Jamie Cunningham, Head of Healthcare Jane Shalders, IMB Feltham
HMP New Hall	West Yorkshire	Julia Spence, Governor HMP New Hall
HMP Grendon	Buckinghamshire	Olivia Phelps, Governor HMP Grendon and Springhill Zoe Thornton, NHS E Head of the Offender Personality Disorder Pathway Kirk Turner, Head of OPD Pathway, HMPPS Health and Care Partnerships
HMP Spring Hill	Buckinghamshire	Olivia Phelps, Governor HMP Grendon and Springhill Zoe Thornton, NHS England Head of the Offender Personality Disorder Pathway Kirk Turner: Head of OPD Pathway, HMPPS Health and Care Partnerships

Probation

Name	Location	Primary people
Durham PDU	Durham	Dr Darren Redgwell, Head of Community Integration Northeast Region
Chelmsford PDU	Essex	David Messam, Head of Essex North PDU Sarah Port, Deputy Head Essex North Nicola Caffell, Health and Justice Partnership Manager Natalie Davison, Health and Justice Co-ordinator
Torquay PDU	Torquay	Louise Arcscott, Head of Devon and Torbay Probation Delivery Unit Mark Benden, Head of Operations South West Region (South) Janet Swift, Clinical lead for OPD Services Angie Powell, Senior Probation Officer/ Head of Offender Management Unit Delivery at HMP Exeter Josh Stunnel, Founder and CEO bthechange Ashley Parsons, Support Time and Recovery Worker Dr Sam Cole, GP Specialist Substance Misuse and Clinical Advisor Public Health Devon Complex Lives Team
Shepherds Bush PDU	London	Karen Tipping, Head of Community Integration, Probation Service London Dr Nicola Lang, Director of Public Health People's services Hammersmith and Fulham Council

Secure hospitals

Name	Location	Primary people
Broadmoor secure hospital	Berkshire	Dr Christian Brown, Consultant forensic psychiatrist Dr Robert Bates, Clinical Director (HSS)
Rampton secure hospital	Nottinghamshire	Dr Trevor Gedeon, Associate Medical Director Kerry Burton, Rampton Hospital General Manager

Children and young people secure estate

Name	Location	Primary people
Adel Beck secure children's home	Leeds	Fiona Stainthorpe: Children and Young People's Programme Manager, Health & Justice NHS England (North East & Yorkshire) Dr Ollie O'Mara: Consultant Clinical Psychologist
Oasis secure school	Rochester	Melissa Beaumont: Nurse Consultant & Clinical Lead – Children & Young People

Other

Name	Location	Primary people
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Glossary

Acronym/ Term	Definition
BBV	A BBV is a blood-borne virus. These are viruses that can be transmitted through contact with infected blood or certain body fluids. The main BBVs are Hepatitis B, Hepatitis C, and HIV.
BOLD	The Better Outcomes through Linked Data (BOLD) government data-linking programme which aims to improve the connectedness of government data in England and Wales.
DHSC	The Department of Health and Social Care (DHSC) supports ministers in leading the nation's health and social care to help people live more independent, healthier lives for longer.
DPH	A Director of Public Health (DPH) is a senior public health professional who provides leadership and strategic direction for improving the health and well-being of a defined population. They act as an advocate for public health, working to reduce health inequalities and protect communities from health threats. DPHs are statutory members of health and wellbeing boards and play a crucial role in local authorities and the wider health and social care system.
DRR/ATR/ CSTR	DRR and ATR are acronyms that stand for drug rehabilitation requirement and alcohol treatment requirement , respectively. They are types of Community Sentence Treatment Requirements (CSTRs) in the UK, used as part of community or suspended sentence orders to address the underlying causes of offending behaviour related to substance misuse.
HBV	HBV stands for Hepatitis B Virus. It is a virus that can cause liver inflammation, known as Hepatitis B. HBV is a serious global health concern, as it can lead to chronic liver disease, cirrhosis, liver cancer, and even death.
HCV	Hepatitis C is an infectious disease caused by the Hepatitis C virus (HCV) that primarily affects the liver; it is a type of viral Hepatitis. Similar to Hepatitis B it can usually be treated.
HMPPS	HM Prison and Probation Service (HMPPS) carry out sentences given by the courts, in custody and the community, and rehabilitate people in our care through education and employment. HMPPS is an executive agency, sponsored by the Ministry of Justice.

Acronym/ Term	Definition
ICB	An ICB, or integrated care board, is a statutory NHS organization responsible for planning and commissioning NHS services within a specific geographic area, known as an integrated care system (ICS). ICBs essentially replaced clinical commissioning groups (CCGs) and took over some of NHS England's direct commissioning functions. They are tasked with improving population health, managing NHS budgets, and ensuring services are in place to meet the needs of their local population.
JSNA	Joint Strategic Needs Assessments (JSNAs) are assessments of the current and future health and social care needs of local communities.
LTBI	LTBI stands for latent tuberculosis infection. It refers to a condition where a person has been infected with the bacteria that causes tuberculosis (TB), but the bacteria are inactive, and the person does not have active TB disease.
MHTR	MHTR stands for mental health treatment requirement. It's a sentence handed down by a court, usually as part of a community or suspended sentence, that provides tailored mental health support to offenders with mental health conditions. The aim is to reduce reoffending by addressing the underlying mental health issues that may have contributed to their actions.
MoJ	The Ministry of Justice (MoJ) is a major government department, at the heart of the justice system. The MoJ work to protect and advance the principles of justice who's vision is to deliver a world-class justice system that works for everyone in society.
NHS H&J	NHS England Health and Justice (NHS H&J) is at the time of writing responsible for commissioning a range of healthcare services that support children and adults throughout the youth justice and criminal justice systems in England.
NIHR	NIHR stands for the National Institute for Health and Care Research. It is the largest funder of health and social care research in the UK, providing financial support, infrastructure, and expertise to researchers and organisations. The NIHR's mission is to improve the health and wealth of the nation through research, and it works in partnership with patients, service users, carers, and communities.

Acronym/ Term	Definition
PMBLO	A Pregnancy and Mother and Baby Liaison Officer (PMBLO) is a dedicated role in women's prisons, acting as a point of contact and information for pregnant women and mothers. They help women navigate the prison system, access support services, and liaise with healthcare professionals and multidisciplinary teams. The role is part of a broader effort to improve support for pregnant women and mothers in the criminal justice system, including the establishment of Mother and Baby Units (MBUs).
RCGP	The Royal College of General Practitioners (RCGP) is the professional body for general (medical) practitioners (GPs/Family Physicians/Primary Care Physicians) in the United Kingdom. The RCGP represents and supports GPs on key issues including licensing, education, training, research and clinical standards.
NHS RECONNECT	NHS RECONNECT is a care after custody service that seeks to improve the continuity of care of people leaving prison or an immigration removal centre (IRC) with an identified health need. This involves working with them before they leave to support their transition to community-based services, thereby safeguarding health gains made while in prison or an immigration removal centre.
ROTL	Release on Temporary Licence (ROTL) facilitates the rehabilitation of people in prison, by helping to prepare them for resettlement in the community once they are released. This includes, among other examples, finding work and rebuilding family ties. It is intended that this will lead to reduced reoffending in the long-term.
SystemOne	SystemOne is a clinical computer system which is used by doctors, nurses and their teams to record important information about their patients and the care they provide.
TB	Tuberculosis (TB) is an infectious disease caused by bacteria called <i>Mycobacterium tuberculosis</i> that primarily affects the lungs but can also impact other parts of the body.
UKHSA	UK Health Security Agency (UKHSA) prevents, prepares for and responds to infectious diseases, and environmental hazards, to keep all our communities safe, save lives and protect livelihoods. UKHSA provide scientific and operational leadership, working with local, national and international partners to protect the public's health and build the nation's health security capability.

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1 Setting the scene on prison and probation health and healthcare

Authors: Dr Nicola Vousden, Danny Duffield, Professor Chris Whitty

History of prison and probation health and care governance

Prisons have always had worse health than the general population, and historically that health was often appalling even by contemporary standards of the day. Mortality rates from prison-acquired infections, significant rates of serious mental illness and other risks were high. Prisons have, and have had, high rates of disease for multiple reasons. The historical records of prisons in the UK and around the world, going back over centuries, have repeatedly remarked on the very poor physical and mental health of prisoners relative to the population from which they are drawn.

Some of the reasons for this poorer health are, and have historically been, due to prison conditions themselves. Prisons are generally crowded relative to normal accommodation, with often sub-optimal ventilation increasing the risk of respiratory and touch diseases, reaching literally epidemic proportions in historical records. They were historically insanitary with high rates of vector-borne diseases such as gaol fever (louse-borne typhus) smallpox and cholera¹, now fortunately long gone in UK prisons, which caused substantial mortality and morbidity in prison inmates and staff. Prison diet has always been an issue, with malnutrition increasing the rates of many communicable and non-communicable diseases and diseases such as scurvy were common.

The physical health of prisoners has also historically been very poor when they entered prison, from both communicable and non-communicable diseases. In large part this reflects the reality that those in prisons have always tended to come disproportionately from the most deprived and poverty-afflicted parts of society, where communicable and non-communicable disease is always clustered. The pre-prison health of prisoners has therefore always been poor relative to the population averages, with the conditions of gaols and prisons then exacerbating this unless determined steps were taken to reverse this ill health. The relatively high prevalence of communicable diseases on entering prison relative to the population have historically always increased the risk of in-prison transmission of infection.

The mental health of prisoners has also historically been significantly worse than the general population. Many people are in prison in part because of their mental health condition. Concerns that prisons have some people incarcerated because the health services cannot manage their mental health conditions are longstanding. The conditions in prison often exacerbate pre-existing mental health and neurodivergent conditions.

While the risks of ill health that are common in prisons relative to the general population cannot be entirely removed, determined efforts at multiple points in history have led to substantial improvements in prisoner health. Sometimes this has been incremental, at other times it has been due to the determined actions of prison reformers, prison staff and the medical and nursing professions.

Prison medical services began in England in 1877, initially staffed by minimally trained officers. In 1919, trained nurses were first employed at HMP Holloway, and by 1928, the Prison Nursing Service was established to train nurses for prisons across England².

Figure 1: prison nurses and other prison staff outside HMP Holloway, 1920s to 1930s



Source: Royal College of Nurses. Credit: National Justice Museum³

Probation in England and Wales has been a formal statutory service since the Probation of Offenders Act in 1907, allowing a legal mechanism for supervision in the community. The act required probation officers to 'advise, assist and befriend' those under supervision⁴. Less is known about the history of the health of people under the supervision of probation. While a diverse group, people in contact with probation services have often been, and continue to be, socially excluded, with higher levels of poverty, unemployment, homelessness and poor mental health. Requirements for psychiatric treatments were first introduced in 1938.

In 1996, a report by Her Majesty's Chief Inspector of Prisons criticised prison healthcare, arguing for 'equivalence', with prisoners having a right to the same level of care as the general population⁵. This led to the establishment of the Joint Prison Service and NHS Executive Working Group in 1999⁶. The group identified issues in strategic planning, accountability,

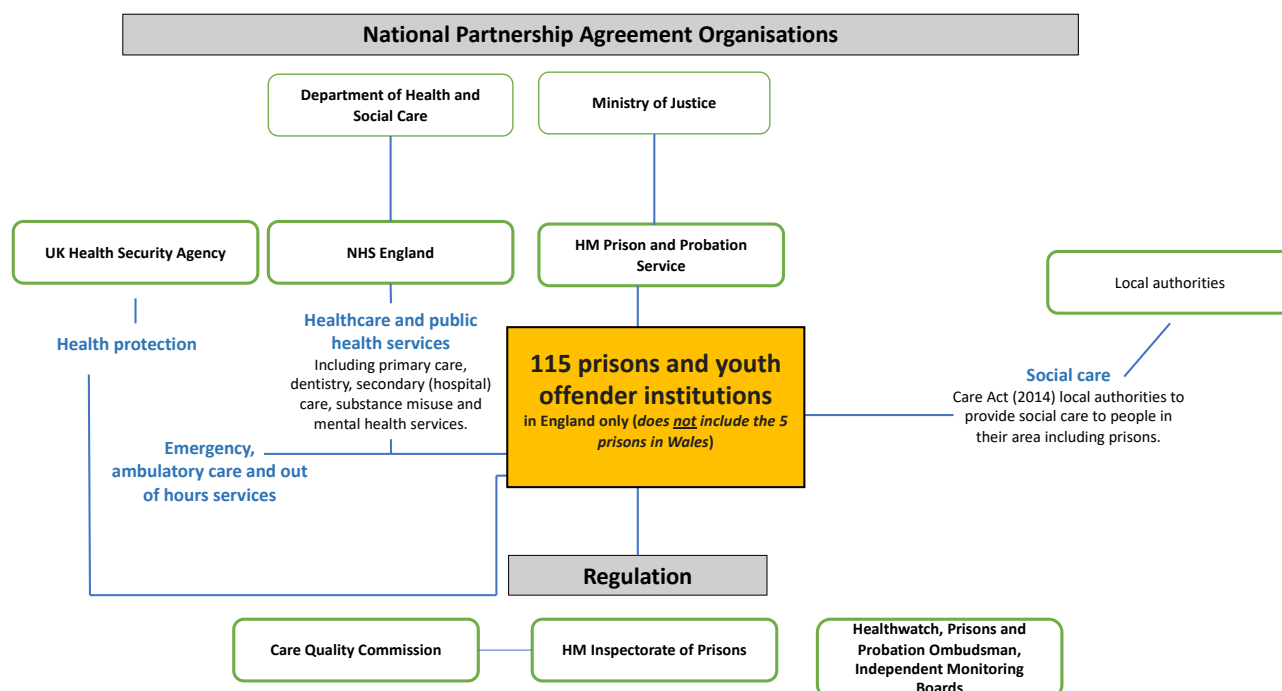
and healthcare professional training, causing inconsistent healthcare across prisons. They recommended joint responsibility between the NHS and Prison Service and the introduction of primary healthcare within prisons by NHS providers, with access to secondary care from local hospitals⁷.

Following the Health and Social Care Act 2012, a National Partnership Agreement was formed between NHS England, National Offender Management Service (now known as HM Prison and Probation Service), and Public Health England (PHE). NHS England took over direct commissioning of health and justice services, commissioning health services for people that are detained, including primary care, hospital care (excluding emergency and ambulatory care), public health, mental health, drug and alcohol services, dental services, and optometry for people in prison and all health services in the children and young people secure estate⁸. People on probation access the same NHS healthcare services as the rest of the general population, which have undergone considerable change over time. After NHS reforms in 2013, there was a split so that clinical commissioning groups (CCGs) were responsible for commissioning the majority of healthcare for offenders in the community. Despite explicit guidance there were long standing concerns over CCG awareness of their responsibility to the population of people on probation⁹.

Current structure and governance for commissioning health in prisons and populations on probation in England

Following the Health and Care Act 2022, NHS England has progressively delegated its specialised commissioning portfolio to integrated care boards (ICBs) within the 42 integrated care systems (ICSs)¹⁰. However, at the time of writing NHS England retains responsibility for national strategic direction and regional health and justice commissioning for secured services (including children and young people), adult mental health liaison and diversion, courts, police custody services, and post-custody services like RECONNECT and Enhanced RECONNECT¹¹. ICBs are responsible for commissioning the majority of NHS services for people on probation (including primary care, acute care and community mental health services). However, local authorities are responsible for commissioning key public health services that have a high relevance for the probation population, such as sexual health and family planning, specialist drug and alcohol services.

Figure 2: organisations involved in overseeing, commissioning and regulating prison health care in England



Adapted from: 'How prison health care in England works' (Nuffield Trust 2021)¹²

National Partnership Agreements for Prison Healthcare in England were updated in 2018 and 2022 following the dismantling of PHE in 2020¹³.

The current National Partnership Agreement is between¹⁴:

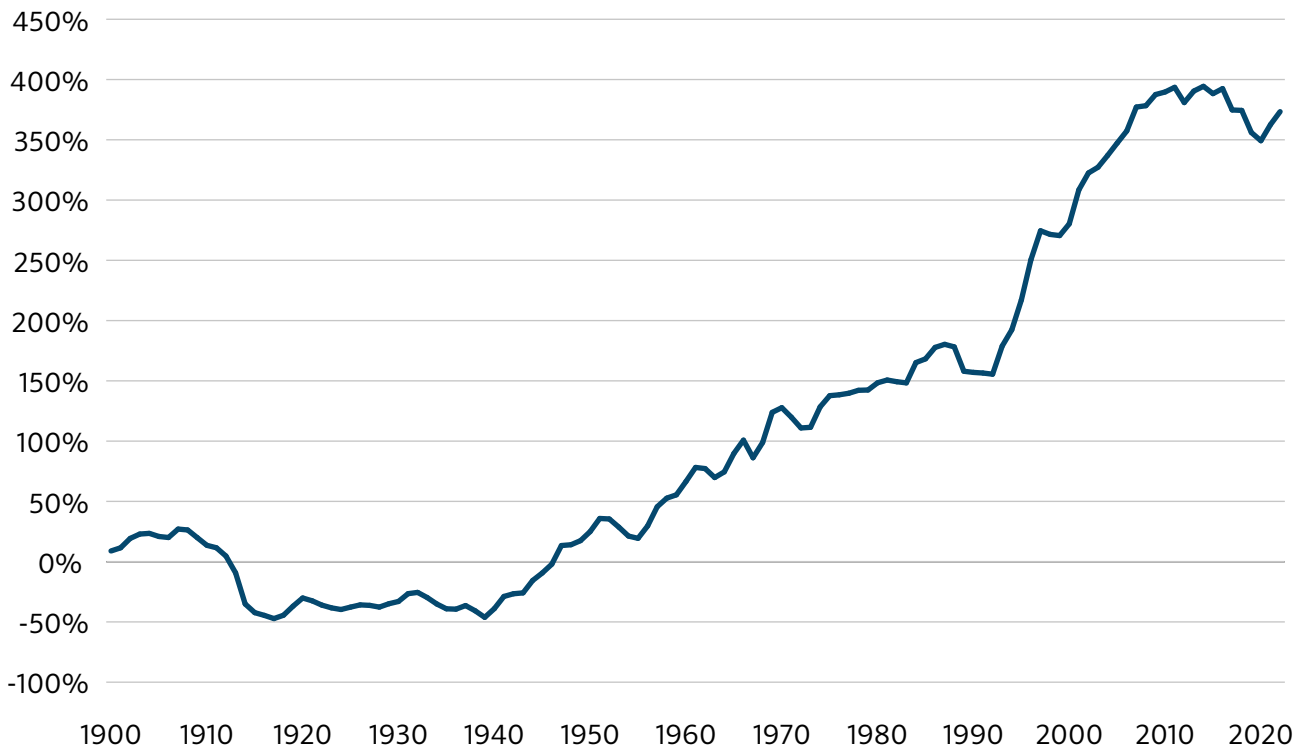
- Department of Health and Social Care (DHSC) which promotes continuity of care, addresses health inequalities through the Office for Health Improvement and Disparities (OHID), and ensures arm's length bodies deliver on plans and commitments
- Ministry of Justice (MoJ) which holds responsibility for courts, prisons, probation services, and community justice
- HMPPS which manages people remanded into custody and carries out court sentences in custody and the community
- NHS England which provides national strategic direction and 7 regional teams to commission healthcare services in specific settings
- UK Health Security Agency (UKHSA) which protects communities from infectious diseases, outbreaks and other environmental health threats

In 2025, NHS transformation continues, driven by Lord Darzi's independent investigation and the government's 10 Year Health Plan for England. There is a focus on neighbourhood health, with place-based NHS organisations, local government, social care and the voluntary, community, faith, and social enterprise (VCFSE) sector collaborating to enhance population health, address health inequalities and improve health and social care efficiency¹⁵.

Recent trends in prison and probation populations

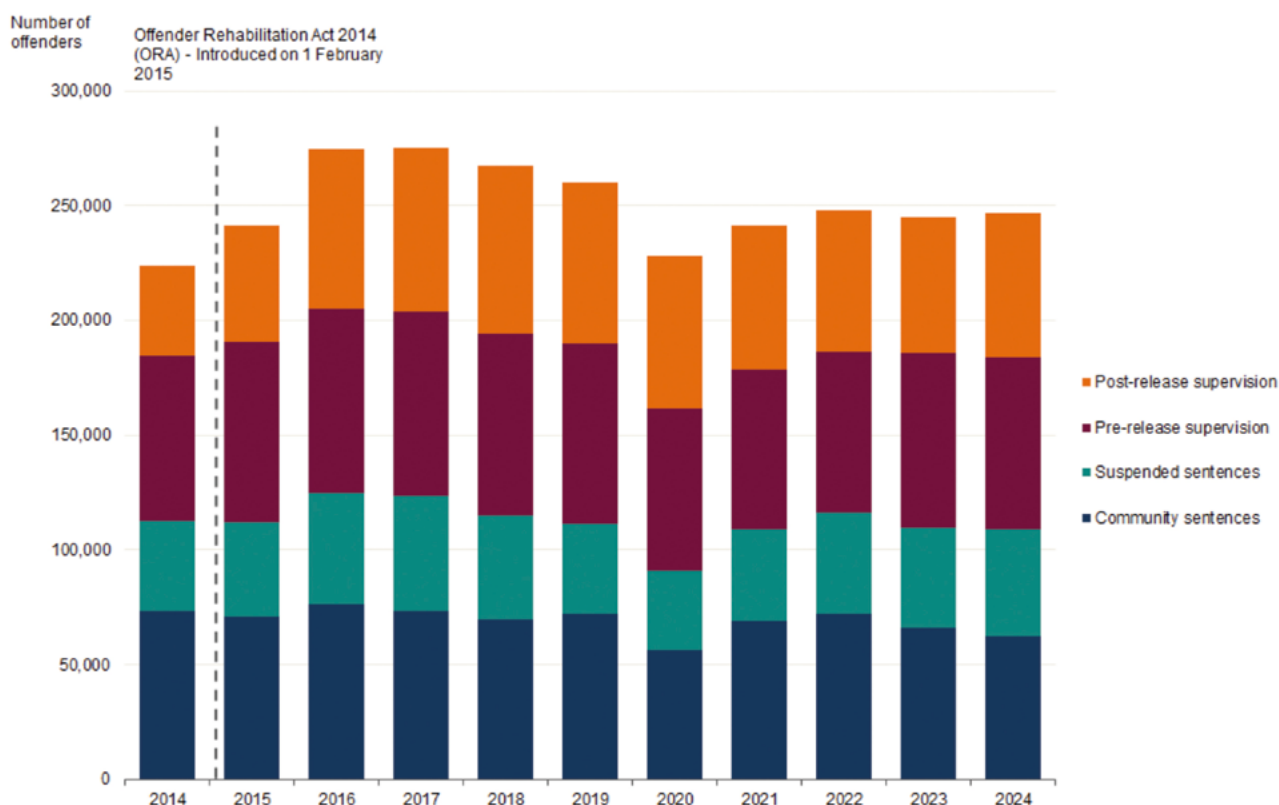
Figure 3 shows that the prison population underwent a period of rapid growth in recent years. The number of people under supervision by probation in England and Wales has remained relatively stable since 2015, with the exception of a substantial reduction in 2020 as a result of the operational restrictions that were put in place in response to the COVID-19 pandemic as shown in figure 4.

Figure 3: change in the prison population in England and Wales since 1990¹⁶



Source: MoJ (England and Wales) Offender management statistics quarterly

Figure 4: number of people under Probation Service supervision, 30 September 2014 to 2024



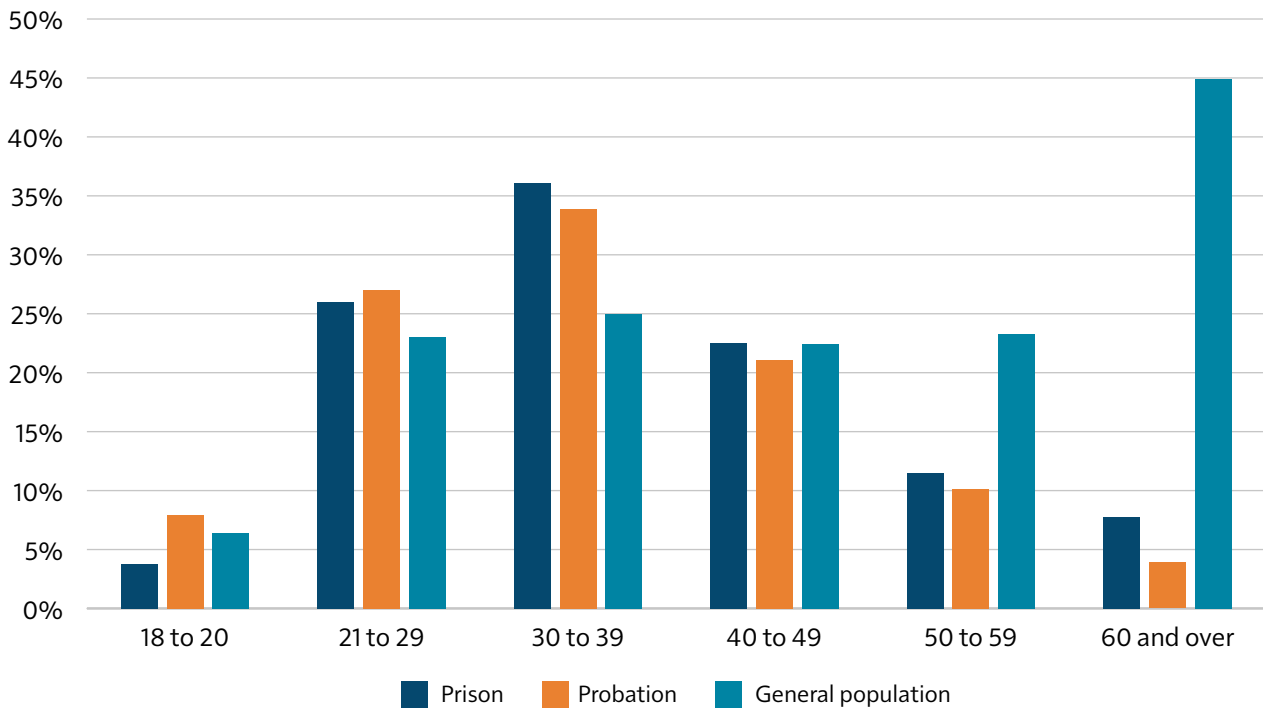
Source: Ministry of Justice. Offender management statistics quarterly: July to September 2024¹⁷

The current and future prison and probation population

As of 31 December 2024 there were 85,372 people in prison and 240,362 people supervised by the probation service^{18 19}. The number of people supervised by probation service is much greater than the number in prison, many of whom have never been in prison²⁰.

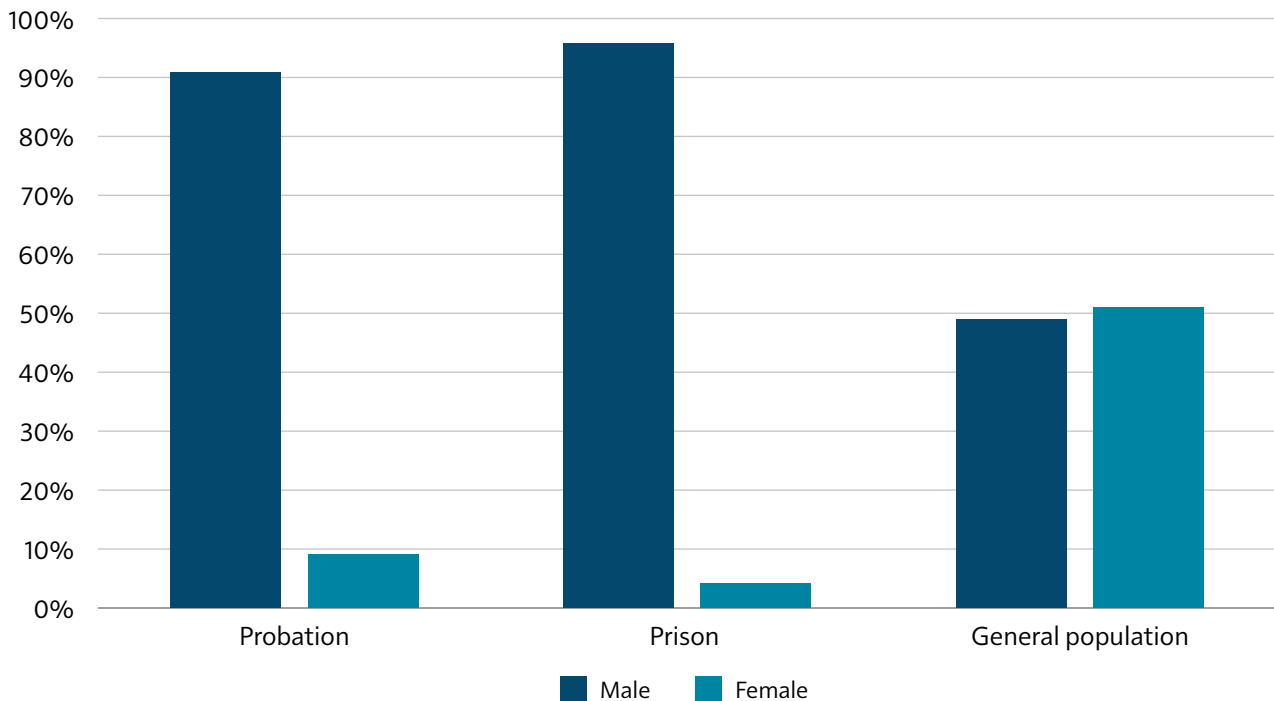
The prison and probation population are predominantly male (figure 5), younger (figure 6) and more ethnically diverse (figure 7) compared to the general population. Data is for England and Wales as they are not publicly available separately.

Figure 6: prison, probation and general population by age



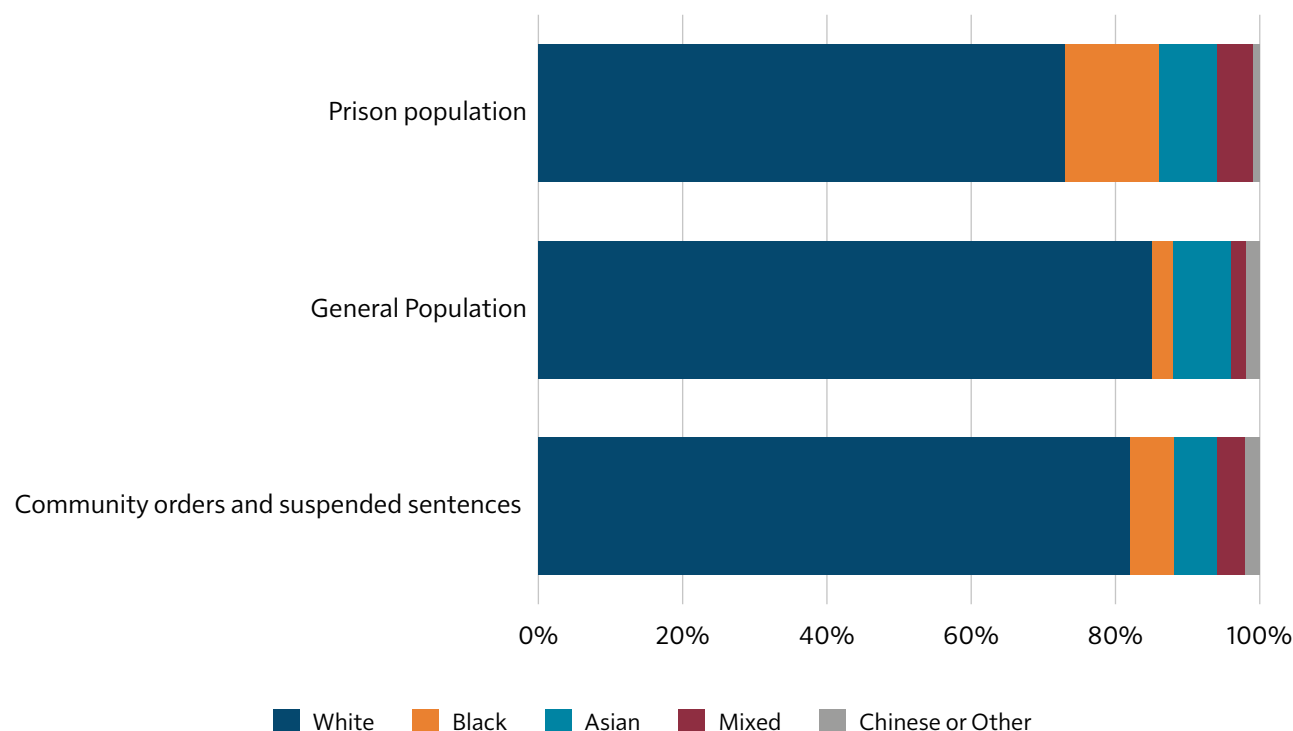
Source: Ministry of Justice prison population by age at 31 March 2025²¹ probation population by age December 2024²² and Office of National Statistics estimates at midpoint of 2024²³

Figure 5: probation, prison and general population by sex



Source: prison and probation data at 30 June 2024 from Ministry of Justice:^{24 25}, general population data from census 2021²⁶

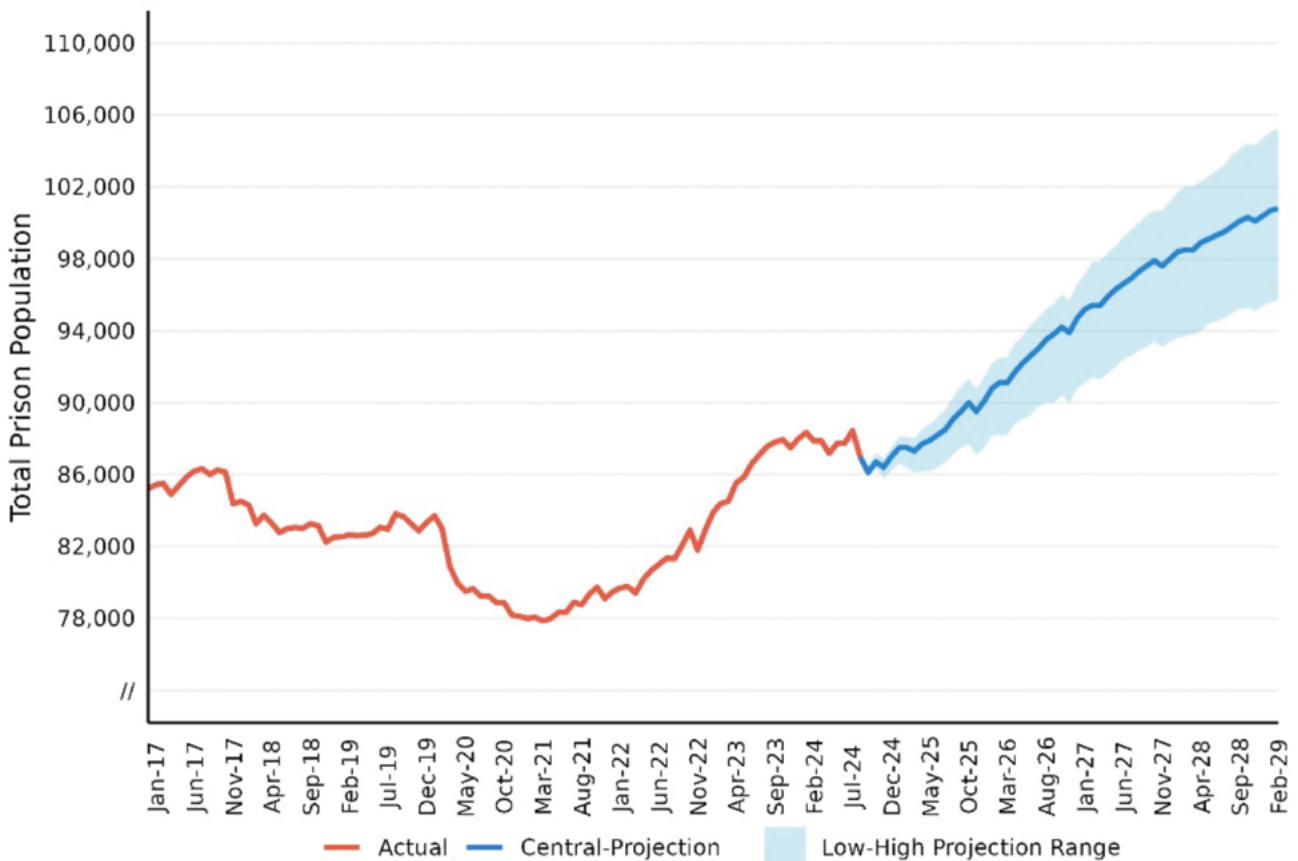
Figure 7: ethnicity proportion for adults in prison compared to adults in the general population and adults on community orders and suspended sentences



Source: Ministry of Justice^{27 28}

There is considerable ‘churn’ in the prison estate, with people moving in and out, and between prisons. The average (mean) custodial sentence length is 20.1 months²⁹ and 18,090 people first moved into prison (new prisoners) between October to December 2024, with 15,730 releases over the same period. Nearly 1 in 4 people in prison were held in crowded accommodation in 2023 to 2024³⁰. These factors are all important as they influence the need for healthcare and ability to provide healthcare.

The prison population has been projected to increase to between 95,700 and 105,200 by March 2029 (figure 8), but this may change as a result of the recent sentencing review³¹. The projected increase in the prison population is driven by several factors including: continued growth in police charging and prosecutorial activity; increased flows into the courts; rising levels of people on remand and changes in sentencing policy and behaviour to keep the most serious offenders in prison for longer. The prison population is also projected to get older as people age in prison (chapter 5). Therefore, the provision of healthcare will need to increase proportionately to meet demand.

Figure 8: total prison population projection, October 2024 to March 2029³²

Source: Ministry of Justice, Prison Population Projections: 2024 to 2029

The population on probation may also increase especially given the recent sentencing review recommending a reduced reliance on custody in favour of more people being managed in the community³³, although projections are not published. This includes recommendations for further investment in the probation service as well as third sector and community organisations, in addition to targeted approaches for different groups including women, older people and people with drug and alcohol misuse. It will be vital to ensure that health services are included and progress in parallel to these sentencing changes since health in the community and particularly mental health is closely intertwined with offending.

Current healthcare service provision in prisons and for people under the supervision of probation

Healthcare provision for prisons in England is delivered by private providers, community interest companies and NHS providers. All prisons have health care services on site. NHS England sets out the specifications of core services, although provision in each prison is nuanced according to the category, size, estate challenges, age profile and according to the health needs assessment of the population held there.

On arrival people receive an initial health care assessment (1st night screen) to identify immediate needs such as medication requirements and assessment of needs such as chronic

health conditions and risk of self-harm or suicide and treatment related to drug or alcohol withdrawal³⁴. A follow up health care assessment should take place within 7 days to address issues raised and undertake screening for infectious diseases such as tuberculosis and blood borne viruses (chapter 11)³⁵.

During a prison stay, people should have access to on site primary care including GPs, mental health, drug and alcohol services, dental and optometry services³⁶. HMPPS are responsible for facilitating access to healthcare, for example escorting someone to the health care unit within the prison. If someone requires specialist services, they may need to access an appointment at the hospital, usually requiring them to be escorted by at least 2 prison officer escorts, or there may be in-reach services to prison, for example in-reach mental health teams (chapter 7). Social care remains the remit of local authorities who are responsible for providing social care services to the people living in prison within their area. People in prison are entitled to screening programmes that they would receive in the community (chapter 12) and advice on improving their health to prevent the onset of health conditions (chapter 13). Pregnant and postnatal women can be sentenced to prison in England. Their maternity care is provided by the local NHS trust and half of the 12 women's prisons in England have a mother and baby unit where women can live with their babies (chapter 2).

Release from prison is a significant transition and continuity of care is key, with services such as NHS England RECONNECT aiming to support this (chapter 14). There are challenges with data sharing to support continuity of care through the criminal justice journey (chapter 17).

People on probation after release from prison, or without a prison stay, access the same healthcare services as the general public including primary care (GPs, community pharmacy, dentistry, eyecare), secondary care (planned care in hospitals, urgent and emergency care and mental health care) tertiary care (such as some specialist mental health services) and community health (district nursing, sexual health services and so on).

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2 Health and care of women through pregnancy, birth and the postnatal period in prison and on probation

Authors: Dr Nicola Vousden, Fiona Grossick, Nikki Luffingham, Dr Lucy Wainright, Dr Christy Pitfield, Dr Laura Abbott

Contributors: Sue Curzon, Sian de Cruz, Dr Joann Hale, Kirsty Kitchen, Ellen Adams, Tracy Wharrier, Dr Jessica Moules, Dr Caroline Pontvert, HMPPS Women's Group

Introduction

In England, pregnant and postnatal women can go to prison. Some women will know they are pregnant at the time of entering prison, others may find out they are pregnant on arrival. As in the community, midwives and obstetricians provide shared care for pregnant and postnatal women. Support is available from primary care, mental health and drug and alcohol treatment teams. Most elements of antenatal and postnatal care will be provided in prison, but scans and specialist referrals are usually facilitated in the NHS hospital closest to the prison, with women usually accompanied by 2 prison officers. When labour begins a woman will be transferred to hospital for birth, accompanied by prison officers, unless she has been granted release on temporary licence in advance. Pregnancy and the postnatal period are times of dramatic changes to biology, psychology and social needs. Evidence shows that experiences and circumstances in the first 1,001 days from conception to a child's second birthday lays the foundation for long-term physical and mental health¹. Therefore, this is a critical time for both mothers and babies in contact with the criminal justice system.

Pregnant women make up a small percentage of the female prison population (approximately 6%). There is an average of 47 pregnant women in prison across any given month. The number of pregnant women and women that gave birth while being held in custody increased in April 2023 to March 2024 compared to the 12 months prior as shown in figure 1 (from 194 to 215 pregnant women in prison and from 33 to 53 births). Ninety-eight per cent of births to women being held in prison were in hospital².

Figure 1: number of pregnant women in prison and that gave birth while being held in custody in 2022 to 2024

2022 to 2023	 194 pregnant women in prison	 33 births to women while spending time in custody
2023 to 2024	215 pregnant women in prison	53 births to women while spending time custody

Source: Ministry of Justice (MoJ) and HM Prison and Probation Service (HMPPS); HMPPS annual digest, April 2023 to March 2024³. Pregnancies are self-reported.

In 2023 to 2024 approximately half of pregnant women in prison were aged over 30 and the majority reported themselves to be White (83%)⁴. Women in prison have a high prevalence of complex issues although there is limited evidence of their prevalence in pregnant women in prison. These factors can influence the way that women access and engage with services prior to prison, or in the community on probation, as well as in prison.

The following are examples of complex circumstances of all women in prison (there is limited evidence for pregnant women in prison):

- 31% spent time in the care system themselves⁵
- 53% report experiencing emotional, physical or sexual abuse as a child⁶
- 60% have experienced domestic abuse⁷
- 5 times more likely to have a mental health concern than the general population⁸
- 70% have at least one child⁹
- 35% and 61% screen positive for drug dependence and problematic alcohol use respectively¹⁰

The nature of the prison environment can also influence experience of pregnancy and the postnatal period and provision of care. For example, women with infants (either having given birth during their sentence or recently prior to arriving in prison) need to choose whether to apply to live with their baby in a mother and baby unit (MBU) or be separated. MBUs are discrete specialist accommodation units for women with infants, usually up to the age of 18 months, managed and supported by both operational prison staff and qualified nursery professionals. They aim to promote and facilitate the development and maintenance of relationships between women and their children during a pivotal attachment and development period, if this is in the best interests of the child¹¹. There are a total of 64 spaces for women and 70 for their children (allowing for multiple births). From April 2023 to March 2024 there were 92 applications for MBUs, an increase from 80 the preceding year¹². Of applications that

proceeded, 79% were approved (54 women). Mothers and expectant mothers apply and can be refused a place if it is not seen to be 'in the best interests of the child' in which case there may be an interim care order by children's services. Since MBUs are located at 6 of the 12 female prisons in England, for most women an MBU placement may allow her time with her baby but mean moving long distances from existing family, established support networks and older children (figure 2: map of 6 female prisons in England with an MBU and pictures of HMP Bronzefield MBU).

Figure 2: map of prison MBU locations and nearby cities and pictures of HMP Bronzefield mother and baby unit



Source: Map is reproduced from Department of Education¹³

Organisational learning and improvements made to support women through pregnancy and early motherhood in prison

During 2019 and 2020, there were 2 tragic deaths of babies during labour of women who were in prison, Baby Aisha at HMP/YOI Bronzefield on 27 September 2019¹⁴ and Baby Brooke-Leigh at HMP/YOI Styal on 18 June 2020¹⁵. HM Prison and Probation Service and Ministry of Justice stated that these were unacceptable and should never happen to any woman or child. Independent investigations by the Prisons and Probation Ombudsman (PPO) made recommendations to the NHS England National Director Health and Justice, Armed Forces and Sexual Assault Services and HMPPS. This included recognition that:

- the clinic-based community model of care is not appropriate to a custodial setting
- all pregnancies in prison are high-risk

These recommendations were accepted and implemented. A summary of the significant recent policy changes and improvements for pregnant women in prison is shown below:

- 2021 – The Women’s Health and Social Care Review commenced in partnership between NHS England and HMPPS
- 2021 – MoJ launched a new policy framework for pregnancy, MBUs and maternal separation. This introduced mandatory requirements for prisons to improve their care for this population. Including:
 - a dedicated Pregnancy and Mother and Baby Liaison Officer (PMBLO) role
 - mandatory, individual care planning for all pregnant women
 - additional welfare checks for women in the third trimester of pregnancy
 - guidance for staff
- 2022 – HMPPS set up the National Advisory Forum on Pregnancy, MBU’s and Maternal Separation. This provides a space for stakeholders to contribute to policy development. Attendees include NHS England, specialist midwifery, Prisons and Probation Ombudsman, HM Inspectorate of Prisons, third sector organisations, clinical representatives and academics
- 2022 to 2023 – HMPPS introduced a new women specific training course for new prison officers. A new e-learning package on pregnancy and perinatal care was added in March 2023
- 2023 – The Women’s Health and Social Care Review was published. This acknowledged that improvements had been made in pregnancy and social care support for women who had been separated from their children, but more needs to be done to drive forward meaningful change. Eight high level recommendations were made
- 2024 – NHS England published the National Service Specification for the care of women who are pregnant or postnatal in secure and detained settings. This is known as the maternity specification. It was accompanied by 8 maternity principles to support operationalisation of the specification
- 2024 – NHS England commenced a comprehensive 3 year programme to deliver and embed improvements. £21m of funding was gained to support regional teams to implement and embed the recommendations from the review and investigations
- 2024 – NHS England and HMPPS convened a jointly chaired national implementation programme board. This includes women with lived experience, NHS England regional commissioners, HMPPS, Ministry of Justice and Department of Health and Social Care
- 2025 – NHS England commenced a review and refresh of the maternity specification. this includes the National Midwifery Lead and maternity clinicians and takes on board the recommendation from the Womens’ Health and Social Care review to include gender specific elements

All pregnancies in prison are deemed high-risk

The Sentencing Council is an independent body that sets guidance on the type and length of sentence in England and Wales. In March 2024 they introduced a new mitigating factor for pregnant and postnatal women, stressing the need to consider their health and avoid imprisonment because of heightened risks¹⁶. In this chapter we explore the risks of imprisonment in pregnancy and early motherhood. This demonstrates that for the majority of women it is medically responsible to avoid imprisonment wherever possible and to prioritise community-based sentences or suspended sentences. For the small number of pregnant women and women with young children who do require custodial sentences, it is important that their health and care, and that of their babies, is equivalent to that available in the community. A framework to explore how pregnancies in prison may be deemed high-risk is provided in table 1.

Table 1: examples of interrelated risks that may impact pregnant and postnatal women in prison and on probation. Adapted from Pitfield and others, 2023¹⁷

Layers of risk	Type of risk
All women that are pregnant and postnatal experience changed needs	■ biological: increased susceptibility to becoming unwell from infections ■ psychological: hormonal changes increase the risk of poor mental health in the postnatal period ■ social: childcare, financial arrangements
Some women in prison have existing factors that can increase risk	■ biological: use of drugs and alcohol during pregnancy can impact health ■ psychological: childhood trauma, domestic abuse, separation of babies from mothers ■ social: shame or stigmatisation, lack of trust in services
The environment of prison could confer further contextual risk	■ access and quality of routine and emergency healthcare ■ information about rights and health ■ safety and autonomy

Risks span through pregnancy, from conception to a child's second birthday: the first 1001 days. This is true for both those who reside with their babies on MBUs, and those who are separated from their babies. However, there is very limited data to define these risks. The initiation of annual public data on the number and demographics of self-declared pregnancy and births by HMPPS in 2023 is very welcome. Since healthcare is provided by the NHS hospital local to the

prison, the electronic health records of women in prison are held within hospital data. However, to date there has been no standardised way to identify this group. This means there is limited understanding of pregnancy outcomes, such as termination of pregnancy, miscarriage and stillbirth. There is also less known about needs of women arriving having recently given birth in the community, who may not self-declare that they are separated from young children. This impacts the ability to inform service commissioning and planning.

The anonymised fictional vignettes that are woven through this chapter are drawn from real cases in research on pregnancy in prison. While the research was undertaken over the last 10 years by one of the authors, Laura Abbott, it reflects many relevant challenges today. In the absence of data, they aim to shed light on the complex realities of navigating pregnancy, early motherhood and healthcare within the prison system.

Identifying pregnancy

Case study: identifying pregnancy in prison

Cleo was sentenced to prison for the first time at 17. She was sentenced to 3 years after a drunken fight turned violent. During reception into prison on remand, in the first night centre, standard health checks took place. The routine pregnancy test came back positive. Cleo had not suspected she was pregnant. This meant she was left to call her mum and tell her: that she was in prison, and that she was pregnant.

Each woman arriving to prison in England is offered a pregnancy test on reception, and at day 7 and day 28. If positive, this triggers initiation of the perinatal pathway, a joint register owned by healthcare and prison. The prisons visited in engagement for this report had clear processes for this follow up.

Pregnancy is a personal experience. It is vital that when pregnancy is identified women have access to information regarding all their possible rights and choices and can talk this through with a trained health care provider, including abortion and application to MBUs¹⁸.

Lived experience: arriving in prison when pregnant

Pregnancy tests on arrival are voluntary and not every woman will accept the offer. This may be more likely for women on short sentences, if there are concerns about social care intervention or previous trauma. For many the 'entry shock' of entering prison can result in confusion and distress. This is magnified when coupled with immense concern about their unborn baby. The following quotes are from women in prison and taken from research papers^{19 20}:

"Not everyone can talk about what they went through, and reception doesn't feel like the right space or support to go into it".

"I was sort of still in shock about coming to prison so I remember them sitting me down to talk to me, but I couldn't tell you what they said. I can't remember it all."



Women often arrive in prison ill-informed about their rights and choices relating to pregnancy in prison. Women reported a lack of information on arrival or in the community when at risk of a prison sentence.

"At the point of risk of prison (police station, court) women should be given information about pregnancy and prison – even if they don't immediately disclose they are pregnant."

"I was going to get an abortion – I didn't know about MBUs. A few weeks in, healthcare came over and said we needed to get me ready for an MBU board. I was like "OMG, can I keep my baby?!"

Image source: Beci Ward (with permission)²¹

Ongoing pregnancy

Case study: the prison environment and experiences of pregnancy

Abi developed severe vomiting known as hyperemesis gravidarum in the first trimester of her pregnancy. Her symptoms of nausea and vomiting were so extreme that she had been hospitalised twice. Abi's nausea was a constant presence and any feelings of hunger or thoughts around prison food made this worse. Having to eat at set mealtimes made it difficult for Abi to maintain nutritional wellbeing, especially with limited choices available to her. Abi found that her acute symptoms were doubted by some staff. Her distress was amplified by the fear of being disciplined because of not wanting to go to work because she felt so ill.

Experience of pregnancy

In all women, pregnancy hormones and physical changes can cause symptoms. In prison, minor pregnancy disorders can be exacerbated by prison conditions and ability to make choices. For example, food quality and choice, inconsistent access to nutrients and pregnancy packs, uncomfortable conditions like inadequate mattresses and hidden challenges such as limited healthcare choices and information may all impact experience of pregnancy. HMPPS policy states that prisons must facilitate access to practical support items including appropriate mattresses and refers to nutrition guidance²². Circumstances during pregnancy impact the mothers experience but also the wellbeing and safety of the unborn infant.

Maternal mental health

In all women, pregnancy and the first year after birth is a time of increased vulnerability to poor mental health. Women in prison can have additional risk factors for poor mental health and the environment may further increase risk. In the community, 1 in 5 women experience mental health difficulties during this time²³. Suicide and substance misuse remain leading causes of maternal mortality in the UK²⁴. Women in prison have higher rates of mental illness than women in the community (78% compared to 15%)²⁵. The higher rates of previous traumatic experiences, unemployment, homelessness, being looked after children themselves, poverty and poor physical health are all risk factors for a decline in perinatal mental health^{26 27}. The prison environment, lack of autonomy, social isolation and uncertainty about applications to MBUs or potential separation from their baby, as well as separation from their other children, may all further increase the risk of decline in mental health in the time around pregnancy²⁸. During our engagement we observed good practice where specialist perinatal mental health teams assessed all pregnant women on their arrival to prison (practice example: NHS prison perinatal mental health). However, other prisons faced challenges accessing prison-based specialist perinatal mental health services and these standards were not met.

Practice example: NHS prison perinatal mental health service

Background

Central and North West London NHS Foundation Trust provides perinatal mental health services to 3 female prisons in the South of England (HMP/YOI Bronzefield, HMP Send and HMP/YOI Downview). The service, based at HMP/YOI Bronzefield is comprised of a multidisciplinary team that are specialists in perinatal mental health including consultant perinatal psychiatry, nursing, psychologists and occupational therapists. All pregnant women, regardless of history or current presentation are offered a perinatal mental health assessment on entry to prison. The service is also available to women in the postnatal period in the MBU or separated from their baby, if they present mental health difficulties. Following assessment, women are offered formulation-based specialist interventions. These include:

- psychiatric input and medication
- nurse led input

- emotion coping skills groups
- individual psychological therapy including EMDR and CBT
- occupational therapy
- parent-infant interventions to all mothers and their babies on the MBU including Circle of Security parenting programme and video interaction guidance intervention

The service also offers parent-infant interventions to all mothers and their babies on the MBU. All interventions aim to prevent the development of perinatal mental health difficulties, treat existing mental health conditions, and break the cycle of transgenerational trauma.

Working with the professional care network

Clinicians work with the professional network around the mother and baby and attend multiagency meetings where mental health, obstetric and health needs and safeguarding concerns are shared and understood.

The team has a role in increasing awareness of maternal mental health and risks to this during the perinatal period, to share psychological based formulations of mental health difficulties and to develop a trauma informed approach that also advocates for both mother and baby's emotional needs.

Psychologists offer supervision, case consultation and reflective practice to health and prison staff working with mothers and babies in prison, recognizing the unique and complex emotional responses that such work entails.

The service has developed bespoke trainings focused on perinatal mental health in a prison setting and trauma informed care for staff. Training also focuses on developing understanding of trauma and the impact on relationships, the importance of validation and development of safe, trusting rapport.

Pregnancy outcomes

Women who are pregnant in prison may experience higher rates of preterm birth, stillbirth and neonatal unit admission. The strength of this evidence is poor as it compares outcomes to the general population, not women who face similar disadvantages in the community. The available research evidence suggests that compared to women in the general population, women in prison are more likely to have a premature birth (11% compared to 6.5%²⁹) and severe maternal morbidity (2.4% compared to 1.6%³⁰). Their babies are more likely to be born at a low birth weight^{31 32}, stillborn (27.1 per 1,000 births compared to 4 per 1000), or admitted to a neonatal unit (25% compared to 14%³³). Women with similar disadvantage in the community may also experience greater challenges in accessing care and worse outcomes³⁴.

Maternity services

All female prisons should have a specialist named midwife to provide care on site, though there can be challenges to the provision of consistent care and support to midwives. NHS Health and Justice maternity principles describe the need for a team-based approach to ensure continuity of care and maintenance of skills. At the time of writing, specialist midwives are in post in all prisons, however, there are some prisons where the service is staffed by one individual, with no cover for planned or unplanned leave³⁵. Prison midwives engaged for this report hugely welcomed the increased provision where it had been achieved, however provision varied widely. Team models of care, with senior midwifery strategic support, that can cross cover over the week was recognised as good practice. Supporting women with multiple medical and psychological needs, on the background of traumatic experiences and potentially limited prior engagement with health services, is intensive, specialist care. Considerable time is required to build trusting relationships, assess and manage these needs. Staff require adequate support from their NHS trust, prison healthcare and perinatal mental health teams to avoid feeling isolated and overwhelmed by the complexity of the caseload.

Practice example: maternity provision across the week

Background

HMP/YOI Eastwood Park's MBU has room for up to 12 women and their babies, as well as living areas, therapeutic spaces, cooking facilities and a nursery. Prior to March 2024, midwifery provision was 20% of one full time midwife (0.2 whole time equivalent, a midwife visiting HMP/YOI Eastwood Park for one day a week). There was limited staff capacity given the complexities of working with such a vulnerable group. Current key performance indicators/outcome measures do not always provide a full picture of the pressures on the service or reflect its positive impact.

Work undertaken

In April 2024 midwifery provision increased to 7 days per week 8am to 6pm. This is supported by a team of 4 midwives who split their time to ensure cover over the week. Each woman is seen in the routine antenatal clinic once a week. The service also includes 10 hours of dedicated input from a consultant obstetrician per week, who is accessible through the week. Specialist perinatal mental health support is provided through Avon and Wiltshire Mental Health Partnership NHS Trust.

Outcomes and impact

The team work together to provide continuity of care to the women across the week. This encourages the development of trusted relationships over sustained periods of time. Support is provided on-site where possible to reduce the need for external appointments, which can be challenging. When external appointments are required, the midwives attend with the woman. The team support women up to 6 weeks postnatally with their baby, or support separation where required for example through creating memory boxes and cards. The team can support each other when managing complex cases complexity.

Case study: maternity provision at night

Anushka was 30 weeks pregnant with her fifth baby and had a past obstetric history of placenta praevia (low lying placenta at risk of bleeding). She was in a room on her own and often locked up for 20 hours a day due to staffing issues. One bank holiday, it was 01.00am when Anushka woke up experiencing abdominal pain and some dark blood loss. She pressed her cell bell; however, it was an especially busy night. The prison wing officer answered the bell after an hour and rang through to healthcare. An ambulance was called via the central control system, however, officers from another prison were needed to cover the staffing issues as 2 prison officers were required to accompany Anushka to hospital and remain with her for security reasons.

Enablement of emergency and routine care

Overnight, the cell doors in prison are locked, presenting physical barriers to getting help. Maternity staff are not often in prison overnight or on weekends. At the time of writing most, but not all, prisons have nursing staff within the primary care team available 24 hours a day, meaning some have no healthcare at night. PPO reports between 2021 and 2022 highlight cases where women's calls for help went unanswered, leading to tragic outcomes. There have been recent policy changes to try to mitigate this. The prison service now has pregnancy mother and baby liaison officers (PMBLOs) in place to ensure timely identification, contact and signposting to support services. Their role was universally well received at the prisons that we visited in preparation for this report. However, their role is operational, not healthcare. HMPPS also have policy, guidance and training for all prison staff on the signs of labour and unexpected delivery. As outlined in policy³⁶, all prisons provide 24-hour access to telephones within the cells of pregnant women which allow direct calls to the local NHS maternity triage. All pregnant women are considered for regular welfare checks by operational staff through the day on an individual basis. In our engagement for this report, we observed positive practice where pregnant women had the choice to be co-located together in a 'pregnancy wing' with other low risk women to help facilitate timely response and personal emergency alarms were placed in each cell.

Operational changes have improved facilitation of external hospital appointments, although some challenges remain. Previously research identified that more women in prison miss obstetrics and midwifery appointments compared to women in the general population (31.5% and 21.5% compared to 16.8% and 16.0% respectively)³⁷. Engagement for this report identified that the changes made to the perinatal pathway were improving this process. Often women are accompanied by specialised midwives allowing prison officers to wait outside, providing better environments for sensitive care. Although women still described challenges in the experience of attending hospital with prison officers, timeliness of transport, and on rare occasions, inappropriate use of restraints³⁸. Policy from MoJ and HMPPS stipulates that restraints must not be used for pregnant and postnatal women when attending medical appointments unless there is a clear justification for doing so³⁹.

Pregnancies that do not end in live birth

There are potential inequalities and variation in processes for abortion care, miscarriage and stillbirth management compared to the community. Navigating decisions and experiences of pregnancies that do not end in live birth, or deciding to end a pregnancy in prison is very challenging and highly sensitive. Women may want to consider multiple factors (for example, sentencing and care arrangements and health). There is variation in practice and experience. In England, abortion services are commissioned by NHS integrated care boards and the majority are provided by independent specialist providers. In the community, women may be offered a medical abortion at home for low-risk early pregnancies, rather than surgical management in hospital. An unpublished audit of 11 of the 12 female estates in England in June 2023 identified that some prisons required referral to the GP or midwifery first, which added to the abortion wait time. Not all women's prisons had a policy in place regarding facilitating medical abortions in the prison and healthcare teams expressed concern about the safety of this provision. There is a need for local healthcare policy that tailors National Institute for Health and Care Excellence (NICE) guidance and NICE Quality Standards on termination of pregnancy to provide a clear pathway in the prison setting. This needs to ensure delays are avoided, appropriate, safe, choice is offered and support is provided for women to make this informed choice.

In the community women can self-refer to an early pregnancy unit if they experience symptoms such as pain or bleeding. Some prisons were able to efficiently organise early pregnancy care or facilitate self-referral. In this case choices could be equivalent to the community, for example to have an early miscarriage in the prison (normally up to 12 weeks). Others had to access care through A&E, which may increase the risk of stigma at an already sensitive time.

Policies for women experiencing pregnancy loss, including stillbirth, are clear but the level and type of support in practice varies. Both the 2023 audit and our engagement identified positive practice where women were facilitated to create memory boxes that were safe for women to keep in their room. In 2021 HMPPS published internal operational guidance for staff in prisons on how to support women who experience pregnancy loss. Support following miscarriage, termination or stillbirth is provided in a variety of ways, including through community bereavement services, specialised perinatal mental health in prison, access to telephone support from abortion providers or third sector, or informally from family, friends and prison officers. However, options and level of support were not consistent across estates and did not always meet women's needs. The lived experience panel below describes the critical need for consistency in this challenging situation. Women who have a pregnancy loss in the recent period prior to entering custody are also likely to have ongoing bereavement needs which should be recognised⁴⁰.

Lived experience: experiences of pregnancies that do not end in live birth in prison

This engagement was undertaken by Empowering People: Inspiring Change (EP:IC) consultants.

Women who had experienced miscarriage, termination or stillbirth in prison described the considerable physical and practical challenges, and emotional turmoil that arose.

“If you haven’t got a shower in your room, being offered a shower when the other girls are locked up would be nice, just so you don’t have to answer any questions. It’s bad enough when you’ve got your period.”

“It was too much to handle. All my sadness went to rage and I kicked out at everyone. Attacked officers, other women. I got added days to my sentence because of it. I was acting out on the emotional pain of this double loss being a mother in prison.”

Women wanted to be:

- acknowledged as pregnant women and for their needs to be considered
- informed of their choices, the support options available, the processes, physical and mental health checks and adjustments to prison regime they can expect. This may involve repeated discussions with health care providers to understand options and make complex decisions
- supported. Women valued choice in where they sought support, including from formalised peer networks or external providers

“I didn’t know when the termination was. They couldn’t tell me and then suddenly the day you’re going out you can’t process it. You know the appointment is coming up, but you don’t feel like you can prepare for it.”

“The prison midwife spoke to me and told me there were 2 ways have termination. Operation or tablets. She gave me leaflets with lots of information on. It was actually too much information on them especially the paperwork that comes with meds. I needed it explaining.”

“I was given extra support officers were knocking on did check on me. I appreciated it I appreciate the chat. On the week of the termination, they gave me the week off.”

Birth, the postnatal period and separation

Case study: the postnatal period in prison

Gemma returned to prison 6 days after undergoing a caesarean section. She was placed in the general population and separated from her baby. Her cellmate noticed a foul odour, likely coming from Gemma's wound. Gemma had been unable to shower or properly care for the incision. It was Sunday, and no maternity staff were available. Gemma was experiencing bleeding, difficulty urinating, and increasing pain. She appeared withdrawn and unwell, but staff assumed her behaviour was due to the emotional impact of being separated from her baby.

Post-birth physical health

Post-birth complications such as infections, secondary haemorrhage and hypertensive disorders are at risk of being overlooked, particularly following separation from their newborns, as women can be quickly reintegrated into the general prison population. Women may give birth in hospital before returning to prison after separation from their baby, or to a mother and baby unit with their baby. Women may also be received in prison after giving birth in the community. There is currently a lack of data or research evidence specifically addressing post-birth complications and needs in prison settings. Our engagement for this report identified that support and services postnatally for women varied, especially when separated from their babies with some women experiencing challenges accessing GPs or adequate support and information.

Post-birth mental health

Women separated from their babies in prison are more likely to have complex mental health problems and are at higher risk of self-harm, suicide, substance misuse, reoffending and further trauma, compared to women who live in prison with their child^{41 42 43 44 45}. Separation may occur in many forms, for example as a result of formal care proceedings (the council will have parental responsibility for the child and determines where they live) or care may be provided by partners and other family members. Qualitative research has revealed that the pain of separation is visceral and intensely physical and traumatic, followed by acute but persisting grief⁴⁶. A comprehensive independent review in 2024 identified that after separation there was a significant reduction in professional support to mothers. A survey undertaken in 2023 as part of the NHS England perinatal workstream involving 11 of the 12 women's prisons identified that while healthcare professionals and operational staff rated their understanding of care proceedings highly, the majority would like further training and support to communicate with women about proceedings⁴⁷. The case of Michelle Barnes, who died by suicide in prison in 2016 after being denied the ability to express breast milk and following the removal of her child, underscores the potential severe consequences of these systemic failings⁴⁸. The survey and our engagement for this report identified that several prisons have implemented multiagency perinatal pathways to support these women. Good practice examples had clear pathways for

ongoing joint support from specialised operational staff and perinatal mental health services, adapted regimes to meet the needs of women and processes for increased observations and external partnerships for independent support. The survey identified that:

- few prisons have dedicated perinatal mental health pathways post separation
- there was no clear pathway for postnatal family planning
- there was a varying local offer of support for the trauma that professionals may experience

Practice example: support for individuals separated from children

In response to the national women's health and social care review, a number of regions have developed more tailored support for individuals separated from children:

- South West region has developed improved accessible information resources
- South East region has developed a 'loss, separation and bereavement subgroup' to deliver work in this area
- London and the South East region have commissioned Birth Companions to deliver practical and emotional support to women on probation
- North East region are piloting parental separation counselling services

Babies' health

Risk during the postnatal period can include the baby. The limited evidence available suggests maternal separation for imprisonment may damage attachment and increase the likelihood of poor developmental outcomes for children⁴⁹. The number of women separated from older children by imprisonment are described in chapter 4. For babies that remain with their mothers on a MBU it is important that they receive equivalent care and support to babies in the community. This includes routine care such as immunisations and developmental reviews, formal and informal support as required from a variety of sources such as on infant feeding and urgent and unplanned care, if a baby is unwell.

Mother and baby unit applications

A mother's decision to apply to an MBU and experiences of placements may be very complex⁵⁰. A review by the chief social worker in 2022 identified concerns in 1 in 3 refused applications, including inconsistency in the application process and social worker input into applications. HMPPS continues to work to implement recommendations from this report, including publicly appointing 7 independent MBU chairs in October 2024. In 2019, Lord Farmer's report on strengthening female offenders' family relationships emphasised the need for social workers to be embedded in every women's prison⁵¹. Local pilots of prison-based social workers have since demonstrated that the approach improves mothers' ability to engage in social care proceedings and supports contact with their children⁵². The early evaluations from these pilots in 4 prisons

(HMP/YOI Bronzefield, HMP/YOI Downview, HMP/YOI Eastwood Park and HMP Send) are promising and demonstrate that they are having an impact on mothers having appropriate contact with children. Our engagement for this report identified ongoing challenges in facilitating timely, accurate assessments for MBU applications from local authority children's services, despite this being included in the updated Working Together to Safeguard Children 2023 statutory guidance⁵³. There is often ambiguity about which local authority holds responsibility, with conflicting guidance regarding which service is responsible. Supporting women through the complex process is vital. Together this supports the need to embed social workers in all women's prisons, as recommended by Lord Farmer.

Continuity of clinical care

Reception into prison

Reception into prison is a time of additional risk. Maternity records are often held on phone applications by the woman, which would not be accessible in custody. Electronic health records held by community maternity teams are not available on reception to prison, until a new record is created by maternity staff when they have their pregnancy booking appointment. The national templates that are used to identify health and care needs in custody are not specific to pregnancy, and maternity staff are not always available to assess at the time of arrival. Electronic maternity records are held by the local NHS trust and do not interface with the prison primary care health record, or operational prison or probation data systems. Although pregnancies in prison are deemed high-risk, there is ambiguity about the extent to which clinical and prison information about an individual should be shared and the need to balance this with confidentiality.

Leaving prison

Transitions back into the community from prison are also a high-risk time. Engagement for this report identified that continuity of maternity care can be challenging. Handover of care from the maternity team local to the prison to another maternity team in the area where the woman will move may not be accepted, as women are required to self-refer their pregnancy, despite the high-risk nature of the pregnancy. Research shows that transition to the community is also a high-risk time for deteriorations in perinatal mental health and there can be challenges ensuring continuity of perinatal mental health care. Disruptions in treatment and support can impact health outcomes⁵⁴. Research undertaken by voluntary sector organisations, Birth Companions and Clinks identified that advocacy, navigator and 'through the gate' roles were beneficial in supporting pregnant women on release from prison. These services were often provided by different voluntary sector professionals⁵⁵. Maternity and probation services can work together to plan and provide support to ensure continuity of care and support to access services, currently this is dependent on individual relationships. There is an opportunity to support this with guidance and policy.

Women on probation

The significant recent policy and practice changes for pregnant and postnatal women in prison, have not yet extended to the needs and circumstances of pregnant women on community sentences or under probation supervision after release from prison. There is lack of evidence regarding physical and mental health needs of perinatal women in probation services in the UK. Research undertaken by voluntary sector organisations Birth Companions and Clinks identified that 79% of midwives felt that involvement in the community criminal justice system had a significant impact on women's antenatal and postnatal care needs, partly due to the extra concerns and stresses they experienced⁵⁶. Therefore, there is a need for clear pathways for integrated care.

Lived experience: midwives and women with lived experience of probation reflect on health needs

Quotes are taken from published research undertaken by Birth Companions and Clinks.⁵⁷ Midwives reflected on the experiences of pregnant women on release from prison:

"Women may delay booking with a maternity unit once released from prison. They feel that midwives may judge them. They are not trusting of professionals. This means they can miss out on opportunities for scans, screening tests etc."

"They often have many appointments to attend which can be very difficult when [their] mental health is not good, feeling threatened by social care and not sure if they will be able to keep their baby. Social care often requires regular engagement with everyone in order to get a positive assessment (psychologists, substance misuse, midwives etc.). This is challenging for them."

Women reflected on the need for probation services to recognise and responsiveness to pregnancy and new mothers:

"When I told her [my probation officer] I was pregnant, she said 'well how do you feel about it?', and I said 'I really don't know', and then no more was really said. I don't feel she really gave me any support... Just a tick box of hello, how are you, see you next week kind of thing."

"They [probation] almost see these women as a kind of leprosy; they are fearful of being asked the question 'am I going to lose my child?'"

"I don't know if I am lucky or unlucky that I have finished probation, so that I haven't got a probation officer. I am not going to lie; my probation officer was lovely. She did bend over backwards to help me. She could see that I was not like a criminal. There were reasons behind what happened."

Summary

Each year there are a relatively small number of women in prison in England that are pregnant, give birth, or recently postnatal. All women experience considerable change during this time, women in prison may be more likely to have additional circumstances that increase their risk during pregnancy, for example childhood trauma and domestic abuse. The prison environment can confer additional risk and impact on experience. This chapter reviews this evidence of risk, in light of recent improvements and developments in care. We identify that times of particular challenge are pregnant and postnatal women arriving and leaving prison, women that experience pregnancies that do not end in live birth and the postnatal period. Being on probation during pregnancy and the recent postnatal period may also significantly impact care needs.

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3 Children and young people in custody or at risk of custody

Authors: Emily Nicol, Professor Nick Hindley, Dr Lucy Thomas, Dr Nicola Vousden

Contributors: Dani Plowman, Caroline Twitchett, Nichola Adcock

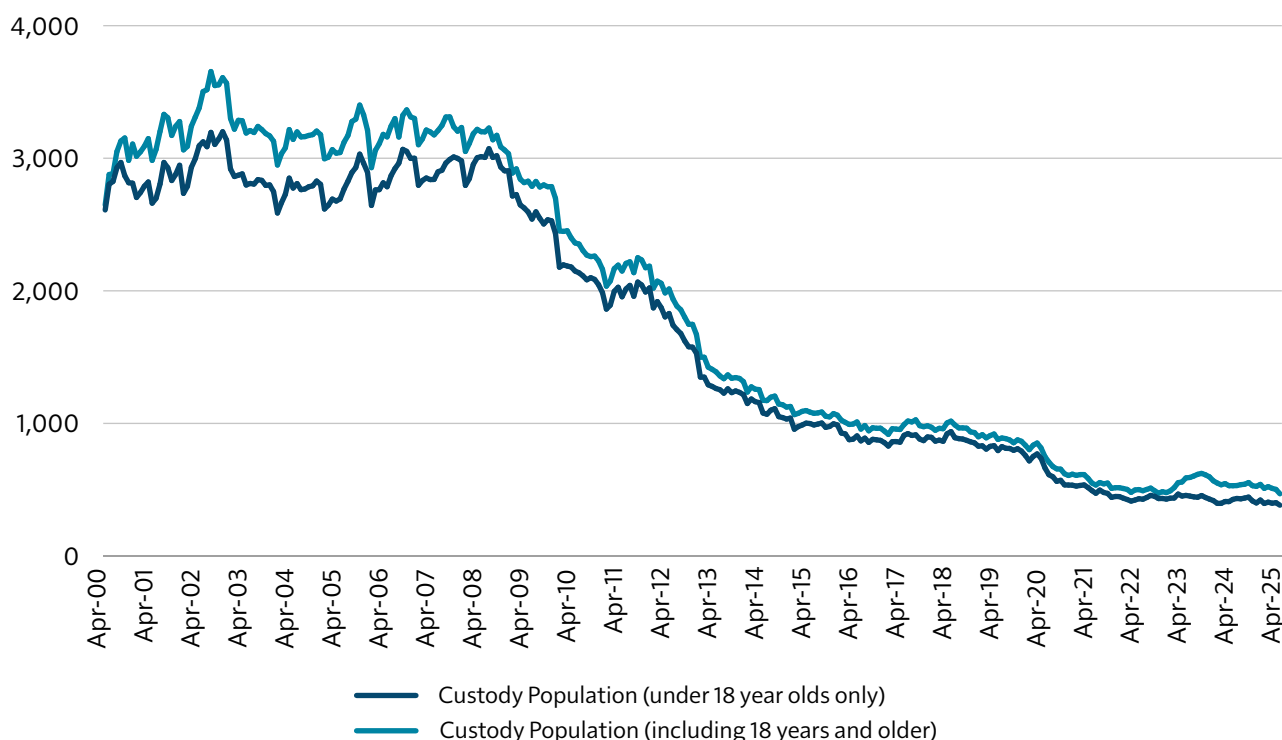
Introduction

Children and young people placed in custody in England often have some of the highest levels of need, adversity, and health and social inequalities in society. Children detained under welfare or mental health grounds in secure settings often have parallel high levels of need. It is widely understood that there are a group of children in the community with similar high levels of health and other social, family and educational needs, that are involved in high risk and/or offending behaviours. From the limited available evidence, physical long-term conditions do not appear to be more prevalent in children and young people in the secure estate compared to the community, with the exception of epilepsy. However, mental health needs, neurodiversity and speech and language needs are more common and therefore have a greater focus in this chapter.

The children and young people secure estate is the collective term for 4 types of locked residential settings where under 18-year-olds can be held. The English secure estate currently consists of 3 young offender institutions (under 18s), one secure training centre, 13 secure children's homes (SCH), and one secure school. The youth justice secure estate at full capacity^a could accommodate 821 children. In April 2025 383 children aged under 18 were accommodated^{b1}. This figure is substantially reduced from an estate that held approximately 3,000 children in 2009 as shown in figure 1². This means there is a smaller cohort of more vulnerable children with complex needs.

^a Oasis Restore Secure School is closed as of September 2025. It will be able to accommodate 49 children once fully open. This figure incorporates the full 49 beds.

^b Exclusive of Oasis Restore secure school which has been in ramp up since opening in August 2024

Figure 1: population of the children and young people in custody from 2000 to 2025^c


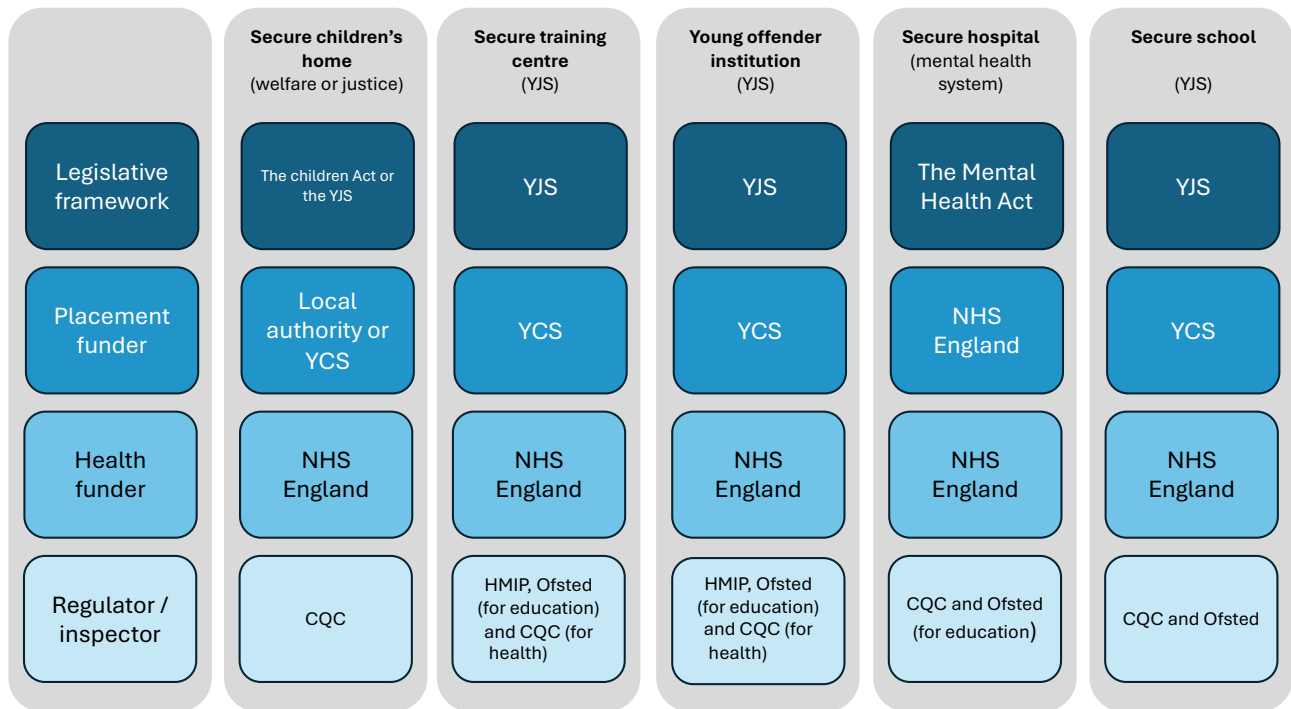
Source: HM Prison and probation service and youth custody data, Youth custody report: April 2025³

Children and young people can be remanded or sentenced to the secure estate by the courts and then placed by the Youth Custody Service, or held under the Children Act 1989⁴ for their own protection or for the safety of others, with separate commissioning and governance structures described in the appendix and summarised in figure 2. This division of the estate results in a government policy focus on ‘young offenders’ and separately on children in need of secure accommodation for their own welfare. A third group, which overlaps with both these cohorts consists of children referred to secure mental health hospitals. In reality, these 3 groups of children and young people form part of a wider group of children and young people frequently having parallel ‘complex needs’^d (figure 3). A recent review commissioned by the Department for Education (DfE), examined mixed placements in SCHs for children in justice and welfare systems and found that ‘they are fundamentally the same children... with some children having repeat admissions on different pathways’⁵.

^c Includes children held for justice reasons, not welfare, includes Wales. Includes Hillside, Parc YOI and Oakhill STC.

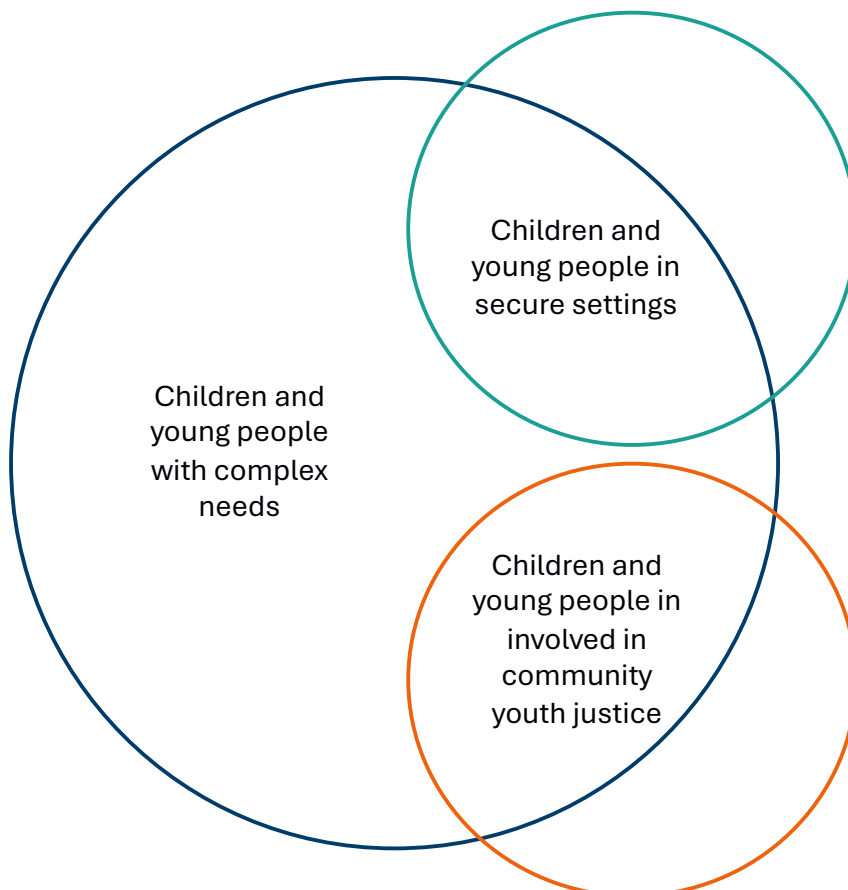
^d The term child/young person ‘with complex needs’ has been criticised as it places problems that are to do with systems and makes them part of a child’s problems alongside their individual problems, but it is commonly used.

Figure 2: description of the children and young people secure estate and secure hospitals



YJS: Youth Justice Service, YCS: Youth Custody Service, CQC: Care Quality Commission, HMIP: HM Inspectorate of Prisons

Figure 3: schematic diagram (not to scale) to show the location of children with 'complex needs'



This chapter first describes the ‘complex needs’ of children and young people in the secure estate, or potentially at risk of contact with the secure estate on welfare, youth justice or mental health grounds. It describes the health needs of this group, the challenges and the evidence of what works in prevention of children and young people reaching a secure setting. Youth justice statistics included in this report are necessarily inclusive of Wales where this information cannot be separated and may also include children up to the age of 19, where they have temporarily remained in the estate prior to release or move to the adult estate.

‘Complex needs’ and trauma

‘Complex needs’ can be defined as those which are⁶:

- multiple and/or not just in one domain such as mental and physical health
- persistent and/or long-term rather than transient, including for example, learning disability, autism or both
- severe and/or not responding to standard ‘clinical’ interventions
- framed by family and social contexts such as early family disruption, loss, inequality and prevalence of adverse childhood experiences (ACEs)

Children and young people who fall within the ‘complex needs’ definition may present with some or most of the following:

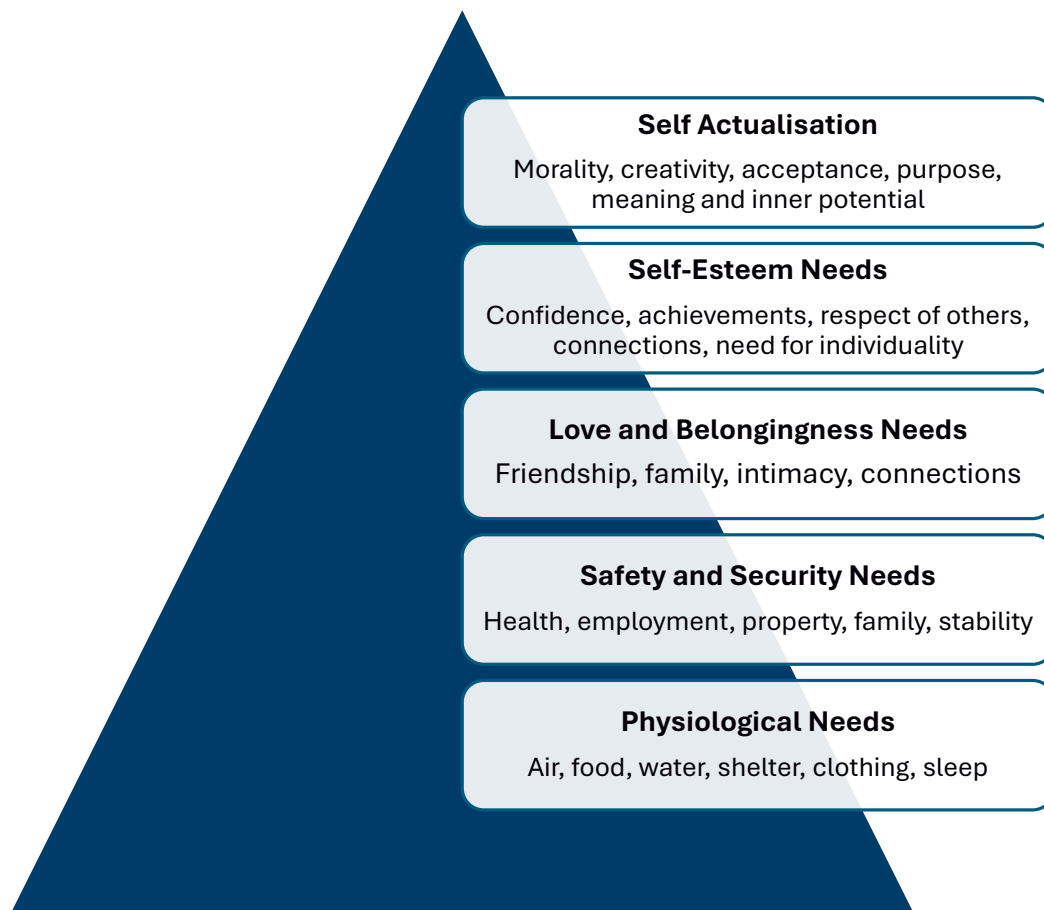
- more than one mental health, neurodevelopmental or emotional difficulty that could be diagnosed, frequently masked by overriding behavioural difficulties
- physical health problems which often have not been identified, or which may be the result of a child not receiving preventative healthcare (immunisations, dental care, sexual health and so on)
- high levels of childhood adversity and traumatic experience
- high rates of family difficulties including parental mental health or substance misuse, financial problems, offending behaviours, separation and conflict and frequent formal involvement with children’s social services
- educational disruption and special educational needs
- high-risk and/or offending behaviours which bring them into contact with the police and youth justice system
- lack of trust or a sense of hopelessness within the child or within the family network around them, resulting either from a lack of support, (failing to meet individual service ‘thresholds’) or involvement with multiple professionals who may have different priorities, opinions and plans to one another

The need for a multi-agency response to complex needs and the Framework for Integrated Care

The complex needs of this group of children means that they require input from multiple agencies including health, welfare, education, youth justice or others. Well-intentioned but uncoordinated responses by multiple professionals can cause children to lack trust and belief in those who are trying so hard to help them. Therefore, single agency responses are less likely to be effective. While these difficulties exist to some extent in all settings, whether institutional (hospitals, schools and residential), or community-focused (GPs, local authority services, voluntary and community sector), they are most evident among this particular group of children.

Maslow's hierarchy of needs (figure 4) links education, health and care and notably does not see the need for safety, security, continuity and trust as isolated to individual systems.

Figure 4: Maslow's hierarchy of needs



In response to this high level of need and the need for system change and a fully integrated approach among agencies, departments and commissioners the Framework for Integrated Care⁷ began to be developed in 2016. It is based on 6 important principles which aim to enable the right system, right culture, right workforce and right approach to delivery and intervention to make a meaningful difference to the lives of children and young people.

There are 3 versions of the framework:

- SECURE STAIRS which was the response to the framework in the existing children and young people secure estate
- the RESTORE Framework in the new secure school
- the Framework for Integrated Care (Community)

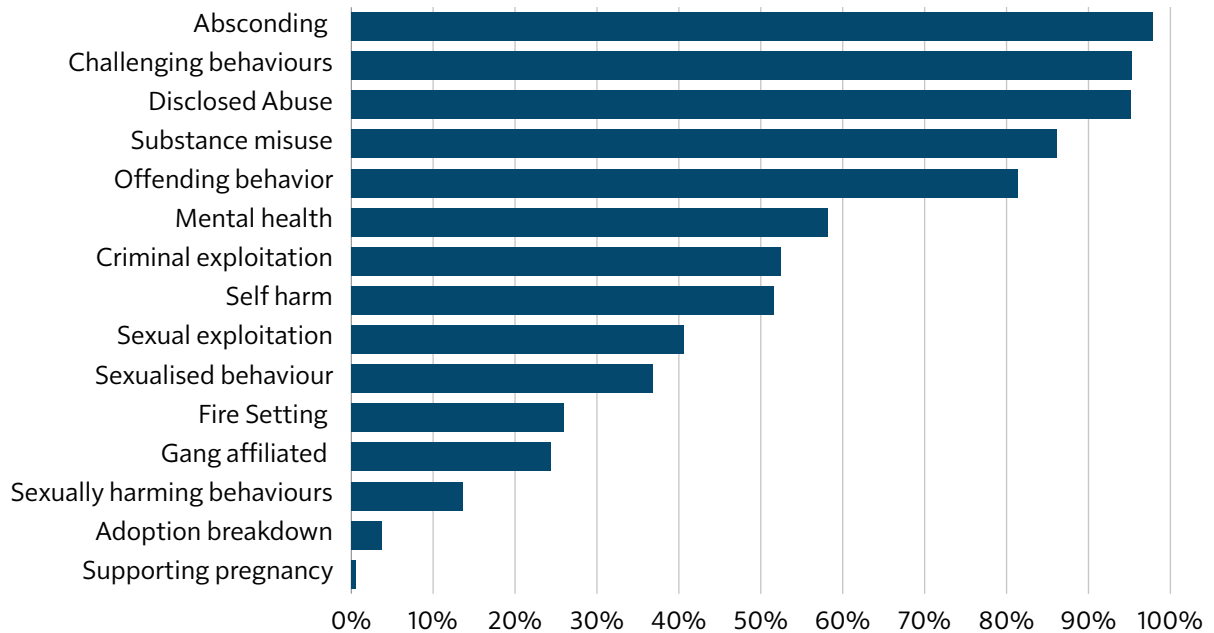
The community pathway targets vulnerable children and young people who may have experienced trauma or adversity and be at risk of encountering a secure setting either on welfare, youth justice or mental health grounds. The community pathway currently targets 19% of the possible cohort of children it could reach across 11 sites known as vanguards. The goals, principles and evaluation of this framework are explored later in this chapter.

Currently there is no single or integrated approach across government to programmes for vulnerable children and young people. Many different departments and agencies are attempting to intervene with different projects and programmes to reach these children and the staff who work with them. Health services are the one link between all types of secure settings within the children and young people secure estate as NHS England has direct commissioning responsibility for health services in all of them. However, a health delivered programme is often seen as health's responsibility alone. In tandem there is no shared narrative at a cross-government level for vulnerable children and young people, which risks siloed systems and a lack of shared understanding. Unless these needs are addressed, such children and young people are at significantly increased risk of negative social, physical and mental health trajectories across their life.

Estimating complex needs in this population

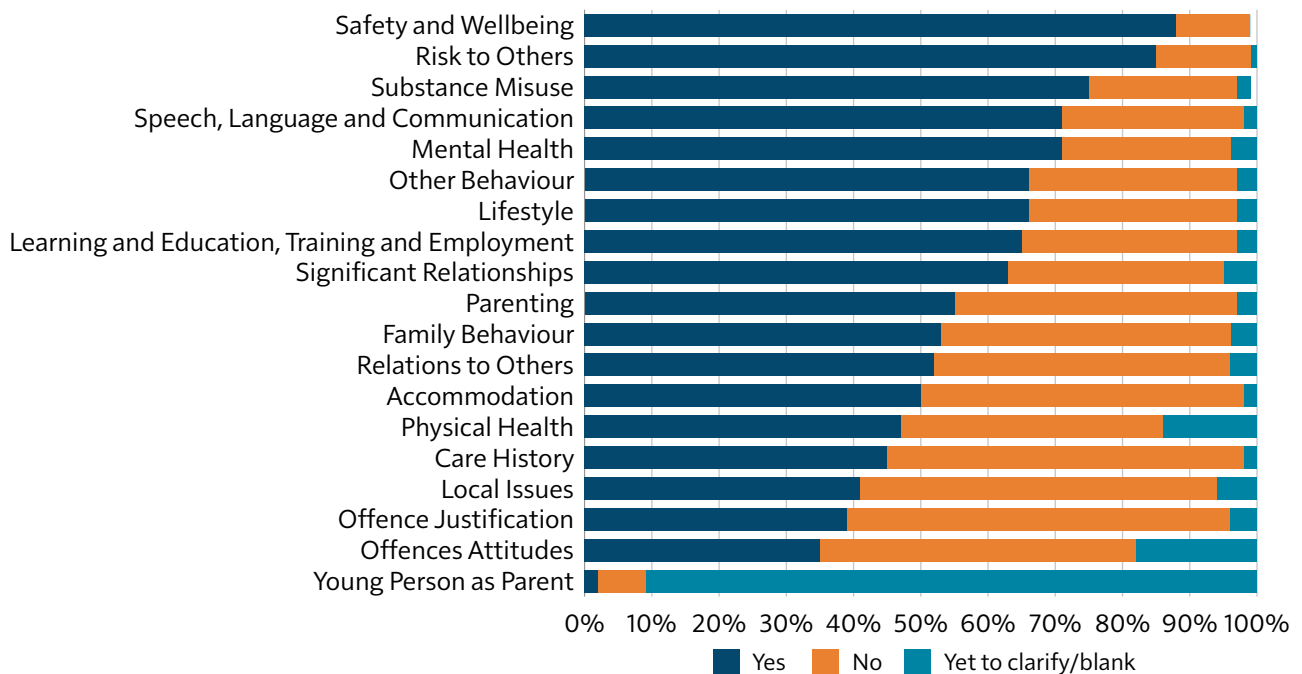
The complexity of the legislative framework, organisation responsible for funding placements and regulators in the children and young people secure estate means that it is challenging to estimate the complex needs of this group of children as a whole. However, figure 5, figure 6 and figure 7 below demonstrate the high proportion of children with multiple needs, irrespective of whether they are placed for welfare or justice reasons or are vulnerable children and young people in the community at risk of encountering a secure setting. Almost universally, children and young people in secure settings have experienced cyclical intergenerational trauma in the community⁸.

Figure 5: most children and young people placed in secure children’s homes for welfare reasons from 2020 to 2024 had multiple presenting needs



Source: Secure Welfare Coordination Unit on behalf of the Department for Education

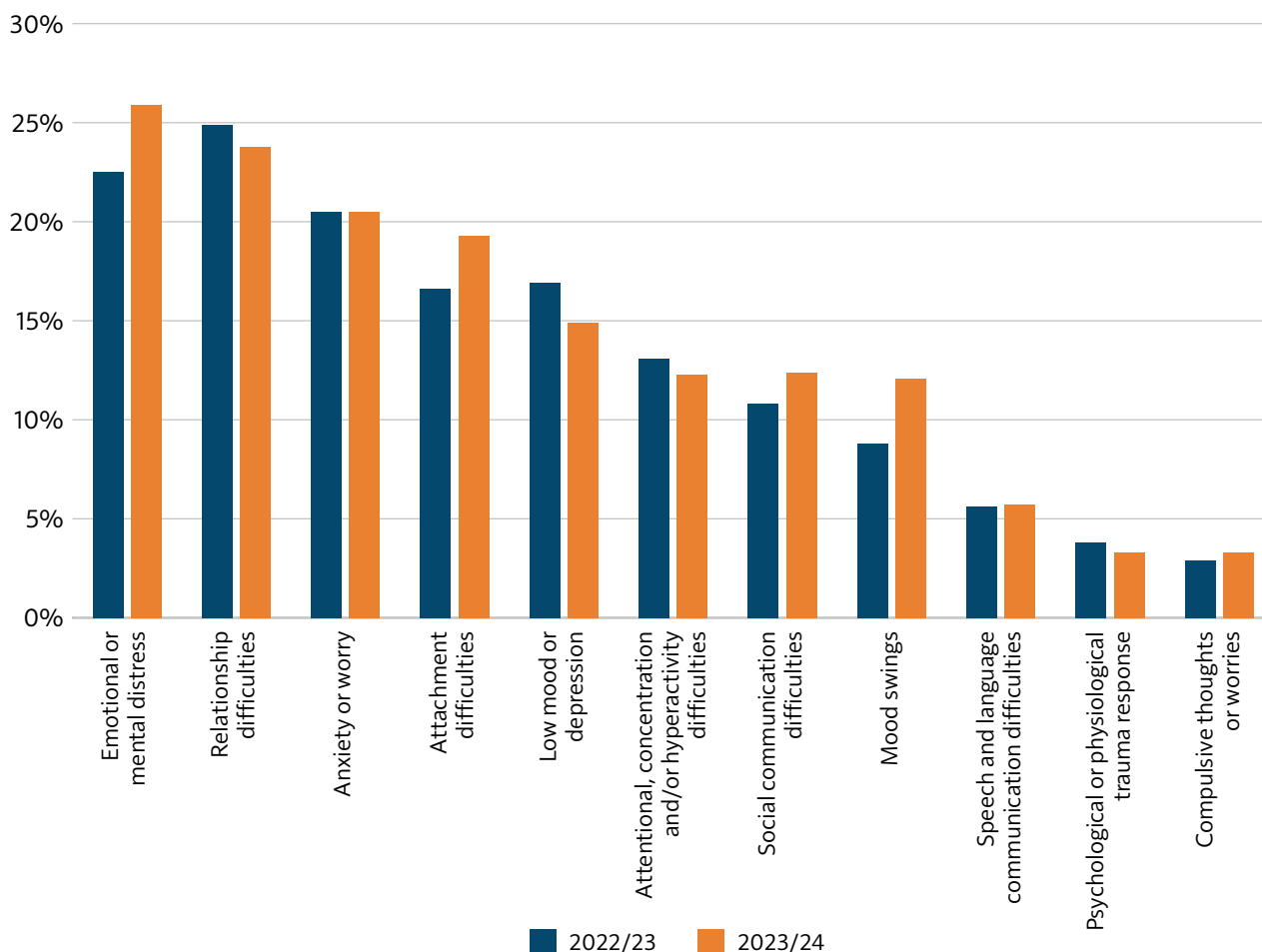
Figure 6: most children and young people assessed by youth offender teams (sentenced) in England and Wales in 2019 had most concern types



Source: Youth Justice Board/Ministry of Justice. Experimental Statistics Bulletin. 2020 Assessing the needs of sentenced children in the youth justice system 2018/19⁹

Approximately 1 in 4 children in the community that have been accepted onto community vanguard pathways have emotional or mental distress and relationship difficulties, as shown in figure 7. Children may be referred because they have experienced trauma or adversity and be at risk of encountering the youth justice system.

Figure 7: the needs of children and young people accepted onto community vanguard pathways in 2022 and 2023

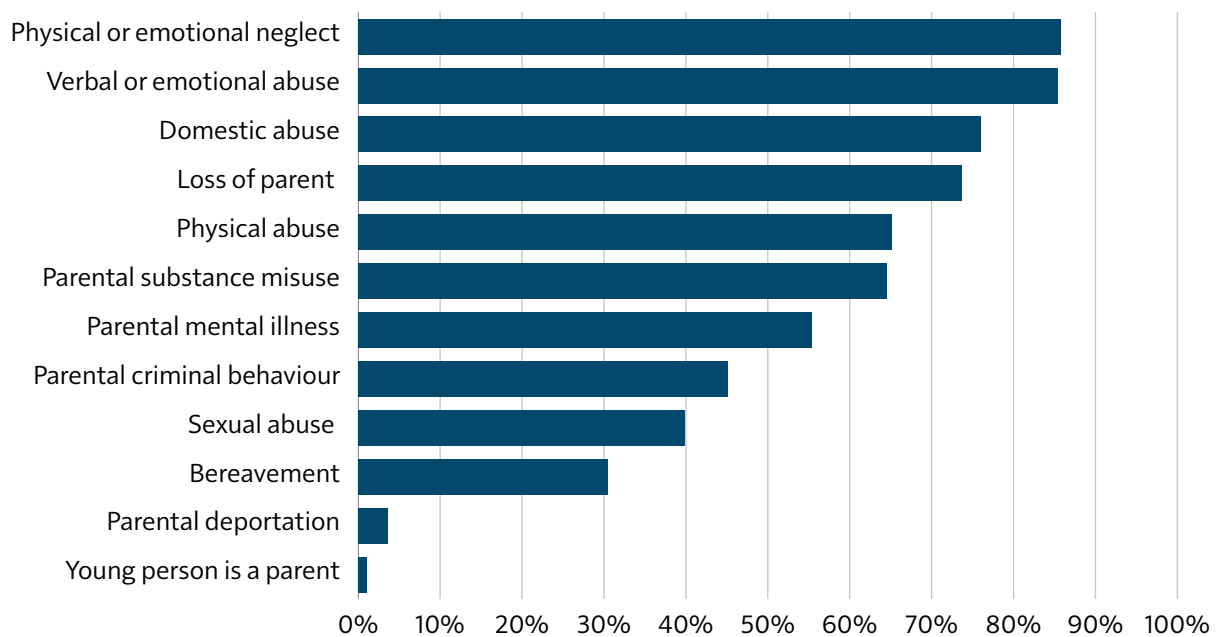


Source: NHS England

The large majority of the children and young people in this cohort have not had the opportunity to experience stability in their care, relationships and living accommodation and many may not be living with their family¹⁰. From 2020 to 2024, 95.3% of children and young people placed in the secure children's home for welfare reasons had been in care prior to placement¹¹. On census in 2016, 37% of children and young people in the youth justice service were looked after children¹². 10% of children and young people in care had 3 or more placements in one year¹³. Children and young people may move between friends and family members or be required to live transiently in residential or foster care, spend time in supported accommodation, residential schools, secure children's homes, secure training centres, secure schools, youth offender institutions, inpatient mental health settings, or unregistered community 'placements'¹⁴.

The majority of children and young people in contact with youth justice services have multiple ACEs. Of children placed in secure children's homes between 2021 and 2024 for welfare reasons 88.2% had 4 or more, and 50.9% had 7 or more ACEs; the reasons for ACEs are shown in figure 8¹⁵. Of 200 children working with youth justice workers in 2020 to 2021, 2 thirds (66%) had 5 or more ACEs and one fifth (22%) had 8 or more¹⁶. This is much higher than the general population; children in this cohort are 1.85 times as likely to have experienced more than one ACE and 13.08 times as likely to have experienced at least 4 ACEs compared to the general population¹⁷. ACEs have been linked to negative outcomes for adult behavioural, physical and mental health and criminal justice system contact^{18 19} with each additional exposure type increasing the likelihood of more extensive youth justice service contact^{20 21 22 23}. Boys that have experienced trauma are more likely to externalise it through violence, whereas girls' trauma may manifest through self-harm and substance misuse²⁴. This demonstrates the need for a gender-responsive approach to trauma informed care.

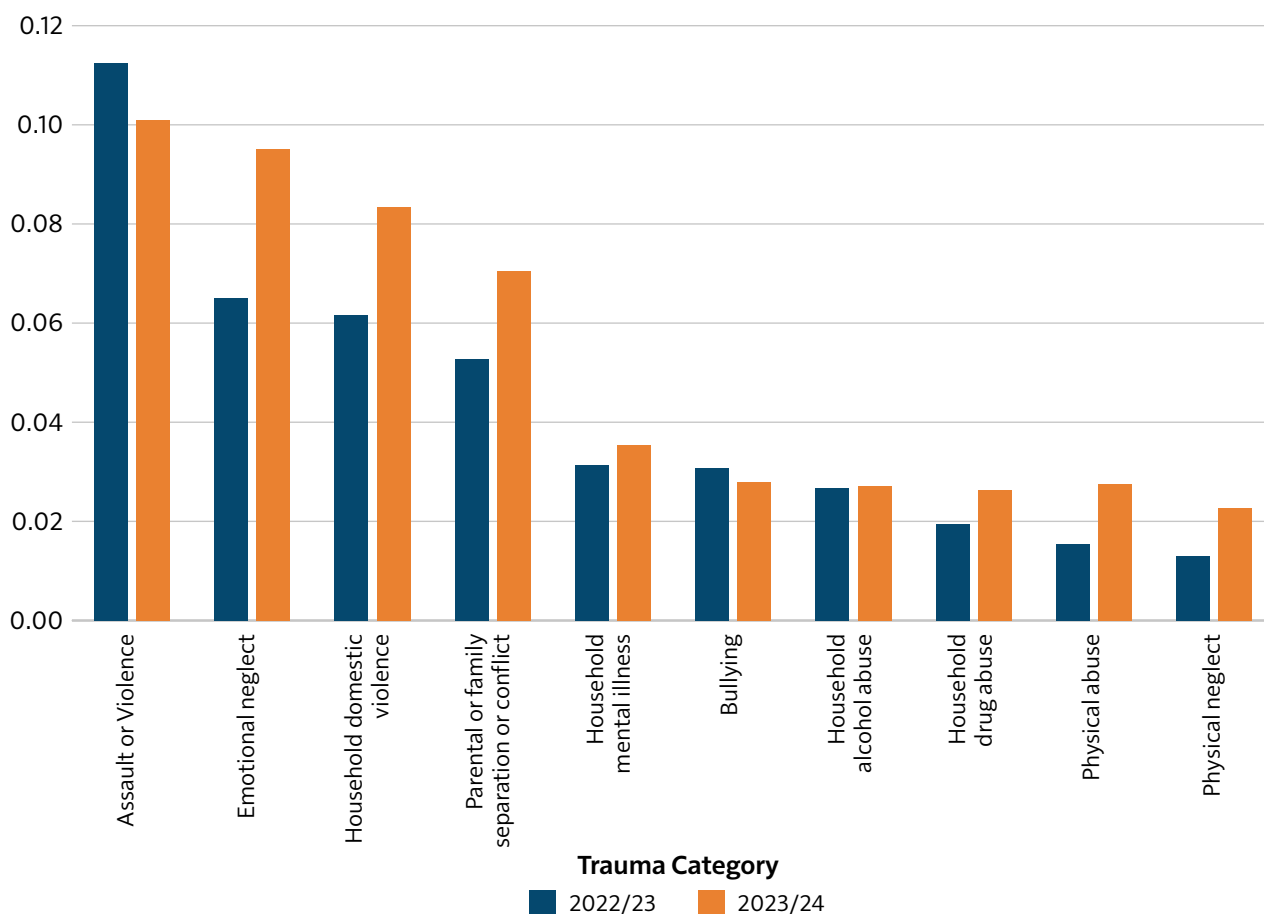
Figure 8: ACEs of children and young people placed for welfare reasons in England between 2021 and 2024



Source: Secure Welfare Coordination Unit on behalf of the Department for Education

Nearly 1 in 5 children and young people on community vanguard pathways also have multiple known traumas. Out of the overall total population accepted on a vanguard pathway, over 50% have been identified as having at least one trauma and 18% have multiple known traumas. Most commonly assault and emotional neglect as shown in figure 9.

Figure 9: proportion of the population accepted onto community vanguard pathways in 2022 to 2023 and 2023 to 2024 with trauma



Source: NHS England

Demographics

While this chapter addresses one fundamental cohort of children and young people with complex needs, there are important differences in demographics by service involvement which are described.

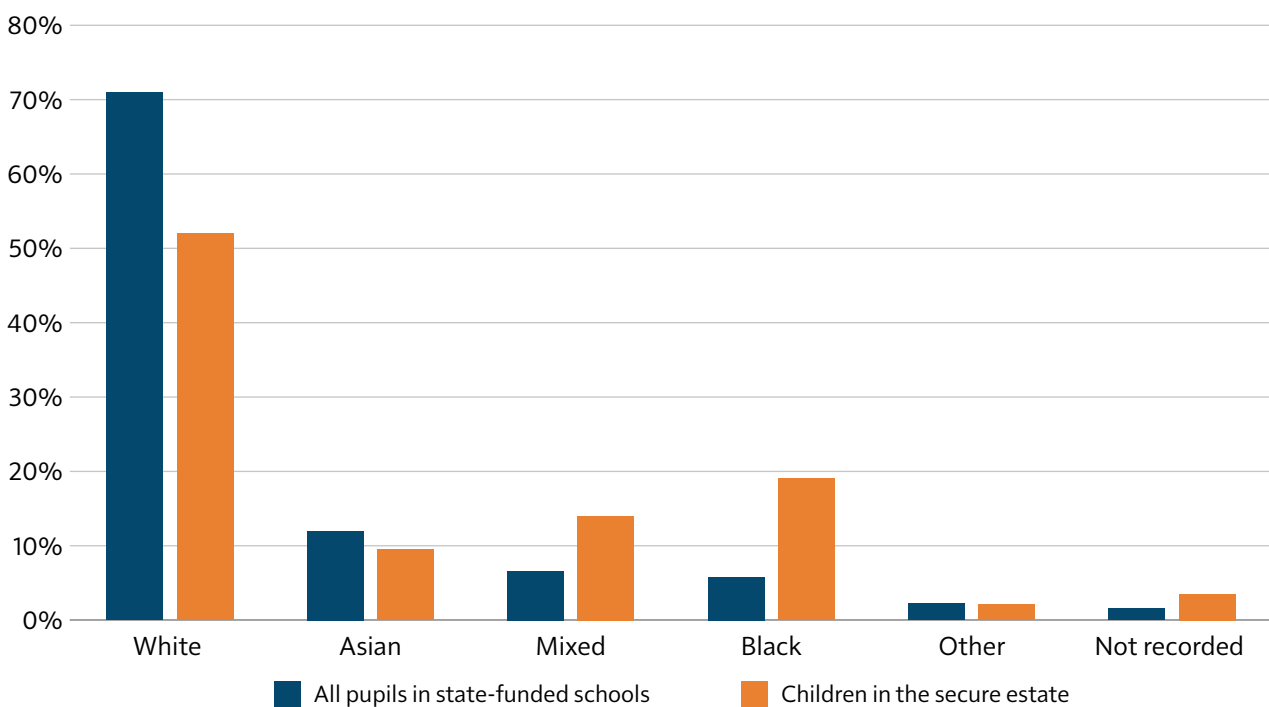
Age

Most children and young people placed for youth justice reasons in the children and young people secure estate are aged 16, 17 and 18 or older (22.9%, 44.3% and 21.6% respectively in 2024). A small proportion are aged 10 to 14 years (3.1% in 2024)²⁵ (published data covers both England and Wales and is not available separately)²⁶. Children and young people placed for welfare reasons in the children and young people secure estate tend to be younger than those placed for justice reasons, with the greatest proportion being aged 14 or younger (38.2%, 31.6% aged 15, 24.6% aged 16 and 5.5% aged 17 in 2024).

Ethnicity

While the majority of children in the children and young people secure estate are White, Black children and young people are overrepresented as shown in figure 10²⁷. This is driven by the proportion of Black children and young people on justice placements (24.0% on placement during 2024)²⁸, rather than welfare placements (13.1% new placements started in 2024). Over the last decade the total number of children placed in custody in these settings has fallen and has done so at different rates for children of different ethnicities. A recent review has explored the drivers of this disproportionality²⁹.

Figure 10: ethnicity of children in the secure estate at any time between 2017 and 2018 and 2021 to 2022 compared to the ethnicity of all pupils in 2021 to 2022



Source: De Souza, R. The educational journeys of children in secure settings. 2025³⁰

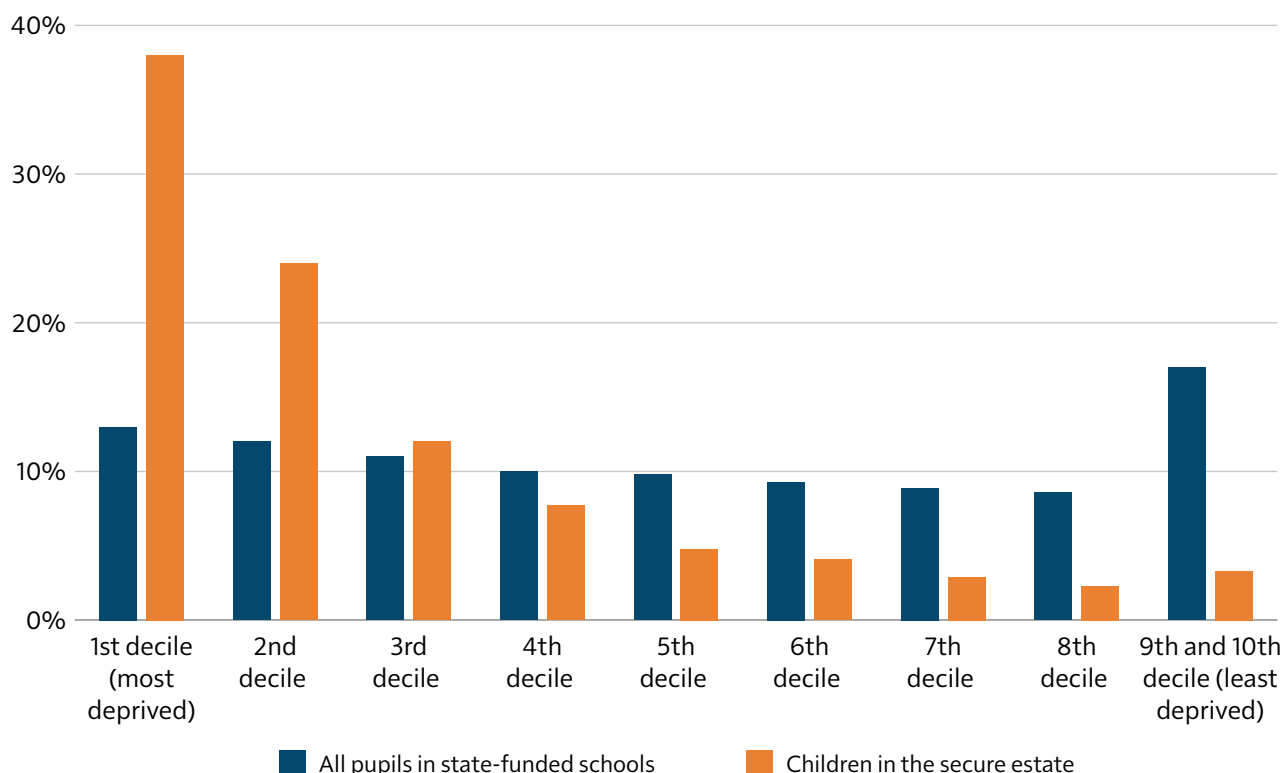
Sex

Boys are also overrepresented in justice placements. Girls currently represent approximately 2% of justice placements. This means that girls in secure settings are in a minority and in some cases may be the only girl in the setting. The proportion of girls and boys placed for welfare reasons were equal in 2024.

Deprivation

Nearly 4 in 10 children in secure settings were living in the most deprived neighbourhoods in England when they were most recently in a state-funded school. Nearly 9 in 10 grew up in areas with above average levels of child poverty³¹. Children and young people from the most deprived areas are twice as likely to have contact with the youth justice system than their peers in the least deprived areas, as shown in figure 11³².

Figure 11: income deprivation affecting children index (IDACI) of most recent home neighbourhood while in a state-funded school before moving into the secure estate, compared to all pupils in 2021 to 2022

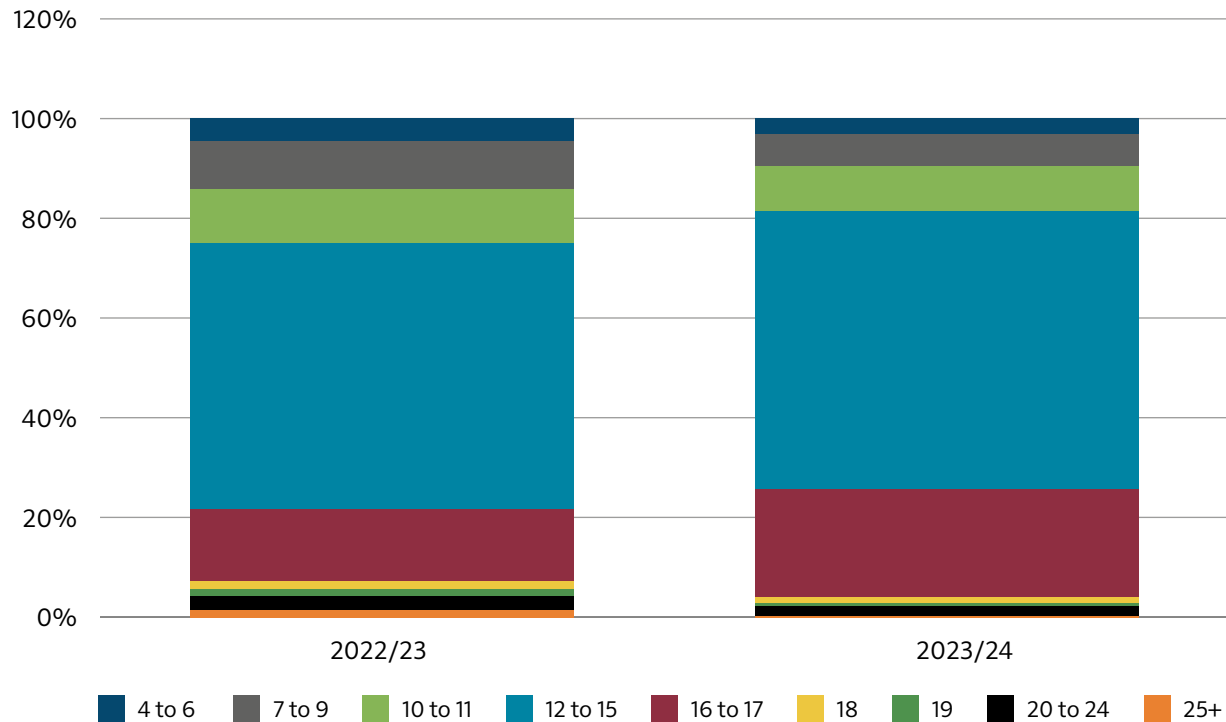


Source: De Souza, R. The educational journeys of children in secure settings 2025³³. The 9th and 10th deciles have been combined to protect the confidentiality of the small number of children from those backgrounds.

Children and young people at risk of encountering secure settings

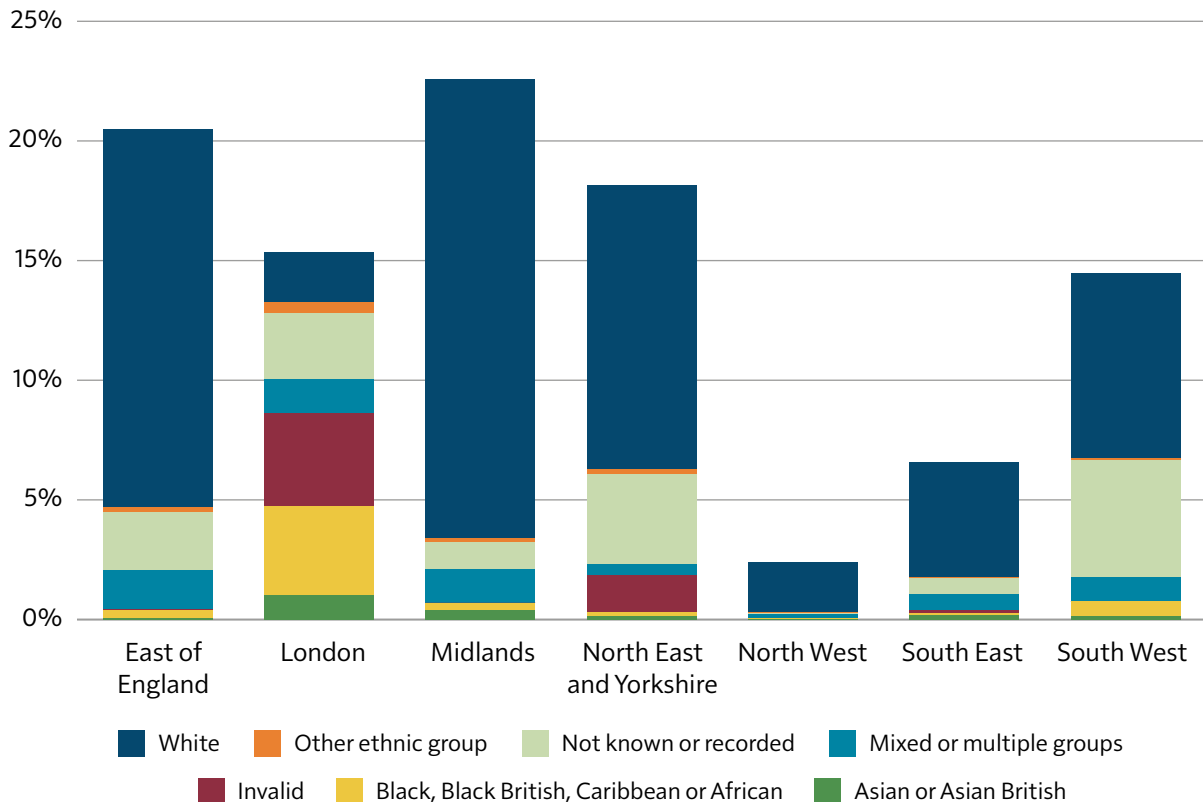
Community vanguard pathways have a choice of the age range that they accept. The greatest proportion of children overall are 12 to 15 years as shown in figure 12. The highest proportion of children and young people are White, however in London over 44% of their accepted population is Black, Black British, Caribbean or African as shown in figure 12.

Figure 12: age range of children and young people accepted onto vanguards in 2023 to 2024 and 2023 to 2024



Source: NHS England

Figure 13: ethnicity of children and young people accepted onto vanguards across regions from 2022 to 2024



Source: NHS England

Health needs and challenges meeting them

A recent review of the health of children and young people in secure environments³⁴ documents the extent of such needs and current efforts to address them within those settings. The data below are unpublished and collated from the Comprehensive Health Assessment Tool (CHAT) in 2024 (England only). This is an evidence based, validated health assessment tool for under 18s, screening for physical health, substance misuse, mental health and neurodiversity. All children in the children and young people secure estate receive screening on arrival to the secure setting, whether they are placed for welfare or justice reasons. Importantly, the CHAT screen asks about developmental needs that are identified, rather than conditions diagnosed by health care professionals.

Neurodiversity

A high proportion of children and young people in the secure estate are identified on admission to have attention deficit hyperactivity disorder (ADHD) and speech, language and communication developmental needs. Children and young people were identified to have the following developmental needs on admission:

- ADHD (35%) – this is significantly higher than diagnoses seen in the general population (4%). It has also increased slightly since 2022 to 2023 (32%), with increases in all young offender institutions
- speech language and communication (32%) – this is significantly higher than diagnoses in the general population (2%). It has remained equal to 2022 to 2023 statistics (32%)
- learning disability (5%) – this is comparable to diagnoses in the general population (6%)
- traumatic brain injury (1%)
- autism is lower than that of the general population, however there are questions around the reliability of this data; this requires further investigation

Of note, CHAT data indicates a substantially higher prevalence of ADHD in children and young people in secure settings than would be expected from epidemiological prevalence studies of detained young people from other countries (17%)³⁵. It is unclear whether this high rate represents an error in the data or a genuinely higher prevalence of ADHD among the detained population in England. If the prevalence of ADHD is genuinely higher in England than other countries, further investigation is needed to understand why, for example due to accessibility of community ADHD services.

Investigation with regional NHS England commissioners has identified that there is varied provision for new ADHD diagnostic assessments across sites in the children and young people secure estate. Not all sites have explicitly commissioned ADHD diagnostic pathways and waiting times vary and can be long. Some sites reported a lack of support and advice after diagnosis is made and suggested that additional consultation and advice provision would be helpful.

Mental health

A very high proportion of children and young people were recorded as receiving mental health medication on admission to the children and young people secure estate at 86% in 2022 to 2023 and 83% in 2023 to 2024. The proportion of boys on mental health medication on admission was slightly higher than girls across both years (both sexes being at over 80%). It should be noted that this includes medication for conditions such as ADHD and it was not possible to disaggregate this data.

Two-thirds (61%) of the population in young offender institutions and 87% of those in secure children's homes in 2023 to 2024 were referred to a specialist mental health service. The vast majority of these referrals were accepted (93% and 100% respectively). This suggests that the proportion with mental health and psychological needs is higher than the general population, where 8% of children were referred to specialist services³⁶. Although, the proportion of children and young people assessed as having a depressed mood on admission (4% in 2022 to 2023 increasing to 5% in 2023 to 2024) is relatively low.

There are substantial differences in mental health needs by gender, as recently described in the reviews by Susannah Hancock³⁷ and by Lorraine Khan³⁸. Almost half (42%) of girls reported a previous suicide attempt, compared to 11% of boys. This is higher than the general population, where 10% of girls have attempted suicide by age 17 compared to 4% of boys³⁹. Girls were more likely to be identified with risk of self-harming on admission (70% for those on welfare placement and 55% on justice placements), significantly higher than those found among girls in the general population⁴⁰. Girls in secure settings frequently suffer post-traumatic stress disorder due to trauma (18.2% compared to 8.6% of boys)⁴¹. Academic evidence is clear that the primary factor impacting on girls' mental health in secure settings is complex trauma from abuse and victimisation⁴².

Data from both NHS England and Ministry of Justice suggest that incidents of self-harm are high. From April to June 2024 there were 560.9 incidents of self-harm per 100 children and young people, an increase of 61% compared to the previous year⁴³.

Speech, language and communication needs

Over 60% of children and young people in contact with the youth justice system and 71% of those sentenced, have speech, language and communication needs⁴⁴. However, only a small proportion (5%) had their needs identified before entering the youth justice system⁴⁵. Speech, language and communications do not impact just our ability to make ourselves understood but also to understand. Therefore, this impacts on many aspects of health including the accuracy of assessments and treatment programmes. There is some evidence that children and young people with developmental language disorder are more likely to reoffend than unaffected peers⁴⁶ and speech and language therapy with children and young people involved in the justice system improves communication skills^{47 48}. There are now more speech and language therapists working in young offender institutions, secure training centres and secure children's homes but our engagement identified varying levels of service capacity in different parts of the system. Estates reflected that even in the absence of a specific speech, language and

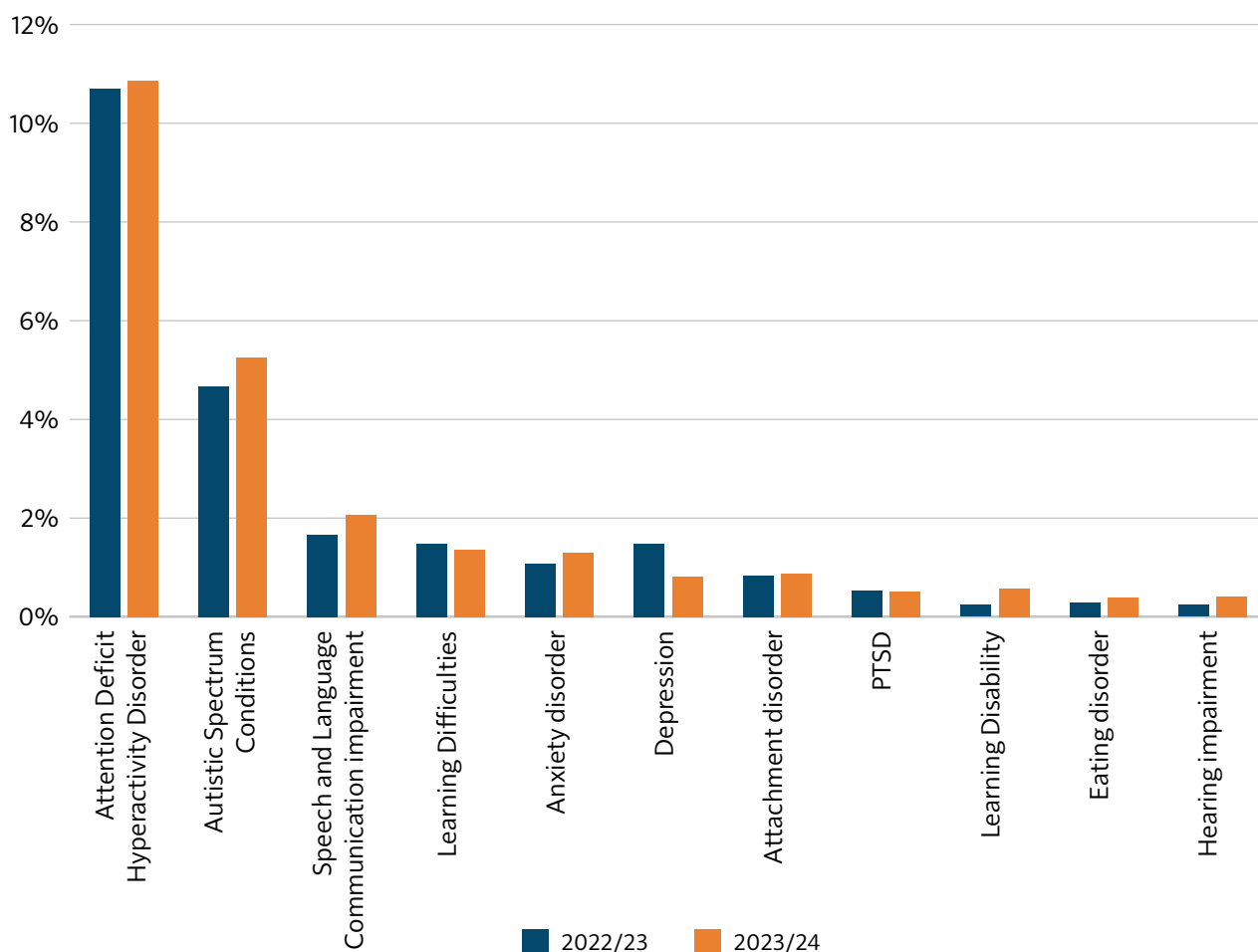
communication need, nearly all children would benefit from reasonable adjustments to remove or reduce disadvantage. A recent enquiry by the children's commissioner identified that⁴⁹:

- 77% of children in custody were persistently or severely absent from their most recent year at a state funded school
- 54% were out of education for at least one academic year before moving into a secure setting
- children and young people were 5 times more likely to have an Education Health and Care Plan compared to pupils in state-funded education

Neurodiversity, mental health, disabilities and speech and language therapy in the community at risk of offending

The proportion of children and young people accepted onto community vanguard with a diagnosed disability, mental health or neurodevelopmental condition is low (figure 14) as often an actual condition is not defined in the statistics received. The most common diagnosis is ADHD at 10.8%, however this is possibly an underestimate.

Figure 14: proportion of children and young people accepted onto a community vanguard with a diagnosed disability, mental health or neurodevelopmental condition

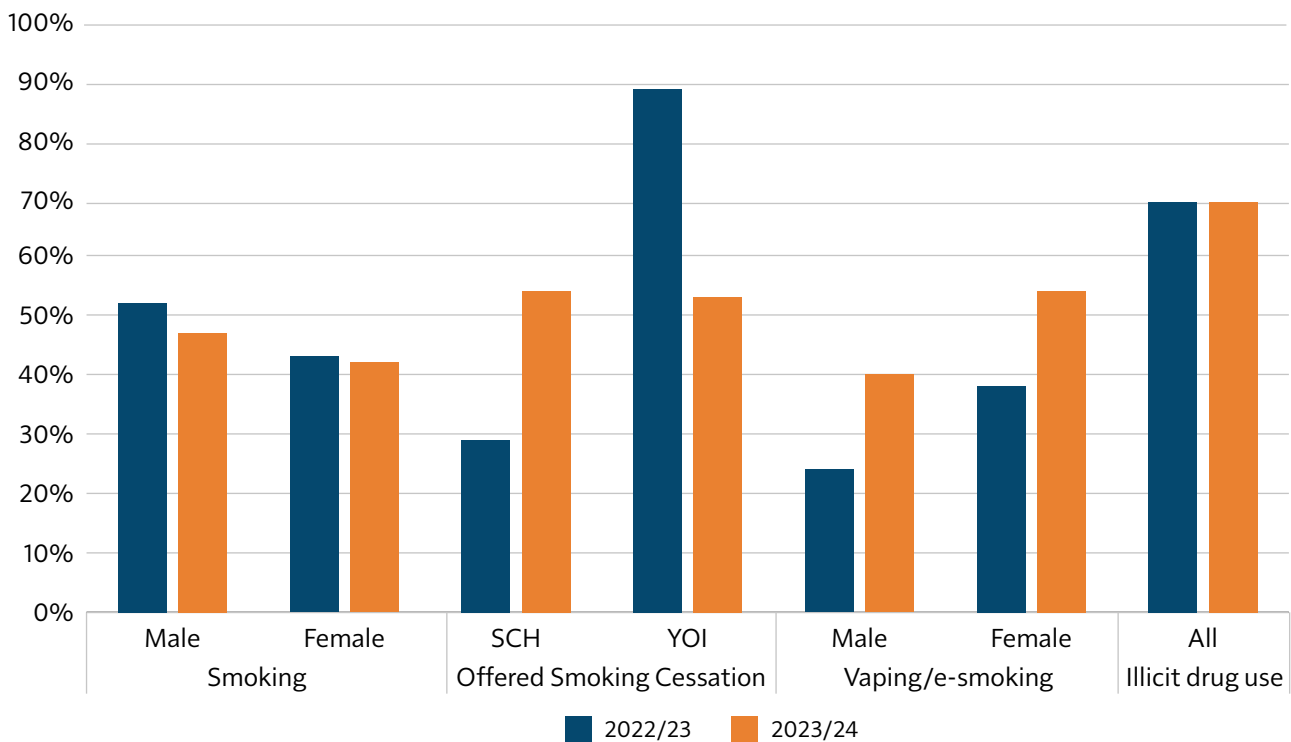


Source: NHS England

Health behaviours within the children and young people secure estate

The smoking rate among children and young people arriving in a secure setting is high (figure 15), compared to the proportion of current smokers (3%) and regular smokers (1%) in secondary school pupils in England⁵⁰.

Figure 15: proportion of children and young people smoking, vaping and using illicit drugs on admission to the children and young people secure estate



Source: NHS England

The proportion of children and young people recorded as current vapers on admission has increased substantially and is high compared to the proportion of secondary school pupils in England that frequently vape (9%)⁵¹.

Two-thirds of children and young people report recent drug use on admission to the children and young people secure estate (69% in 2022 to 2023 and 2023 to 2024).

Long-term conditions and other physical health needs

There is limited information around long-term conditions in the children and young people secure estate, but levels appear low. The CHAT physical health assessment data for 2023 to 2024 indicates that:

- a small proportion (1%) of the children and young people admitted to a secure setting in this period had confirmed or suspected diabetes. There is no information available regarding the type of diabetes
- 3% of children and young people admitted into the secure estate had confirmed or suspected epilepsy, compared to less than 1% in the general population⁵²

- 7% of children reported they were currently in pain on admission, increasing to 10% in girls

These proportions have remained similar across 2022 to 2023.

Communicable diseases

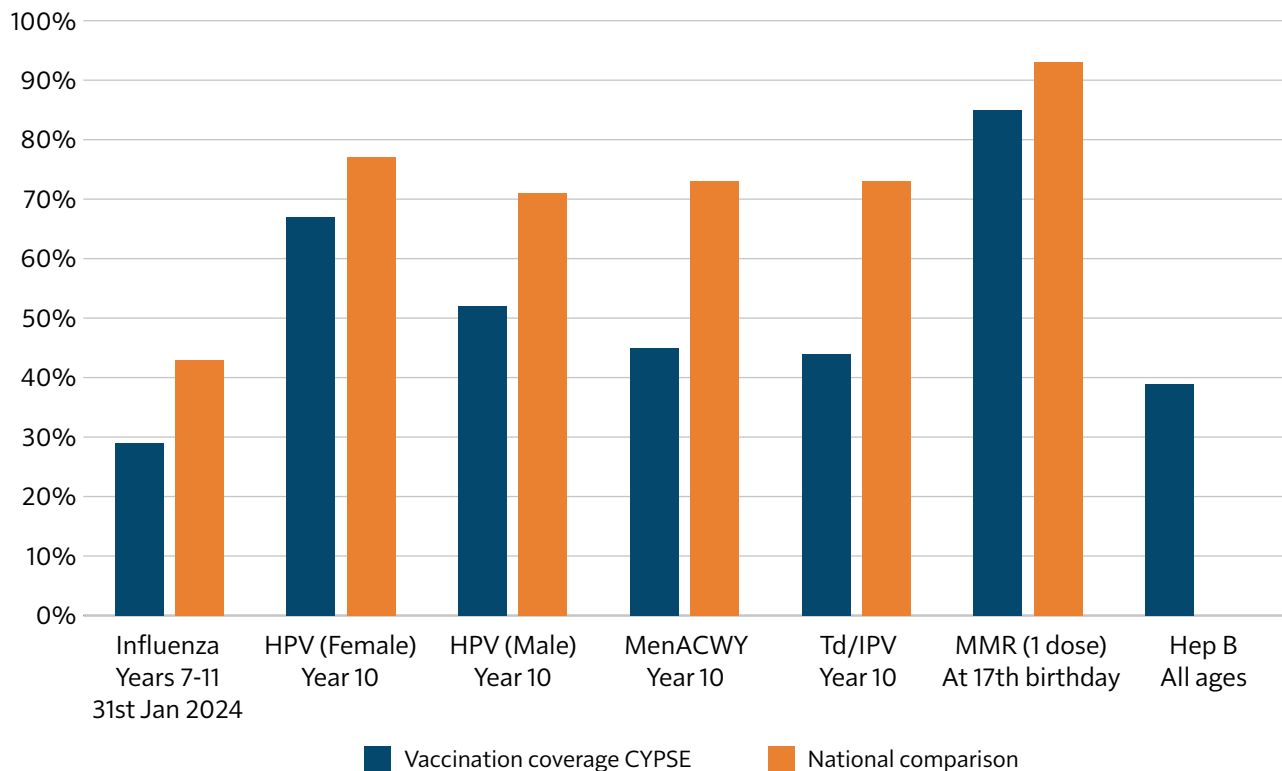
Immunisations

Children and young people in the children and young people secure estate should have access to all the vaccinations available to their peers in the community. Entry into the children and young people secure estate provides an opportunity to offer catch-up childhood vaccinations to those who are not already fully vaccinated and to offer the vaccines given in childhood. In addition, all residents in the children and young people secure estate are eligible to receive the Hepatitis B vaccine (Hep B).

In a recent audit of vaccine provision in secure settings in England (2023), all the settings in the children and young people secure estate that responded (13 of 17) reported that they check a child's immunisation status on reception screening and offer all relevant catch-up vaccinations.

Figure 16 shows the proportion of eligible children in relevant age cohorts in the children and young people's secure estate reported to have received specific vaccines in 2023 to 2024. A description of the data sources is available in the appendix. The graph shows that not only is vaccine coverage below target levels for all vaccines, but that it is lower than the national comparator for all vaccines. For the vaccines given in adolescence the disparities are particularly large, with 29% lower coverage for the 3 in 1 tetanus, diphtheria and polio (Td/IPV), 28% lower coverage for meningococcal bacteria A, C, W and Y (MenACWY), and 19% lower coverage for human papilloma vaccine (HPV) in boys compared to their peers nationally.

Figure 16: vaccination coverage in eligible children in the children and young people secure estate in 2023 to 2024 compared to national rates in the general population



Source: National Commissioning Data Repository (NCDR) dashboard, NHS England

An investigation by UKHSA identified that residential staff are vital trusted sources of information for children and young people in their care and their influence on vaccine uptake should not be underestimated. Yet many report a lack of knowledge about vaccinations with only 1 in 10 feeling very confident talking about vaccines. Other factors that influence vaccine uptake in the children and young people secure estate are trust in staff, fear of needles, needing time to think about it and parental resistance. UKHSA has created a video with basic information on vaccines spoken about by 2 young people for dissemination in the children and young people secure estate.

Communicable disease incidents and outbreaks

Between 2011 and 2024, 57 communicable disease incidents or outbreaks in settings in the children and young people secure estate were reported to the UKHSA. The most common pathogens reported in these incidents or outbreaks were COVID-19 (39 incidents; 68%) and norovirus (9 incidents; 16%).

Pregnancy and sexual health

Data from the CHAT assessment regarding menstruation and pregnancy was available but over 80% consistently have missing data on their pregnancy status, resulting in small numbers for analysis. Less than 1% of girls in secure settings were reported to be possibly pregnant. Too few cases of previous pregnancy were reported through the CHAT tool for presentation here. There is no mother and baby unit in the children and young people estate in England at this time.

In young offender institutions, in 2022 to 2023, 79% of those that accepted a referral for sexual health screening were screened. However, there is no data available as to the prevalence of common sexually transmitted infections based on this screening.

Current services

A census undertaken in 2016 which looked at pathways of care in secure settings across the children and young people secure estate and adolescent secure mental health estate, commissioned by NHS England, references the issues with different parts of the system all dealing with the same vulnerable and complex cohort of children⁵³:

“Co-ordinated commissioning for these young people would make use of all relevant multi-agency expertise. Within risk assessment arenas...and in adult prisons...these mechanisms are well established and operate to some extent at a frontline level for young people. However, the commissioning streams for this population operate in silos. The high levels of mental health morbidity in the YJS (youth justice service) and welfare placements, the high levels of LAC (looked after children) in all systems, the high levels of young people in welfare placements with a history of YOT (youth offending team) contact all suggest there is a case to be made for regional multi-sector panels that would combine an understanding of legislation, available local placements and type of need. In planning terms, a degree of national oversight of the entire system might bridge government departments and aid mutual understanding”

The same document also argues that the children dealt with by these systems seem to stay in the system that picks them up. Those who move around systems probably continue to have the same needs wherever they are and the report argues that it is sometimes chance which part of the system picks them up.

Framework for Integrated Care (Community) vanguards

The Framework for Integrated Care offers a coherent structure for a comprehensive, trauma-informed system of care that unifies staff and services⁵⁴.

The primary goals of the Framework for Integrated Care can be categorised into 3 areas:

- system change – a transformation of culture and practice
- targeting changes in children and young people
- focusing on enhancing the context of their lives (which often involves supporting the adults around them to make changes too)

Through this approach, care planning is provided for children using the principle of ‘formulation’. A formulation (or ‘my story’) is a collaboratively developed and shared understanding of a child’s needs that summarises the core difficulties, explains why they may be happening and, drawing on psychological theory, is an attempt to make sense of them. It draws together all the relevant information about a young person and their experiences into a shared and coherent ‘story’. This is not tied to any particular label or diagnosis. It is a ‘plausible account’ of a young person’s situation that has meaning to all those who read it.

The community pathway targets vulnerable children and young people who may have experienced trauma or adversity and be at risk of encountering the youth justice system or secure children and young peoples estate. The community pathway currently targets 19% of the possible cohort of children it could reach, across 11 sites known as vanguards. A review of the statistics collected from April to March 2024 completed by NHS England shows that a total number of 5,849 referrals have been received and from this number, 89% were accepted entered onto a vanguard pathway. Over the last year statistics have doubled as vanguards have integrated into care provider footprints and continued to develop their programmes. Vanguards have been required to demonstrate partnership working across multiple agencies including health, local authority, education and crime agencies, demonstrating how they will deliver the Framework and the outcomes within it. Emerging evidence (collected as part of the annual review process and the collation of case studies from the roll out of the Framework for Integrated Care (Community)) is beginning to demonstrate benefits, this is described further in the appendix.

Practice example: community vanguard Bristol

One vanguard in Bristol is working with local services providing 7 pathways according to individual needs. Examples include:

- a therapeutic coaching service to prevent school exclusions – based on an initial 36 children and young people referred this has demonstrated a 93% success rate with respect to heading off permanent exclusions for children and young people at risk of permanent exclusion, and on average, a reduction in difficulties scores from the Strengths and Difficulties Questionnaire
- Bristol Drugs Project pathway – follow up on 10 randomly selected children and young people reported that all 10 children remained in education, with none receiving further exclusions for drug and alcohol related incidents. Five children and young people were not using any substances after the intervention and a further 5 had reduced and made changes to their substance use

Case study: Thames Valley vanguard

Background

B is an adolescent male with diagnoses of Autism and ADHD. B had several moves in his early childhood. Children's Services became involved with the family due to B's behavioural difficulties. Then there was a serious incident at home and B and his siblings were all placed under Child Protection and Child in Need Plans under the emotional neglect category. As a result of B's emotional, behavioural and mental health difficulties, he has had numerous exclusions from mainstream, independent, specialist and residential schools. Tuition outside school did not work and he was out of education for prolonged periods. Prior to exclusion he was isolated often, exposed to inconsistent and prolonged use of physical intervention, and spent long periods unsupervised online and there were concerns of exploitation.

B became looked after under section 20 of the Children Act following a breakdown at home. A short emergency placement was successful but then followed with several poorly planned moves within a short time. This was reflected in B's behaviour with multiple missing episodes, several arrests for assault, property damage, public order offences and concerns about criminal exploitation plus significant escalation in drug and alcohol use. This was combined with episodes of suicide and self-harm.

Support provided by the vanguard

The vanguard worker met with both B and his parent to think about some of his behaviours, to share observations and to reflect on how Autism, ADHD, and experiences of trauma may affect B's experience of the environment and the people around him and his interpretation or response to them. B's parent has been supported with psychoeducation on neurodiversity and traumatic stress, alongside how their own behaviour may impact on B. The support is flexible as needed. The Consultant Psychiatrist supporting the vanguard has taken part in some joint sessions that both parents have attended, and one parent attends all his medical reviews.

Outcomes

The vanguard has helped the family, professionals and B understand each other's perspectives. B has been engaged in positive mental health treatment and been supported to be in a regulated placement which is more stable and therapeutic than his previous placement. Wider systems have been supported to understand B's overall formulation. This has been vital to helping understanding of B's behaviours, even when those behaviours are very concerning. Fundamentally the vanguard believe that they have delayed Youth Offending Service intervention. It is the vanguard's view that this work has prevented B's escalation into secure residential care.

Community Forensic Children Mental Health services

Community Forensic Children Mental Health services (known as FCAMHS) currently provide a specialist service for high-risk children and young people. The services ensure that there are clear links between youth justice and welfare provision (community and detention), hospital secure or specialist settings for high-risk children and young people and core provision whether within specific children mental health services or other services. For example, they may provide in-reach to the secure estate, professional support and training and continuity between services on release into the community. Rollout of FCAMHS by NHS England with 13 services now covering all NHS England regions, ensures equitable access to all who need them. An independent evaluation commissioned from the Anna Freud Centre for Children and Families⁵⁵ found that following this service rollout there was a positive impact on the mental health and wellbeing of the cohort, improvements in quality of life and reduced variation in England, and that if 1 out of 100 children and young people aged 15 to 17 avoided detention that this made FCAMHS cost neutral.

Healthcare providers

The services that NHS England commission in secure settings in the children and young people secure estate include primary care (general practice services) and secondary care (hospital services) for both physical and mental health needs, substance misuse services, ophthalmology, dentistry and auditory services. Emergency services are accessed outside the setting as they would be in the community when they are needed. Regardless of size of setting all types of setting operate to the same core NHS England specifications which are benchmarked by the healthcare standards for children and young people in secure settings, however the way in which provision is delivered may differ. In general, access to healthcare within the settings is good, and this data is explored further in the appendix.

Secure mental health services for children

Tier 4 inpatient Child and Adolescent Mental Health Services (CAMHS) in England offer care at 4 levels to support the effective management of differing nature of risk presented by children and young people under 18.

Medium secure, low secure and psychiatric intensive care units (PICU) services provide a range of physical, procedural and relational security measures not required in general adolescent services to ensure effective treatment and care while providing for the safety of children and young people, staff and the public. Medium secure services accommodate children and young people with mental and neurodevelopmental disorders (including learning disability and autism) who present with the highest levels of risk of harm to others including those who have committed grave crimes. Low secure services accommodate children and young people with mental and neurodevelopmental disorders at lower but significant levels of physical, relational and procedural security. Children and young people may belong to one of 2 groups: those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-forensic' presentations principally associated with behaviour that challenges, self-harm

and vulnerability. PICU manage short-term behavioural disturbance which cannot be contained within a Tier 4 CAMHS general adolescent service. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security. General adolescent services provide inpatient care without the need for enhanced physical or procedural security measures. The clinical management network and pathways into secure mental health services for children are described in the appendix.

Overarching challenges for care of children and young people in the secure estate

Implementation of the Framework for Integrated Care

The Framework for Integrated Care recognises that any form of meaningful health or other intervention may only be achieved with children and young people with complex needs when all practitioners work in a therapeutic way. This means they must be trauma trained and supported with opportunities for reflective practice. This may appear to be a 'soft' process, but it needs informed oversight and co-ordination often by an experienced mental health professional and can be demanding in terms of co-ordinating different professional opinions and, at times, resolving interprofessional conflict. Our engagement for this report identified challenges in recruitment and retention to the workforce of the children and young people secure estate, in part this was thought to be due to the vicarious trauma associated with this group of children and young people.

Secure settings have been enthusiastic in delivering SECURE STAIRS and 10 of the 17 sites within scope of the project were fully delivering the Framework for Integrated Care (SECURE STAIRS) by the end of 2022. Of the others, 4 were making progress towards this and 3 were still experiencing some issues needing resolution to achieve full implementation. It is important to note that the implementation of the Framework has been less successful in young offender institutions. This has required sustained attention and the Youth Custody Service and NHS England have supported the implementation of 'road maps' post the end of the original project to address some important issues. An independent review of the framework identified a number of recommendations to support implementation⁵⁶.

Data and research to inform a multi-agency response

A lack of research on the health and wellbeing of children post-placement in the children and young people secure estate means a parallel lack of evidence on the long-term outcomes for these children. As children move from the commissioned NHS England services within the estate directly to community services on leaving, this makes long-term follow up difficult to achieve without improving data linkage. Given the complex needs of this cohort, ideally information on education, reoffending, housing and health need to be considered together but this whole picture does not currently exist. Currently information has to be collected manually

from individual children and young people secure estate sites. This is inefficient and does not allow the organisation to have a regular and comprehensive assessment of national need.

Preventing children and young people from coming into contact with the youth justice system or entering the secure estate

Children can often come into contact with the Youth Justice System when earlier intervention could have avoided it. While the number of children and young people in the secure estate is small, youth justice statistics for England and Wales⁵⁷ show that 58,899 children were arrested in the period 2023 to 2024. The percentage of arrests has remained stable to the previous year in comparison to adults and arrests of children has accounted for 8% of total arrests.

Considerable resources are spent on youth justice intervention to tackle issues that could have been dealt with sooner. The costs associated with entering the children and young people secure estate are described in the appendix. These costs are higher than intervening early, with an estimated cost of late intervention in England and Wales at around £17 billion per year. This estimate captures the costs of acute, statutory services that are required when children and young people experience difficulties, many of which might have been prevented⁵⁸.

Arguably there will always be some children who need secure residential care and for whom this 'late intervention' is not avoidable, but for most this journey of escalation could be avoided. By diverting children from the youth justice system, there is the potential to change the trajectory of a child's life and to reduce the health inequalities they are experiencing, as well as to avoid the very significant costs incurred from progression into the adult justice system. However, because children and young people vulnerable to entering the youth justice system (and welfare system) often have complex needs, health services are a key part of this. Effective prevention and diversion work therefore relies on multi-agency collaboration. There are examples of good practice towards preventative approaches with integrated working as shown in the example below. However, presently, there are 11 vanguards that reach approximately 19% of the population of children with these needs. There is promising evidence of benefit in these sites and national scale up may be warranted.

Transitions

Professionals working with this group of children advise that transition points, including discharge from the children and young people secure estate or transfer to another secure setting, including the adult estate, can be particularly challenging for health and wellbeing. A large proportion of children are looked after and therefore their discharge is reliant on an appropriate community placement, this may not be confirmed until just before discharge meaning that advance planning is not possible. Unpublished data collated by NHS England (children and young people indicators of performance, CYPIPs) showed that for children who required a supply of medication on discharge and/or transfer, 49% of those in young offender institutions were provided with at least a 7-day supply or an FP10 (the standard form for prescribing in England). This compares to 100% of children in secure children's homes who were discharged or transferred.

For children from young offender institutions who were discharged into the community in 2023 to 2024, 83% were registered with a community GP practice prior to discharge. For those discharged from secure children's homes, 91% were registered with a GP before discharge (CYPIPs). Similarly secure children's homes were more likely than young offender institutions to send a CHAT discharge summary to their community GP (95% compared to 57%, CYPIPs data 2023 to 2024). For children transferred to another secure setting in 2023 to 2024, 95% from secure children's homes had their CHAT discharge summary sent to the new GP and healthcare manager. For young offender institutions, this figure was 58%. This is in part likely to result from the different nature of the settings, where secure children's homes are able to register children and young people with their local area GP practice to ensure their full health record is automatically transferred (GMS registration) and can be readily relocated upon release. In comparison, health records of children in youth offender institutions or secure training centres will be transferred when they register with a GP on release.

Medication management

Medicines reconciliation is the process of identifying an accurate list of a patient's current medicines and comparing these to those currently in use. In 2023 to 2024 just over half (52%) of children and young people admitted or transferred into the children and young people secure estate that needed a medicines reconciliation, had one completed within 72 hours of admission. One example of the challenges of continuity of medicines management is in children and young people that require medicine to treat ADHD. A confirmed diagnosis of ADHD is required before medication can be prescribed. Investigation with regional NHS England commissioners and engagement for this report found that some sites reported that children and young people who had been established on medication within secure settings subsequently struggled to obtain their medication on release. This was for varying reasons including primary care requiring specialist care to prescribe, and diagnoses of ADHD that had been made in the secure estate not being upheld in the community, meaning that children and young people join the usually long waiting list for assessment.

Opportunities to make progress for these children and young people

Irrespective of inconsistent data on current identified diagnoses, there is clear evidence of multiple and overlapping needs and risk factors for future social, behavioural and health difficulties within this cohort.

The Framework for Integrated Care (Community) is currently supporting the prevention of children from entering youth justice, welfare systems and secure hospital. To ensure equitable access to all children to this preventative approach, there would be benefit from rolling out the Framework for Integrated Care vanguards across the country to meet the needs of the 80% of children and young people who are currently not able to benefit.

These children need a 'whole pathway' approach as they often emerge in different parts of the system, be this youth justice, secure welfare, or secure mental health. Scope for further

integration between commissioners of these 'family of services' could be considered at either national level within NHS England, and Department of Health and Social Care, or at regional and local level. More targeted and integrated spend of resources at a preventative level is likely to have the most benefit to improved life outcomes for children and for wider society as a whole. This is in line with the current mission led governments move 'from sickness to prevention' and 'breaking down barriers to opportunity'.

There is a strong desire across government to able to track long-term outcomes for children in the children and young people secure estate after transitioning out. Improvements to data collection and data linkage is necessary to provide better evidence and spending for this complex and vulnerable group of children. This is also in line with the government priority to move from 'analogue to digital'.

A cross-government approach on children with complex needs would support a more joined up and integrated approach to a cohort of highly vulnerable children and young people across society in the England who are in extremely complex situations and experience some of the highest levels of need and health inequality. The efforts of wider strategic leaders are needed to effect strong partnerships and align resources to ensure that vulnerable children and young people's needs are identified earlier, and sustainable and effective prevention and diversion interventions put in place. This includes support from local authorities, children's social care, children and young people mental health services, GPs and health providers, schools and/or colleges, local voluntary and community providers and more widely.

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4 Women in prison and on probation in England

Authors: Dr Nicola Vousden

Contributors: Dr Caroline Watson, Dr Emma Mastrocola, Professor Emma Plugge, Nikki Luffingham, Eleanor Kershaw, Dr Alice Llambias-Maw

Introduction

Across England and Wales, there are currently 12 female prisons, all of which are in England. Females make up 4% of the overall prison population and 12% of people under the supervision of probation in the community¹.

Women tend to serve shorter prison sentences than men. In 2023, 49% of females who were sentenced to custody received sentences up to and including 3 months². Theft from shops was the most common indictable offence for females in 2023³.

There have been a number of recent important reports about women in prison. In November 2023 NHS England published the final report from the National Women's Prisons Health and Social Care Review (Women's Review)⁴, building on the aims of the Ministry of Justice's (MoJ) Female Offender Strategy of 2018⁵ and Female Offender Strategy Delivery Plan 2022 to 2025⁶. The Women's Review was informed by women with lived experience, led by an independent chair and guided by a multi-agency board with input from NHS England and HM Prison and Probation Service (HMPPS). It included extensive engagement, with over 2,250 contributions from women with lived experience, visits to the female prisons and literature reviews and identified 8 main findings and associated strategic recommendations. Engagement for this report has identified that the 8 Women's Review recommendations reflect current national priorities for the health of women in prison and upon release.

In September 2024 the government announced plans to reduce the number of women in custody and the Women's Justice Board was established shortly after, with representation from health stakeholders on the partnership delivery group⁷. This is supported by several recommendations from the final report of the independent sentencing review, published in March 2025, which encourage women to be diverted away from prison and to sanction and support in the community⁸.

The Women's Review included the health of women in prison and upon release but the health needs of women on probation were not included. Therefore, the aim of this chapter is to:

- share statistics on the health needs of women in prison and on probation
- update on actions to support health since the Women's Review

- describe challenges and opportunities to support health for women at risk of criminal justice contact and on probation

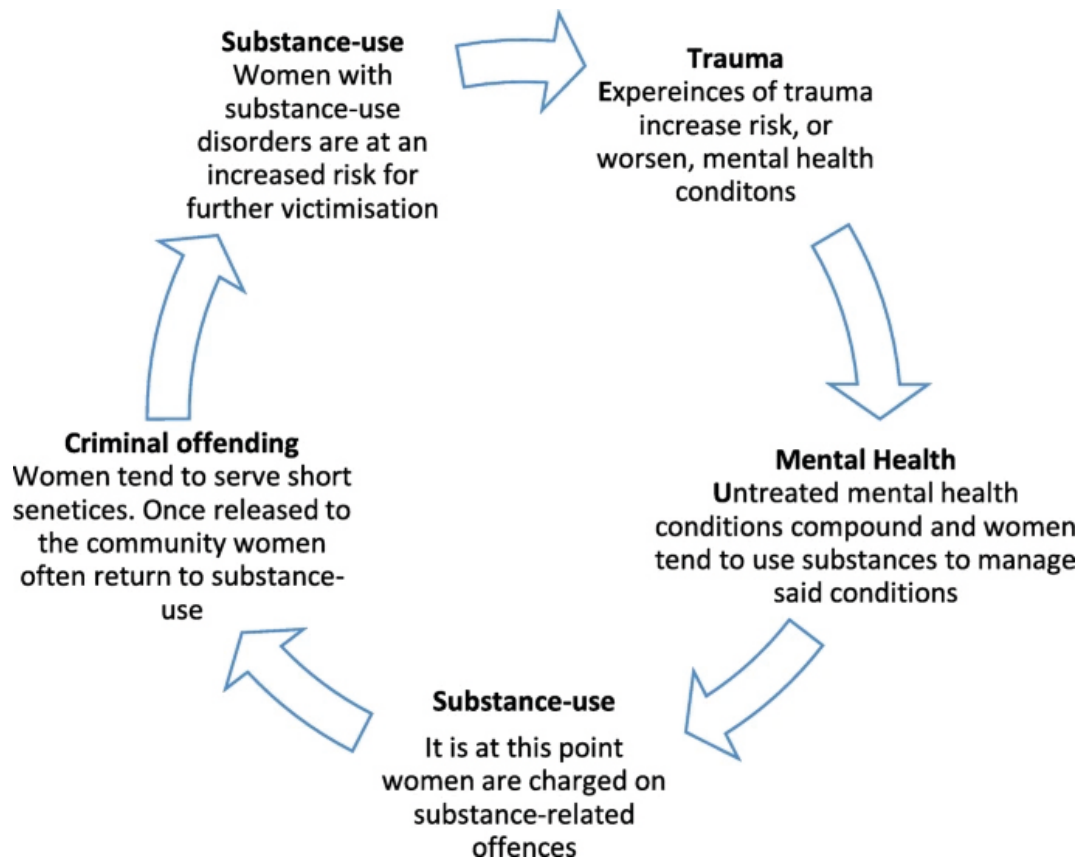
Health needs of women in prison and on probation

Most women in prison are aged 30 to 49⁹. Although the greatest proportion of women in prison and on probation are White, women from minoritised ethnic groups are overrepresented at every stage of the criminal justice system¹⁰.

Most women in contact with the criminal justice system have experienced trauma at some stage in their lives. For example, 68% of women with a custodial sentence were identified as a victim of domestic abuse (compared to 10% of males), similar to the proportion (67%) of those on probation^{11,12}. Over half (53%) of women in prison report experiencing emotional, physical or sexual abuse as a child¹³. These are often underreported and the true burden may be higher. Experiences of trauma can influence health, for example increasing substance use and/or risk of poor mental health. Women in prison are more likely to use substances than men (51% compared with 30%)¹⁴, often reporting this is to alleviate the pain of trauma and manage mental health. This is on top of social factors contributing to social exclusion and harm such as poverty, unemployment and homelessness, which are more common than in the general population. Experiences of trauma therefore need to inform the way that healthcare is delivered.

The relationship between these factors and offending is complex, multidirectional^{15,16} and cyclical, as shown in figure 1. It is therefore vital that activities aiming to support women in contact with the justice system consider and evaluate impacts on health, as well as offending. Outcomes need to be jointly owned by health system partners (integrated care boards (ICBs), local authorities, Department of Health and Social Care and NHS England) and justice (HMPPS and Ministry of Justice).

Figure 1: pathways to women's offending



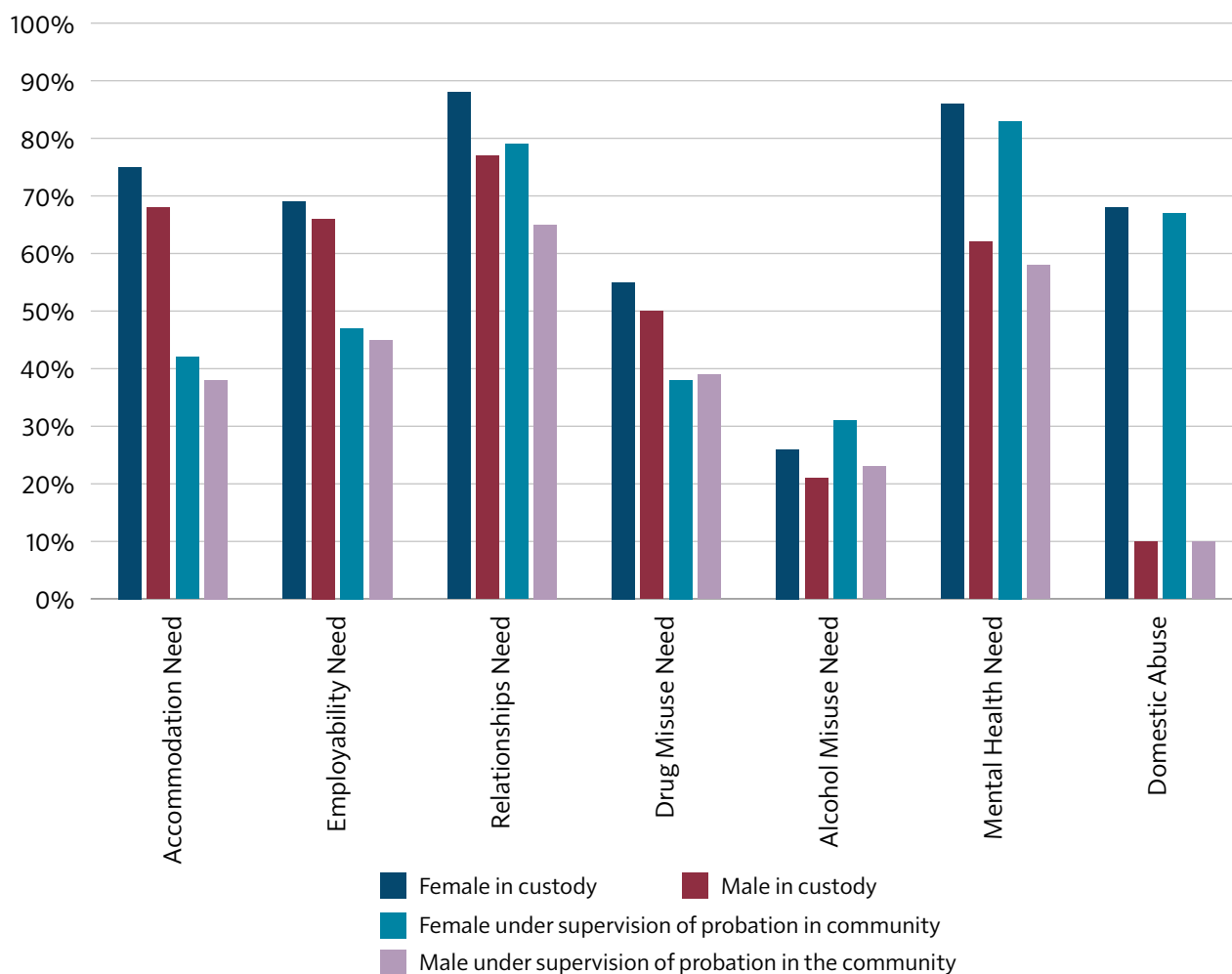
Source: Edwards, L., Jamieson, S.K., Bowman, J. et al. 2022¹⁷. Reproduced without adaptation under creative common licence.

As for the general population, the conditions that impact on women's health are not identical to men's. Women's health includes sex-specific issues such as menstrual health, menopause and pregnancy (discussed in chapter 2) and conditions such as endometriosis. Women's health outcomes are also impacted by conditions affecting both men and women. Some of these affect women differently with a higher disease burden, such as osteoporosis, or disproportionately with a higher prevalence, such as depression. The greatest burden of ill-health for women globally is related to those conditions that disproportionately affect women, but can occur in both men and women^{18 19}.

There is limited research and data to describe the health needs of women in prison^{20 21}. A review published in 2025 summarising the health of women in prison did not include any studies from the UK²². The global evidence described the prevalence of sexually transmitted and blood-borne infections and mental health conditions, with gaps in the evidence about non-communicable conditions in custody²³. Similarly, even less research is available describing health needs of women on probation, with many studies not disaggregating results by sex^{24 25}. The available research evidence suggests that women in the criminal justice system may have higher mental health needs than men and than the general population^{26 27 28}.

National probation and prison system data that assesses needs related to offending suggests that women in prison and on probation are more likely than men to report a mental health or alcohol misuse need²⁹ (figure 2).

Figure 2: selected health-related identified needs by gender of people in custody and under supervision of probation



Source: Ministry of Justice identified needs of offenders in custody and the community from the Offender Assessment System, 31 October 2024³⁰

The rate of self-harm for women in prison is higher than in men. In 2024, 28% of all self-harm incidents in prison were in women³¹, despite them making up 4% of the prison population. Of self-harm incidents in females, 35% were in those aged 20 or younger³², despite them representing around 3% of the females in prison. A survey of people in prison identified that a high proportion of women report feeling depressed (56%), feeling suicidal (26%), have other mental health problems (42%) or physical health problems (25%) on arrival in prison³³. While rates of self-harm for women on probation are unknown, in 2023 to 2024 there were 176 deaths to females on probation and 38% were self-inflicted³⁴, 32% were due to naturally occurring health conditions and there were 3 deaths from homicide³⁵.

It is estimated that 78% of people in prison have children³⁶. While this is relevant for both men and women, women are more often the main carers for dependent children. Women are often placed significant distances from their home – on average in 2021 this was 46 miles³⁷. Research suggests that only 5% of children with a mother in prison remain in their family home during a mother's imprisonment³⁸. Imprisoning mothers causes harm to children and can entrench cycles of adverse experiences within families³⁹.

Women have shorter stays in prison but there is still an opportunity through prison and probation contacts for women to engage with health and care services and ensure that:

- national screening programmes are up to date (including breast, cervical and bowel screening as described in chapter 13)
- screening for sexually transmitted infections (STIs) and blood-borne viruses is offered, given higher rates of STIs in women in prison (chapter 12)
- health promoting advice is given to encourage changes that prevent the onset of conditions that affect the whole population (such as smoking to prevent ischaemic heart disease) and conditions that disproportionately affect women (such as dementia⁴⁰ and osteoporosis⁴¹). Advice should support women to manage symptoms and maintain wellbeing during life stages such as menopause, for example through diet and exercise
- contraceptive counselling and provision is offered, given the opportunity to bring this service to women in prison and the barriers women can face accessing contraception for both management of menstrual health and for birth control in the community
- women are supported and healthcare is provided in a way that is sensitive to pre-existing trauma and separation from children and families, including adequate time out of cell, purposeful activity, talking therapies and peer support
- the needs of older women, including frailty, dementia and barriers to accessing services are identified and met (chapter 5)

Actions to improve health since the Women's Review

Since the Women's Review, a joint NHS England and HMPPS implementation group has been formed to provide strategic overview of the actions taken to meet the recommendations. Nationally, NHS England has developed a national service specification for Women's Health and Wellbeing Hubs in prison which is being tailored locally to ensure the hubs complement current prison health services. These are expected to be rolled out across all women's prisons from July 2025 and completed by December 2025. They aim to tackle health inequalities, support women's privacy needs, provide trauma-informed care and improve access to health information. Further examples of national work includes:

- continuing the review of all Health and Justice Service Specifications, ensuring that women specific elements are included
- ongoing development of a national Health and Social Care Needs Assessment toolkit which is currently in pilot across the women's estate and due for roll out in 2026 to 2027
- publication of the principles for safe maternity care
- improvements in continuity of care for medicines management in prison and post release, and through improvements to clinical pharmacy services

Progress against the recommendations in the regions and establishments include:

- improving access to gynecological and screening services
- development for an in-reach service to support women disclosing sexual assault/domestic
- employment of specialist staff in mental health
- neuro-disability and brain injury link workers
- piloting parental separation counselling services
- piloting support services from women's centres for women in contact with the criminal justice system to support women upon release

Opportunities to support health for women with criminal justice contact in the community

Early intervention and prevention

Diversion away from custody allows women to maintain ties to their community and family, childcare responsibilities, housing, employment and continuity of healthcare. Chapter 8 on mental health describes the role of NHS liaison and diversion services in identifying people with a health need, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice and aiming to prevent escalation of offending behaviours. The independent review of sentencing recommended expanding the use of liaison and diversion⁴² and a recent internal review has identified recommendations to improve the service. Gender specific female pathways are fully embedded within NHS England commissioned liaison and diversion services. Each service has a nominated female lead, prioritising screening within police custody and court settings, using gender specific screening tools and adopting a holistic trauma-informed approach to practice. Services will support females to navigate through the criminal justice system and to make appropriate referrals into relevant, gender specific community health and social care services.

Other justice activities for earlier intervention and diversion that are closely linked with health include:

- problem solving courts – these aim to address factors underlying behavioural issues that contribute to offending. Greater Manchester has a women's specific court aiming to address gender-specific needs such as domestic abuse, substance misuse, sexual exploitation and involvement in sex work and support access to appropriate women's services in the community⁴³
- intensive supervision courts – these aim to divert people with complex needs away from short prison sentences into enhanced community sentences. Early outcomes from an interim evaluation indicate improved mental health and wellbeing and relationships with families⁴⁴. There is one women's specific service in Birmingham where women are provided with an

integrated package of gender specific, trauma informed care that is personalised to their needs

- other diversion services such as the London Women's Diversion Service, funded by the London Mayor's Office for Policing and Crime and the Ministry of Justice. This aims to address underlying causes of offending such as the impact of trauma and abuse on drug and alcohol use and mental health to break the cycle of offending and a high uptake and improved health and wellbeing was reported⁴⁵

From a health lens, preventing people from entering prison starts with addressing the root causes of offending, which requires women to be able to access effective drug, alcohol domestic abuse and mental health services in the community. This is explored in more detail below.

Women's centres and specialist women's community services

Often women at risk of entering the criminal justice system or on probation need to access multiple services in different locations, creating a high burden of care and barriers to access. Women's centres offer support to address multiple and complex needs such as housing, substance misuse, mental health and employment, often referred to as a 'one-stop-shop'. Services are delivered in a tailored and trauma informed way to reach and engage women that may not access standard services. A survey of women's centres identified that alongside many services that would benefit health, 79% and 58% include specific mental and physical health services, respectively⁴⁶. Engagement suggests physical health services are often limited to signposting and information rather than integrated NHS physical health services. The model is well established, with around 40 women's centres across England and Wales. Research has identified it is cost effective, highly valued⁴⁷ and effective at improving mental health and other dimensions such as housing, relationships and physical health⁴⁸. There are women's organisations such as SHEWISE and the Phoebe Centre that specialise in providing community holistic services for women from minoritised ethnic groups. A directory and map of women's centres and specialist services is produced by the [National Women's Justice Coalition](#).

There is a postcode lottery in access to women's centres and challenges with short term funding from a complex mix of organisations⁴⁹. The independent sentencing review recommended more sustainable and long-term funding to women's centres⁵⁰. There is also opportunity within the 10 Year Plan as health shifts to neighbourhood models⁵¹ to build on this existing, trusted resource for women with multiple disadvantage.

Residential women's centres

There are a small number of residential women's centres across the UK, that support a small number of women with multiple disadvantages. These include Willowdene Farm in Shropshire and Trevi House in the South West. The residential centre at Trevi, Jasmine Mother's Recovery, accommodates up to 11 women with their children supporting them to undertake trauma informed therapeutic rehabilitation over 12 to 24 weeks. In 2022 to 2023, 80% of women left the service drug and alcohol free and 8 out of 10 children stayed with their mothers⁵². Hope

Street is a community-based, residential setting in Southampton that can be offered for women on probation, as an alternative to prison, or as a supportive pathway on leaving prison. Women can receive treatment, therapy and support and have the possibility to keep their children with them⁵³. The service is still growing after opening and a full initial evaluation is anticipated.

Healthcare that meets holistic needs

There are some good examples of women's healthcare delivered in a trauma informed way and addressing women's holistic needs. Two examples of these are provided in the practice example boxes below, one where NHS health providers were embedded in a women's centre to provide trauma informed women's health services and the second linking primary care and gynaecology to provide a specialised pathway for women with disadvantage. Bringing services together in trauma informed pathways is important as women can experience stigma and bias, and lack of trust in services, which may influence engagement. This is in addition to physical challenges accessing and navigating multiple services, for example reproductive and gynaecology services such as contraception and sexual health are commissioned and managed by different organisations with minimal join up to other health services such as primary care. Unfortunately, many local initiatives to co-locate healthcare professionals in probation or women's centres have not had long-term success due to challenges with consistent funding, space and appropriately trained trauma informed healthcare professionals.

The Women's Health Strategy for England (2022) encouraged the expansion of women's health hubs models of care⁵⁴. These aim to bring together healthcare professionals and existing services to provide integrated women's health services in the community, to improve access to and experiences of healthcare for menstrual problems, contraception, pelvic pain, menopause care and more, improve health outcomes and reduce health inequalities. Most ICBs now have at least one women's health hub⁵⁵. While their impact on population-level access to care or health outcomes is not yet known⁵⁶, women's health hubs have demonstrated positive local outcomes. The women's health hubs core specification recommended that local health systems reflect on the need to meet women's health needs holistically and suggests that women's health hubs can develop care pathways into women's centres⁵⁷.

There is a current political commitment in the 10 Year Health Plan (2025) to Neighbourhood Health Services, with co-location of health, local authority and voluntary sector services in Neighbourhood Health Services. The plan highlights the opportunity for Neighbourhood Health Centres to improve care for people facing systematic challenges around co-ordination of care, which is of relevance to people involved in the justice system. It also suggests that Neighbourhood Health Centres build on the evidence provided by women's health hubs to improve access for women and tackle health inequalities⁵⁸. There is therefore an opportunity to strengthen the community women's health hub model to ensure that this specifically meets the holistic health needs of women with criminal justice system involvement and multiple disadvantages such as domestic abuse, mental illness and substance misuse who may be at risk of offending. This could also build on learning and offer continuity, from the women's health hubs in prisons.

Practice example: Black Country women's trauma informed community healthcare project

Background: Many women have not had routine health checks because of fear, anxiety or stigma. The project was developed in collaboration with probation, public health and the Black Country ICB, to provide easier access to healthcare services for women, in a trauma informed way. The project won the Butler Trust, Kathy Biggar Trophy in 2023.

Activities: The project commenced in 2022, with an aim to deliver services to women in a non-clinical, female only setting, recognising the barriers for women who already experience societal inequalities. It was jointly funded by NHS, a local women's centre and probation. The service is located in a women's centre in Sandwell. NHS health practitioners that are trained in working with people that have suffered trauma or barriers to care such as domestic abuse treat, advise or signpost in relation to women's health including:

- cervical screening
- sexual health
- BBV testing
- menopause

Outcomes: An independent evaluation by the University of Birmingham (unpublished at time of writing) highlighted that a trauma informed approach is essential to engaging women and having an additional understanding of the complexities for women in CJS. However, it also highlighted that services should be expanded, to offer further healthcare interventions in this way.

Practice example: Wildflowers clinic, Peterborough⁵⁹

Wildflowers clinic links local GP health inequalities leads with local gynaecology consultants to provide trauma informed pathways for cancer screening and supports engagement with treatment for women with disadvantage, including sexual trauma and domestic abuse. Since the clinic launched cervical screening rates have increased from 19% to 93% and women have been supported to attend the dedicated colposcopy clinic for 'vulnerable' women at Stamford and Rutland Hospital. Effective partnership working and the support of the integrated care board was key to the project's success.

Advocacy and peer support

Women's centres and many other voluntary, community and social enterprises (VCSE) provide an important role in helping women navigate to services, advocate for their needs and provide support, including through peer mentors. This can work to close the gap where services are not integrated and there are barriers to access. One example is below.

Practice example: Beth Centre, Lambeth, London

The Beth Centre is a women's centre in Lambeth run by the charity Women In Prison, that provides expert support for women at risk of, or affected by, the criminal justice system. They aim to reduce reoffending and develop positive family relationships and reduce the use of custody. Support includes advice and advocacy around housing, welfare, education and employment, substance use, health, parenting and others. This includes support from 15 peer mentors who focus on increasing women's confidence and independence.

Supporting families

There is clear evidence that exposure to adverse childhood experiences increases the risk of various health conditions, including anxiety and depression and problematic drug use⁶⁰. Children of imprisoned parents may be more likely to experience both mental^{61 62} and physical health problems⁶³. Adults who have experienced imprisonment of their mother are more likely than their peers to die before the age of 65⁶⁴. Mothers in prison that had regular, supported contact with their children reported mental health improvements and reduced self-harm⁶⁵. There is research, guidance and training, that sets out the critical importance of sentencers taking into consideration the impact on child dependents when sentencing mothers⁶⁶.

There are a wide range of statutory and VCSE services that support families involved in contact with the justice system in the community, for example, early intervention programmes and children's social care. However, some simple practical steps such as childcare to allow women to comply with criminal justice proceedings and ensuring women are reunited with their children on release from prison without delay (a recommendation from Lord Farmers 2019 review⁶⁷) remain challenges.

Community sentences

Chapter 16 describes the health needs and opportunities to support people on probation. Many of these factors will include and be relevant for women. People on probation access the same healthcare services as the rest of the general population, NHS services including primary care, acute care and community mental health services and public health services such as sexual health and family planning, specialist drug and alcohol services. There is a wide number of services, which may be geographically dispersed and fragmented. Given the different experiences of trauma and early life experiences and different health needs for women described in this chapter, there is a need to consider how access and engagement to services can be optimised. A report by Users Voice identified that 42% of probation appointments are

undertaken in female only facilities⁶⁸. Of those that attended mixed facilities, 1 in 3 did not like this and felt intimidated, anxious or nervous. Female only probation facilities could be delivered on a 'ladies day' or at a specific women's centre or hub, which incorporated holistic services. The lived experience panel below shows how these were valued.

Lived experience: women's experience of probation

A report by Users Voice as part of the HM Inspectorate of prisons thematic report on women in prison identified the valuable role probation can play in supporting women to access services, the benefit of those services and activities being co-located and specific for women⁶⁹:

"They got me into a women's hostel and I felt really safe. Got me referred to the mental health crisis team and was assigned a community mental health nurse and also a support worker who spends 1hr a week with me. Probation Office helped me to secure my own accommodation with a housing association."

"I speak to Women's Matter and my Probation Officer all together. ... Everything's done under that one building, which makes it easier and better for me, to do it all in that one day, so I don't have to keep going back and forth."

Chapter 8 on mental health and chapter 16 on probation describe the use of community sentence treatment requirements designed to ensure that people with mental health or drug and alcohol needs access appropriate treatment and support as part of their sentence. Women specific mental health treatment requirements (MHTR) are already available, focusing on an empathetic approach to the delivery of treatment and support. Within these pathways:

- probation and the providers will liaise with the individual to understand the underlying support requirements, along with caring responsibilities, trauma/issues/safeguarding, with attention paid to current past trauma/abuse
- each woman will work with the providers to develop and agree their individualised case formulation, this will consider the underlying reasons why she has appeared in court (mental health/social care /victim of abuse/neurodiversity and so on)
- the interventions will be delivered within an appropriate gender specific environment (women centre if available) and flexibility around treatment session times, to fit in with caring responsibilities, working and education
- the providers will work with the woman to ensure a post treatment and support plan is in place, ensuring continued support

The independent review of sentencing recommended additional women's specific pathways for drug and alcohol treatment requirements⁷⁰.

Data and research

The absence of evidence describing health needs of this group is reflective of a wider health services research gap on women's health needs and the impacts of health conditions, with women historically under-represented in studies and data analysis often not adequately accounting for sex and gender. An important finding from the Women's Review was the need for improved availability and quality of data that describes and informs women's health and social care needs and services. This aligns with the broader research recommendations in the Women's Health Strategy for England published in 2022, several of which are addressed through the National Institute for Health and Care Research Inclusion Strategy 2022 to 2027⁷¹.

At a local level, probation services also collect health data within diversity and inclusion assessments and in some services, using a specific Women's Risk and Needs Assessment licenced tool⁷². However, this data is not often shared with health partners and primary care services do not often record criminal justice involvement in health records. There is an opportunity for ICBs and local authorities to work with probation services to understand this population's health needs.

Summary

Women in contact with the justice system often have complex health and social needs which impact on health and access and engagement with health services. The Women's Review identified 8 key findings and recommendations. A year on there is much positive action to meet these recommendations and our engagement supported the need for continued work towards these. The Women's Justice Board has been formed with the purpose of reducing the number of women in prison and increasing the number supported in the community⁷³. Given the complex interrelation between health and offending in women, it is vital that healthcare services are equal partners in the activities and planning of this group.

In this chapter we describe positive examples of health and justice working in partnership to create co-located holistic services that are designed with women to meet their needs. There is a need to improve access to these to overcome the current geographical inequity. This requires longer term joint funding and ongoing evaluation to demonstrate their impact on health as well as offending outcomes. The commitment to neighbourhood health centres in the 10 Year Plan provides an opportunity for integrated care boards to build on existing progress of women's health hubs and integrate women's centres and specialised services that support women with risk factors for offending or reoffending and poor health, such as domestic abuse, mental illness and substance misuse.

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5 Older people in prison

Author: Dr Mary Piper

Contributors: Laura Spowage, Cath Hadfield

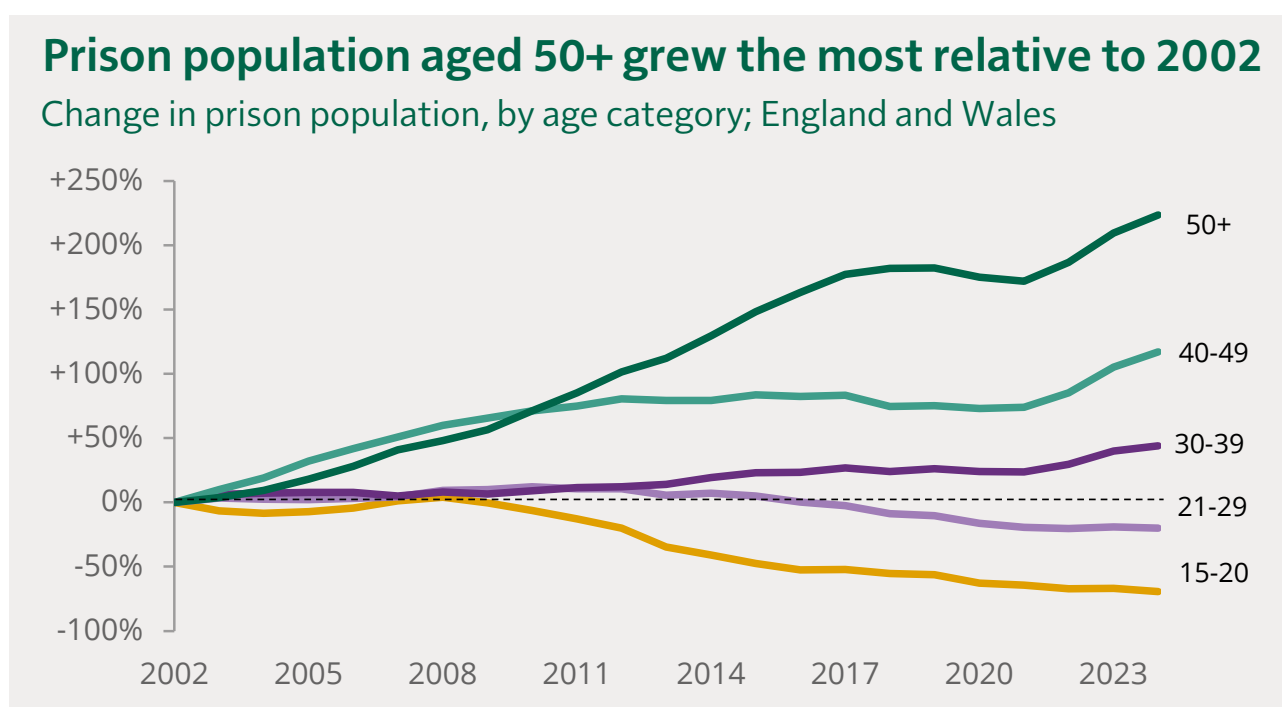
Introduction

Chronic physical and mental health issues are common in old age. People in contact with the criminal justice system on average have higher levels of socio-economic disadvantage, smoking and poor diet and higher likelihood of alcohol and illicit substance misuse. Often this can be associated with a chaotic life, with consequential limited health service engagement and earlier poor health¹. The criminal justice system defines individuals aged 50 and above as 'older', noting this tendency for earlier onset of disease-related illnesses, dependency, frailty and reduced life expectancy.

Older population

The prison population is ageing (figure 1). The number of people in prison over 50 has increased from 10% in 2011 to 24% in 2024². The proportion of women over 50 in prison has similarly increased³. The population of people aged 60 and over has quadrupled over the same time period.

Figure 1: changes in the proportion of people in prison aged 50 or over in England and Wales from 2002 to 2024

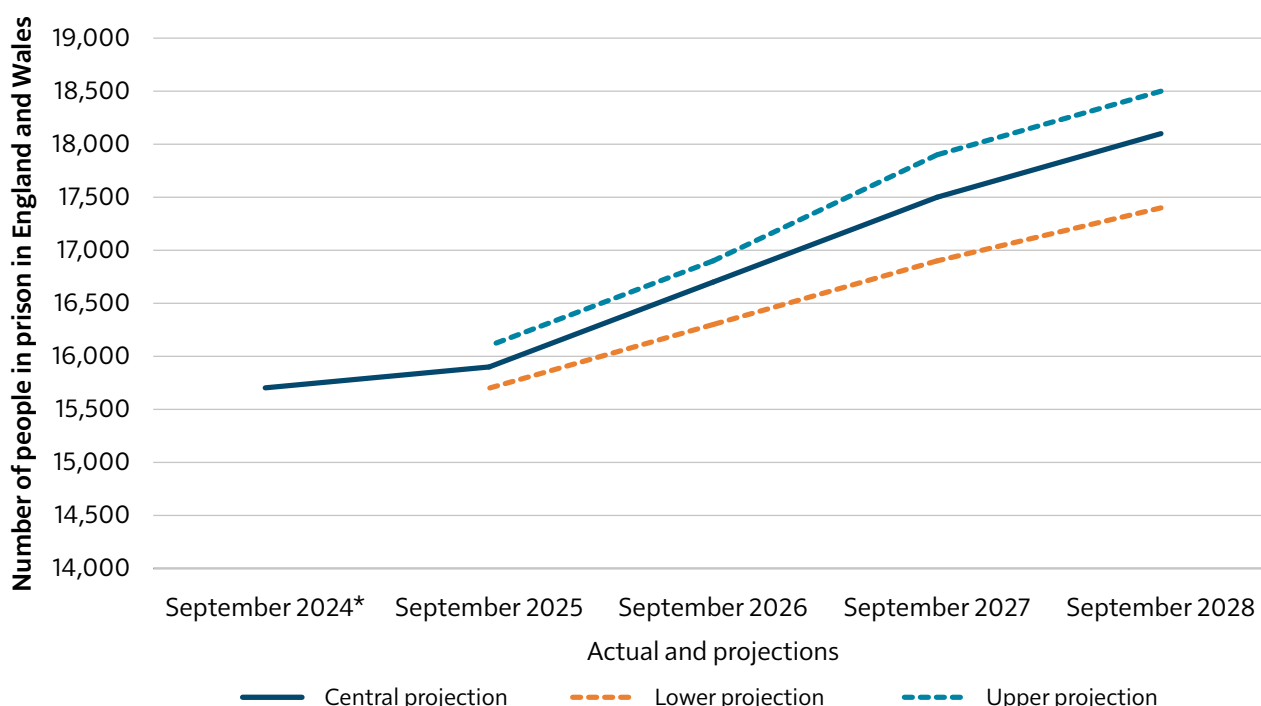


Source: Sturge, G., 2024. Uk prison population statistics. House of commons library⁴

This increase is due to a combination of factors including longer prison sentences meaning that more people are ageing in prison and an increase in people imprisoned for historical offences later in life⁵⁶. More than 2 in 5 men in prison aged over 50 (43%), and almost 100% of over 80's, are serving sentences for sexual offences committed decades ago⁷.

The government projects a 15% rise in the prison population by 2028 (figure 2). While the proportion of older people in prison will remain similar, the number will increase. Those aged 50 and over are expected to grow by 2,400 (15%), and those aged 70 and over by 700 (35%)⁸.

Figure 2: actual number of people aged 50 and over in prison in September 2024 and projected number of people between 2026 and 2028 (upper and lower projections)



Source: Created from Ministry of Justice data⁹

People in prison aged over 50 are a diverse population¹⁰. 82% describe their ethnic origin as White compared to 72% of the general prison population¹¹. They are more likely to have had a stable life prior to custody, for example, more likely to possess higher qualifications and less likely to use drugs immediately prior to prison compared to younger people in prison¹², and 1% reported being homeless prior to prison¹³ compared to 15% in the general population in prison¹⁴. Women over 50 have high rates of past physical and mental abuse¹⁵.

The physical and mental health needs of older people in prison are not routinely evaluated or reported at a national level and therefore this chapter is based on research evidence, primarily from the UK, with varied sample sizes of older people in prison¹⁶. There is very limited research on the health needs of older women in prison.

Physical health

The physical health of older men in prison is worse than older men in the community¹⁷. Among those over 60, 85% have a major illness and 28% a physical disability¹⁸. A minority of older

people in prison report their health as very good (11%), whereas more than 1 in 4 report health to be bad or very bad (28%)¹⁹. Older people in prison are more likely to suffer from chronic disease, disability, decreased mobility and sensory impairment than younger people in prison²⁰. For example, meta-analysis suggests that chronic obstructive pulmonary disease (COPD) was 8 times higher than peers in the general population (8% compared to 1%), diabetes 10 times higher (10% compared to 1%) and ischaemic heart disease 13 times higher (13% compared to 1%)²¹. Overall disease prevalence was at least double in older people in prison compared to community peers of the same age²². The most common physical health diagnoses among people in prison over 60 were musculoskeletal issues (24%), angina or ischemic heart disease (19.7%), osteoarthritis (13.3%), hypertension (13.3%), diabetes (8.4%) and COPD (5.4%)²³. A small number of people with complex health conditions can result in significant operational impacts, for example, in 2019 to 2020, a study of all hospital admissions data in England identified that 9 men in prison with chronic kidney disease had 747 hospital admissions for dialysis, accounting for 15% of all hospital admissions by older people in prison²⁴.

Mental health

The prevalence of depression in older people in prison is reported to range from 30%²⁵ to 55%²⁶, of which 23% had severe symptoms²⁷. This is 5 times greater than younger adult people in prison and elderly people in the community²⁸. Older people with depression in prison have higher unmet physical health needs and greater need for appropriate daytime activities²⁹. Much depression in this population is undetected and/or under treated³⁰.

Older prisoner deaths

In 2024, people in prison aged 70 or over were more likely to die in custody compared to any other age group (47.3 per 1,000 people in prison). This equates to 95 deaths in custody in people aged over 70 in 2024, 92 of which (97%) were from natural (medical and some preventable) causes. Overall, 89% of all natural deaths occurred in individuals over the age of 50 in 2024³¹. Although some of these deaths were unexpected (for example deaths from heart attacks), many could to some extent be anticipated, given the age, poor health and frailty of the people in prison concerned³². Therefore, there is a role for end of life care planning. People with a palliative diagnosis may be eligible to apply to be considered for early release on compassionate grounds if they wish to. A total of 7 people were released early on compassionate grounds in 2023 and 1 in 2022³³. Release on compassionate grounds is explored further in the chapter 6: palliative care and end of life in prisons.

The rate of self-inflicted deaths was highest for people in prison aged 60 to 69 (2.1 per 1,000 people in prison), followed by 40 to 49 and 50 to 59 age groups (both at 1.5 per 1,000 people in prison)³⁴. Overarching trends in self-inflicted deaths and strategies to prevent this are explored in chapter 10: self-harm and suicide in prison.

Dementia and cognitive impairment

A study that screened people in prison aged over 50 found 7% had mild cognitive impairment or suspected dementia³⁵, although the cause of cognitive impairment could not be determined

and other factors such as learning disabilities, severe depression, or hearing impairments could not be excluded. For example, traumatic brain injury can lead to cognitive, behavioural and emotional difficulties³⁶. One in 3 (33.5%) of older people in prison reported a past injury with loss of consciousness³⁷.

Research indicates that less than half of people that screened positive for mild cognitive impairment or suspected dementia had a diagnosis recorded in their prison healthcare notes. This suggests there is underdiagnosis and unmet need³⁸. It is hard to compare prison prevalence to the general population as routine screening and assessment do not occur but approximately 4% of the general population in England are diagnosed with dementia³⁹. Conditions resulting in dementia include Alzheimer's disease, Lewy body dementia and vascular dementia. Vascular dementia may well be more common in older people in prison due to higher rates of cardiovascular disease, hypertension and diabetes.

The impact of dementia in the prison population remains largely unexplained and unexplored. The limited research to date suggests that people with mild cognitive impairment or suspected dementia have difficulties with prison environment and regime, resulting from high staff turnover (which can exacerbate feelings of disorientation), limited staff knowledge and training on how to identify the symptoms of dementia⁴⁰. People with assessment rating scores suggestive of dementia should be referred to a specialist dementia diagnostic service, such as a memory clinic or community old age psychiatry service⁴¹.

Continence

There is limited research indicating the current prevalence of incontinence in people in prison in the UK. A 2010 survey of 100 males in prison aged 60 or over did not report any concerns over continence⁴². However, urinary incontinence symptoms may be underreported to healthcare professionals, despite frequent symptoms⁴³. Indeed, a recent review of hospital admissions in 2018 to 2019 in older adults in prison identified 62 admissions from 48 individuals in relation to urinary incontinence and 13 admissions in 11 individuals for faecal incontinence⁴⁴. Our engagement identified that sheets and towels are changed weekly, but for those with continence issues, they need to be changed more frequently. Urinary and/or faecal incontinence may significantly impact quality of life and is distressing and embarrassing for those in prison.

Sensory impairment

The prevalence of impaired vision in prison has been reported to range from 20% to 84%, while 31% of older people had impaired hearing (review of studies predominantly undertaken in North America)⁴⁵. In the UK, a sample of older people in prison identified that 1 in 10 used a hearing aid and 91% used glasses or contact lenses⁴⁶. Visual impairments, low vision aids and hearing aids most likely require NHS specialist assessment. Policy states that people in prison must retain access to essential disability aids, especially on transfer between prisons⁴⁷. However, independent monitoring reports from across prisons state instances where healthcare equipment including disability and mobility aids, such as wheelchairs, prosthetic limbs, hearing

aids, heart monitors, voice boxes and glasses are lost and often not replaced for prolonged periods⁴⁸.

Frailty

While individual conditions pose challenges, their combination is significantly more problematic⁴⁹. Frailty is characterised by loss of biological reserves, failure of physiological mechanisms with increased risk of adverse outcomes compared to others of the same age⁵⁰. Individuals who are frail often have multiple chronic conditions and a reduced life expectancy. They may exhibit symptoms such as fatigue, weight loss, decreased gait speed, diminished muscular strength, and low levels of physical activity⁵¹. Frailty can lead to adverse outcomes including falls, fractures, increased immobility, delirium, incontinence, medication side effects, hospital admissions and the need for long-term care⁵².

In the general population around 47% of hospital inpatients aged over 65 are affected by frailty. In prison, more than 40% of men over 50 who were admitted to hospital in an emergency showed signs of frailty⁵³. People in prison who were frail were found to be more likely to suffer from mobility problems, anxiety and depression, incontinence and dementia. Frailty is not an inevitable part of aging⁵⁴. Preventing frailty and improving understanding and knowledge of how to support people in prison with frailty is key.

Overall research on frailty in older people in prison using standardised scales is limited. Some studies identify specific frailty domains, but most do not explore the impact or challenges for the older person, healthcare, operational staff, or social care in prisons. One study of 203 people in prison identified that 9% of males aged 60 or over had some level of functional disability (assessed using Barthel Index, scored less than 20), mostly being unable to climb stairs, 2.5% also had difficulties such as washing independently⁵⁵. Similarly, a survey of people in prison aged over 55 identified 26% could not walk more than 100m, 18.9% could not manage stairs unaided and 30.7% had a fall in the last 2 years. This led to consequent feelings of insecurity and vulnerability⁵⁶.

Current challenges to caring for older people in prison

Gaps in our understanding

There is a significant lack of prevalence studies regarding age-related conditions and symptoms in prisons. Existing studies often have small sample sizes and employ varying assessment rating scales. There is also a lack of robust evidence describing the impact of these conditions, the needs of older people in prison and efficacy of interventions in this group, including in older women⁵⁷. Further research on age-related morbidity and frailty is essential to inform effective healthcare commissioning, social care commissioning and enhance knowledge within prisons and the wider health and care services.

Identification of needs

Older people in prison may underreport symptoms of diseases due to limited health literacy, embarrassment, or believing it is part of ageing and untreatable. Screening at reception is crucial for early identification of health issues and to ensure safety on first night. People coming into prison may be tired and anxious, particularly if it is their first time in custody, making disclosure of age-related conditions less likely. The standard reception screening instrument used during reception to prison includes a combined question about disabilities, personal care needs and social care arrangements. It does not include standardised questions related to specific age-related needs, such as frailty, memory or cognition. The screening questionnaire questions about personal care and social care needs are not routinely reported or used at a national level within HM Prison and Probation Service (HMPPS) or NHS England to plan operational and healthcare responses. For example, to plan a dementia friendly prison wing we need to be able to identify which prisons have a high proportion of individuals with dementia.

In the general population there are simple tools to triage older people on arrival at emergency departments, for example the Rockwood Frailty Score. A higher score indicates the need for a Comprehensive Geriatric Assessment⁵⁸. In prison these tools could be used to facilitate a systematic review of needs on the reception and second stage health screening.

Meeting healthcare needs

Recent research from Nuffield Trust shows that hospital admission rates for males in prison aged over 50 are lower than the general population of the same age⁵⁹. This indicates that older people in prison are admitted to hospital less frequently than expected, despite their higher health care needs. There are many possible reasons for this, including unrecognised or unmet need, lack of recognition of deteriorating medical condition⁶⁰, lack of availability of staff to provide an escort or potentially prison healthcare identifying health needs earlier or that prison might be a more supportive environment compared to living alone in the community. Research points to real difficulties for prisons and healthcare services working together to co-ordinate and escort people in prison to hospital appointments⁶¹. This could disproportionately impact older people with more health conditions. As the older prison population grows, more widespread application of digital solutions like telemedicine need urgent consideration. This is explored further in chapter 11.

Living environment

Prisons holding large numbers of young physically able people in prison may be noisy, confusing, and intimidating for older individuals, especially if it is their first time in custody. Older people imprisoned for the first time often suffer from 'entry shock', made worse by a lack of information and an unfamiliarity with prison regimes and expectations fearing their health and care will be ignored⁶².

Older people in prison may face greater risk of isolation. 16% of older people in prison felt there was nobody they could talk to if they had a problem and 20% rarely or never left their cell during association. Those convicted of sexual offences may have concerns about their safety

and potential reactions from other inmates. The nature of offending can distance them from family and friends, resulting in fewer or no visits impacting on health and wellbeing. Women face additional challenges due to the limited number of prisons, often far from home, making it hard to maintain family ties, especially with elderly parents and dependent children⁶³.

Current overcrowding contributes to additional challenges in this population. Sharing a cell may involve younger cellmates, bunk beds, in-cell sanitation or frequent nighttime toilet use, all contributing to embarrassment and loss of dignity. Reduced 'time out of cell' results in greater isolation and necessities more rapid use of shared toilet and bathing facilities. Showers can be hazardous for less able people in prison, often without doors, possibly with slippery floors, used by others at the same time which can be intimidating and may cause anxiety or embarrassment. These seemingly minor issues can contribute to a broader sense of helplessness, dehumanisation and isolation.

Case study: challenges with findings suitable placements

Mr A, age 85, was detained in a Category C training establishment. He was discovered in his cell unable to move, taken to local emergency department, diagnosed with cerebrovascular accident. Following admission to a stroke unit, he remained in hospital with 2 escorting officers 24 hours a day until he was assessed as suitable for discharge from acute care.

The prison environment was not able to accommodate his rehabilitation needs. He was assessed and required a care home placement. He remained in the care home in the community for 11 months with 24/7 officer supervision. Early release on temporary license and compassionate release were explored but unsuccessful.

Assessment by social care and extensive work by NHS England commenced to find suitable prison accommodation, across East Midlands and the whole prison estate. The HMPPS custodial manager attended the calls to review suitable placements. Eventually a placement was found in a prison in a new geographic area and has created difficulties in maintaining family ties.

People at risk of frailty and falls may find the prison environment challenging. Older buildings often have stairs and long corridors without seating. Not many prison estates have accessible rooms that can be adapted to suit mobility needs. While there is an absence of data, our engagement with stakeholders highlighted that this could result in individuals being unable to progress through the different types of prisons as their sentence passes.

Access to meaningful activities is crucial for the health and wellbeing of all people in prison, but especially older people in prison. However, for those that are unable to work or beyond working age, our engagement identified that this provision is often limited. This means that older people in prison may spend excessive time isolated in their cells with impacts on mental health and rehabilitation.

Lived experience: experiences of being older in prison

Quotes taken from Prison Reform Trust: Growing Old and Dying inside, 2024⁶⁴

“Shared cells are a major issue for the elderly who have health (mental and physical) issues. It is a cause of great anxiety, it affects health, anxiety and general attitude. I shared a cell with a prisoner who had incontinence. This caused him great anxiety because of the lack of privacy. I also had a period of time with a person who was diagnosed with dementia. I had trained to work with dementia patients but 24 hours a day really had an effect on me. (Male prisoner)”

“Generally everything is based on younger people, all courses, education, rehabilitation, work-based roles are aimed specifically for getting people into work and away from addictions. But for me, I won’t want to work and don’t have any addictions, although it is tempting to get some, in order to receive assistance. The system loves a broken person that they can fix, not an old person who needs care and treatment. (Female, life sentence aged 55 to 59)”

A national strategy for older prisoners has been proposed several times⁶⁵, most recently the Independent Sentencing Review recommended its development with input from stakeholders, such as Department for Health and Social Care⁶⁶.

Social needs

People in prison with social care needs may require assistance with tasks such as maintaining personal hygiene, using the toilet, managing and maintaining nutrition, ensuring safety in their cell, and moving around the prison. While social care needs are not restricted to older people in prison, they may be more common. Extensive review of social care provision in prisons is outside the scope of this chapter and report. There is national and local policy and guidance to support referral for social care in prisons, which is the responsibility of local authorities^{67 68 69}. The local authority will undertake a needs assessment and if the individual in prison has eligible needs work in partnership with prison, the individual and occasionally other professionals such as specialist social workers, occupational therapists or healthcare staff to develop a care and support plan. This plan will outline how the identified needs will be addressed and specify how the local authority will meet those eligible needs. HMPPS have a responsibility to apply Reasonable Adjustments in accordance with The Equality Act and with consideration to security, safety and risk. Aids and adaptations to support needs in prison, such as raised toilet seats, walking aids, ergonomic chairs, and hospital beds, can be offered as part of a social care plan or via a clinical pathway (such as the Memory Clinic).

Resettlement and release planning

On release there is an increased likelihood of health and mobility problems which increases anxieties and needs in relation to travel, safety, loss of possessions, support networks and

continuity of healthcare⁷⁰. Appropriate housing that is accessible and safe is vital⁷¹. A significant number will be entering retirement rather than seeking employment, which has financial implications. There is no national bespoke resettlement programme which aims to prepare older people in prison for more positive release. The organisation 'Resettlement and care for older ex-offenders and prisoners' (RECOOP)⁷² are currently piloting the delivery of their resettlement programme in partnership with Greater Manchester probation at 5 of its wellbeing hubs. This is important when considering underdiagnosis of dementia or cognitive impairment or frailty and falls risk. Challenges with identifying suitable supported or assisted housing and care homes that impact the general population are also relevant for older people leaving prison. Resettlement planning can be hampered by the need for suitable accommodation. Sometimes this can mean that individuals are moved to where they can be accommodated, which may not be near their support network.

Lived experience: challenges with resettlement and release planning for older people in prison

Quotes directly taken from Prison Reform Trust: Growing Old and Dying inside, 2024⁷³.

"I am already feeling the effects on my physical health and who knows what damage has been done to me mentally, poverty already covered... but I have no home, no pension and no employment hopes (I will be retired upon release) and isolation. My circle of friends on the outside is now virtually non-existent, there is a possibility that the few left might be in 'homes' or even dead because they are older than me. But that is made on the assumption that I will even leave prison alive! A very sobering thought, isn't it?
(Female aged 55 to 59)"

Opportunities to meet the needs of older people in prison

Identification of needs

In 2008 the Department of Health recommended that assessments to identify the health and social care needs in prison should automatically begin at 60 years of age and be repeated, as a minimum, at 6 monthly intervals⁷⁴. Currently there is no routine standardised tool to facilitate this assessment. Assessment rating scales assist the management and monitoring older people with multiple morbidities and frailty through assessment of medical conditions, mental health, functional capabilities and social needs⁷⁵.

A standardised healthcare reception screening questionnaire specific for older people in prison is required to swiftly identify age related issues, such as poor mobility, sensory and possible cognitive impairment. Such information is essential for informing wing staff of additional difficulties an older prisoner may face. There are local instances where a Comprehensive Geriatric Assessment (CGA) has been implemented. For example, Oxleas NHS Trust has developed frailty clinics and similar initiatives have been introduced in 2 prisons in the South

West to assist with service planning. Additionally, HMP Wandsworth has established an over-50s clinic. However, implementation of standardised rating scales across all prisons is essential to inform service planning, track trends and ensure more consistent provision between prisons. Box 1 in the appendix indicates the range and nature of assessment rating scales for older people. Expert guidance is necessary to establish a systematic evidence-based process for evaluating health and frailty in older people in prison.

Recent research assessed a tool designed to assess and review the health needs of older adults in prison, create care plans and action referrals (the Older Prisoner Health and Social Care Assessment and Plan), patients and staff found the tool to be acceptable and feasible⁷⁶. However, its use did not reduce the number of unmet health and social care needs. In part this was attributed to failure to implement the tool as planned due to levels of staffing, loss of support roles and disruptions in the daily regime^{77,78}. This highlights the importance of prison health gaining operational support for new prison wide initiatives and testing to ensure they are operationally viable.

Practice example: West Midlands developmental advanced clinical practitioner role

In the West Midlands prisons, a developmental advanced clinical practitioner role has been developed to oversee the care of frail people in prison and prevent and manage long-term conditions, working across a number of prisons⁷⁹.

The role includes:

- assessing needs and identifying frailty and developing personalised care plans.
- addressing emotional wellbeing and social isolation and supporting independence
- collaborating with the multidisciplinary team to make referrals for example to physiotherapists, occupational therapists, social prescribers and safer custody teams.

Meeting healthcare needs

Providing care for older adults with complex conditions requires a multidisciplinary approach, which includes prison operational staff, NHS specialists and local authority social services. Referrals to geriatricians, old age psychiatrists and specialist nurses are essential for diagnosing, assessing and managing complex health conditions, increasing frailty, or cognitive impairment. Prison healthcare should directly refer patients to specialist clinics, particularly for the evaluation and management of cognitive impairment and incontinence.

Specialist nurses assess and manage conditions such as incontinence, tissue viability (assessment, prevention and management of wounds) and diabetes, as well as advising older people in prison, and healthcare and operational staff. Healthcare providers should ensure people in prison receive pads or continence aids only after a healthcare assessment, which

may result in a referral to a urodynamic clinic or specialist nurse for evaluation and management advice⁸⁰.

Meeting needs of daily living

Prison healthcare must work closely with prison governors and staff to help older people with their life in prison. Prison officers monitor people in prison and are well placed to observe when difficulties arise. They may identify issues that individuals may not notice or find too embarrassing to mention. However, they may have limited experience or understanding of conditions associated with ageing such as dementia, frailty and falls. In prisons with a high proportion of older people it may be appropriate to offer training and support for prison staff taking these roles, supported by healthcare professionals and local authorities, this is already being achieved in some prisons. Sharing essential medical information with operational staff is essential where this may impact on the physical and sociological needs of people on the residential wings. This will assist operational staff recognise acute or more gradual health deterioration. For example, prison healthcare staff should advise on the requirement for a single cell and advise wing staff that this is required on medical grounds. Availability of extra bedding is often essential so sheets can be changed more frequently. Laundry bags for bedding and continence pads would avoid embarrassment.

Some prisons have good examples of dedicated provision for age-related concerns. However, movement to a dedicated place should consider individual preferences, especially those on long sentences with established relationships and routines. It is therefore vital that there is adequate accessible provision across the entire prison estate. The use of standardised assessment rating scale will allow more effective planning and location of dementia friendly and complex needs wings.

Informal support through ‘buddy schemes’⁸¹ can be particularly beneficial in the early days of custody, ensuring that older people in prison become familiar with prison life such as ordering from the canteen. Informal support may also be appropriate for tasks such as cleaning cells or carrying food trays. However, people in prison who formally assist other people in prison must be chosen carefully, evaluated for risk, trained, supported and supervised and existing policy supports this. Those aiding other people in prison and those receiving assistance must be made aware of safeguarding policies and how to raise concerns if they witness or experience instances of abuse or neglect⁸². Fellow people in prison cannot provide intimate care or administer medication to other people in prison. A range of programmes are available, for example through a programme such as RECOOP. Peer programmes are associated with a range of benefits to wider society, prison, staff, buddies and recipients but there is a lack of data to independently evaluate impact⁸³.

There is a requirement for suitable activities which promote positive health, including socialisation and slower paced exercise. Between 2022 and 2024, over 5% of physical education (PE) instructors across 26 prisons were trained in chair-based exercise. An online catalogue of training options is expected to be launched to governors in 2026. Some prisons engaged for this report had good examples of this with programmes, led by prison PE departments and third

sector providers, in safe spaces that allowed older adults to meet from across the prison. However, access to this is variable.

Practice example: buddy scheme

RECOOP is a charitable organisation that has been pioneering new and effective ways to support older people in prison. Their buddy support worker training programme trains people in prison to deliver health and social care support to fellow prisoners. The programme was developed for prisons by adapting National Care Certificate standards. RECOOP is currently delivering this programme in prisons across Devon (HMP Channings Wood and HMP Exeter) and the North West (HMP Wymott, HMP Preston and HMP Kirkham)⁸⁴.

Evaluation of RECOOP buddy support from 27 participants in North West prisons in February 2025, by Professor Helen Codd, RECOOP⁸⁵, identified that:

- 60% agreed or agreed strongly that they had been able to 'get out of their cell more' since they had a buddy.
- over 90% described their buddy as helping them manage their healthcare needs at least some over the time, a quarter saying that their buddy helped them manage their healthcare needs all the time.
- over 90% said their buddy gave them the support they need, that they were reliable and that they trusted them.
- nearly all agreed or agreed strongly with the statement that their 'daily life has improved since their buddy started working with them, and the other 2 neither agreed nor disagreed.

Conclusions

The prison population of older individuals has increased over the past 20 years. The available research suggests that older people in prison are less healthy than their community peers, with evidence that physical and mental illness is often undiagnosed or untreated. The increase in the older prisoner population is likely to lead to a higher number of people in prison experiencing frailty requiring a multidisciplinary approach for assessment, management and care. There is currently no universally used tool tailored to identify the physical and mental health needs of older people in prison and therefore an absence of data with which to inform both health service provision and operational planning. The limited research on the health and social care needs, especially for older women in prison creates difficulties planning and provision of gender-specific health care, prison accommodation, and services. Joint working between governors, operational staff, local authorities, social care providers and prison healthcare is essential to maximise the health and wellbeing of older people in prison in their care.

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6 Palliative and end of life care in prisons

Authors: Dr Annelise Matthews, Maria O’Neil

Introduction

Death and dying are inevitable. Being able to live as well as possible until we die is something that we all value. The needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes. Personalised care in the last years and months of life will result in a better experience, tailored around what really matters to the person, and more sustainable health and care services¹.

Palliative care is defined by the World Health Organization as an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-limiting illness, usually progressive. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems whether physical, psychosocial or spiritual².

In England, the term ‘end of life care’ refers to the last year of life. As the prison population grows and ages, natural death (from naturally occurring disease processes) in prison, historically a rare event, is becoming more frequent. Dying well wherever you are and whatever your background or circumstances are fundamental aspects of human dignity. As part of a compassionate humane society, we need to do everything we can to make sure that people who are facing their last months, weeks and days of life receive the best possible palliative and end of life care. Those who care for them, including their families, others important to them and staff around them, equally deserve this consideration and support³.

This chapter is authored by a palliative care consultant and palliative clinical nurse specialist working in prisons and, unless referenced, includes case studies and reflections based on their current clinical practice.

Palliative and end of life care in prisons

Palliative and end of life care is an increasing area of need within prisons. The older populations in prison are the fastest growing⁴. These population changes, the health needs of older people in prison and challenges and opportunities to providing care are described in chapter 5. With a greater number of people in prison aged over 60, there has been a resulting increase in deaths from naturally occurring diseases. In the 12 months up to December 2024 there were 192 deaths in prison categorised as due to natural causes across England and Wales⁵. The average age of people in prison who died from natural death in 2019 to 2020 was 63.8 years old, yet 2 in every 3 had at least mild frailty and most had long-term conditions (87.8%)⁶.

Prison is a unique environment in which to carry out end of life care. In recent years there have been multiple reports recommending improvements to palliative and end of life care in prisons^{7 8 9 10 11 12}. In addition, all deaths in custody are reviewed by the Prison and Probation Ombudsman (PPO) with individual reports and thematic documents on end of life in prisons with recommendations. It is noticeable that despite the quantity of recent reports on palliative and end of life care in prisons, all making very similar recommendations, little change of practice is documented, although every report makes note of individual examples of good practice. The nature of these reports and recommendations has been that action is voluntary and not necessarily supported by commissioning by health and social care or change in policy of the prison or parole service.

In 2018 the unique challenges of providing equality in end of life care in prisons was recognised and the dying well in custody charter and self-assessment tool produced, which was updated in 2024 and republished jointly by NHS England and HM Prison and Probation Service (HMPPS)¹³. However, the charter was not nationally adopted by the prison service and remains for local implementation in individual prisons.

Quality in end of life care for adults has been defined by the National Institute for Health and Care Excellence (NICE) in Quality Standard 13 in 2021 with 5 quality statements¹⁴. This chapter uses the NICE Quality Statements for end of life care to demonstrate issues in end of life and palliative care in prisons and make recommendations for change.

NICE Quality Statements for end of life care for adults

Statement 1 – Adults who are likely to be approaching the end of their life are identified using a systematic approach. (2011, updated in 2021)

Statement 2 – Adults approaching the end of their life have opportunities to discuss advance care planning. (new in 2021)

Statement 3 – Adults approaching the end of their life receive care that is co-ordinated between health and social care practitioners within and across different services and organisations. (2011, updated in 2021)

Statement 4 – Adults approaching the end of their life and their carers have access to support 24 hours a day, 7 days a week. (2011, updated in 2021)

Statement 5 – Carers providing end of life care to people at home are supported to access local services that can provide assistance. (new in 2021)

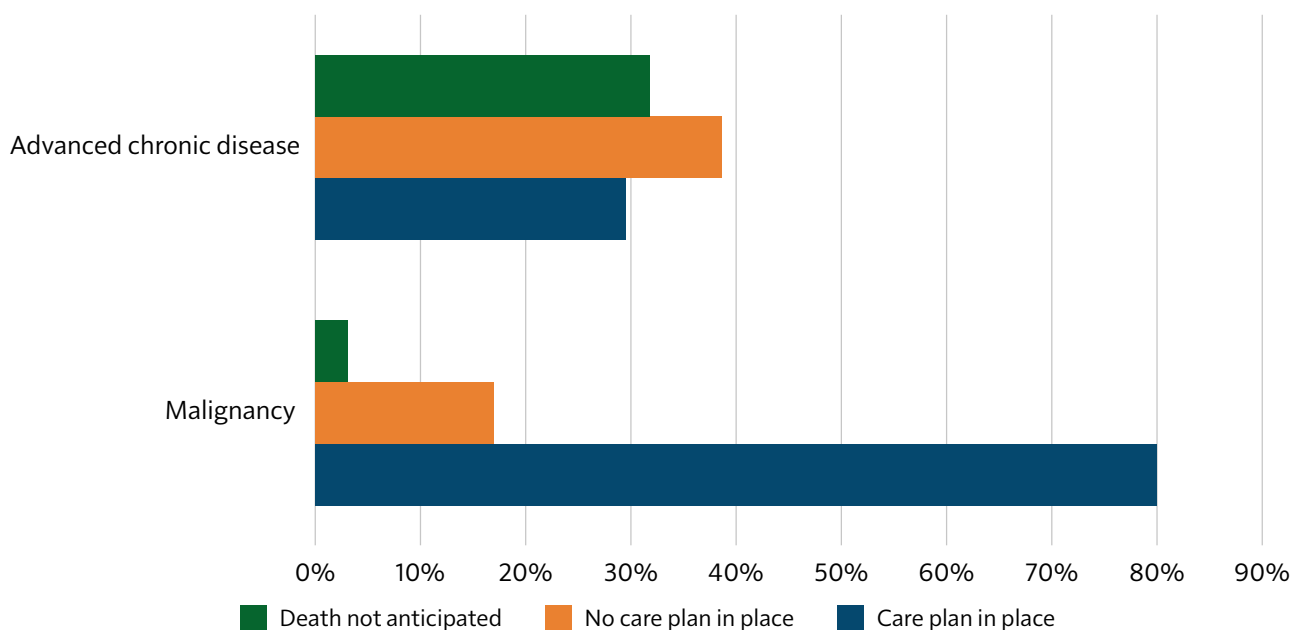
Systematic identification of end of life

Case study: late recognition of palliative care diagnosis

A 67-year-old is diagnosed with chronic obstructive pulmonary disease (COPD), heart failure, type 2 diabetes and hypertension. He has had increasingly frequent admissions to hospital with 4 admissions in the last 6 months, with exacerbations of COPD and heart failure. He has a supportive family who visit often. He and his family are unaware how unwell he is and he is hoping to survive to his release date in 4 years' time. On his last admission he is critically unwell and dies. He has not had the opportunity to talk to his family, who are shocked when told of his death by the family liaison officer.

The national confidential enquiry into patient outcome and death (NCEPOD) report, Inside Healthcare, reviewed all deaths in prison between 2018 and 2020. This showed that 44% of natural deaths had been identified as palliative or end of life and had a care plan created. However, an additional 23.5% of patients could have been identified as palliative and were not¹⁵. Patients with cancer (malignancy) were more likely to be identified as end of life and have a care plan in place compared to individuals with advanced chronic diseases such as heart failure (figure 1). This is likely due to cancer patients being most easily identified as palliative as this is clear in the oncology treatment plan. For long-term conditions, patients' prognosis can be harder to estimate as they may live with frailty for long periods of time. Tools have been developed to aid with identification of palliative, end of life and frailty needs and there is growing evidence to support use in the community^{16 17 18}.

Figure 1: proportion of people with palliative and/or end of life care plans in place for malignancy and other advanced chronic conditions in 2019 and 2020



Source: National confidential enquiry into patient outcome and death (NCEPOD), 2024, Inside Healthcare¹⁹

Practice example: Supportive and Palliative Care Indicators Tool

The Supportive and Palliative Care Indicators Tool (SPICT-4ALL²⁰) is a clinical tool used to help identify adults with deteriorating health due to serious health conditions affecting their physical or mental health, family or social situation, and personal or spiritual wellbeing. This allows a holistic assessment of palliative care needs and future care planning to help them live as well as possible.

The tool has been adapted for use in prisons as SPICT-4ALL in Prisons. It is specifically designed to be used by healthcare professionals who are not familiar with specialist palliative care to identify patients at risk.

Integrating use of tools such as SPICT-4ALL in Prisons into processes such as long-term condition clinics, multidisciplinary teams and handover of patients of concern may aid identification of palliative, end of life and frailty needs in patients.

Opportunities to discuss advance care planning

Advance care planning is a voluntary process of discussion about future care between an individual and their care providers, irrespective of clinical discipline. An advance care planning discussion might include:

- the individual's concerns and wishes
- their important values or personal goals for care
- their understanding about their illness and prognosis
- their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these

Case study: advance care planning

This case study is from national enquiry into patient outcome and death, Inside Healthcare 2024²¹. An older person in prison had several admissions to hospital in the 6 months prior to death with advanced heart failure and deterioration of chronic kidney disease. In the last month of life, they were largely bedbound. An advance care plan was not discussed and an escalation of treatment decision was not made or a decision regarding future resuscitation. They were admitted to hospital as an emergency for the last 48 hours of their life.

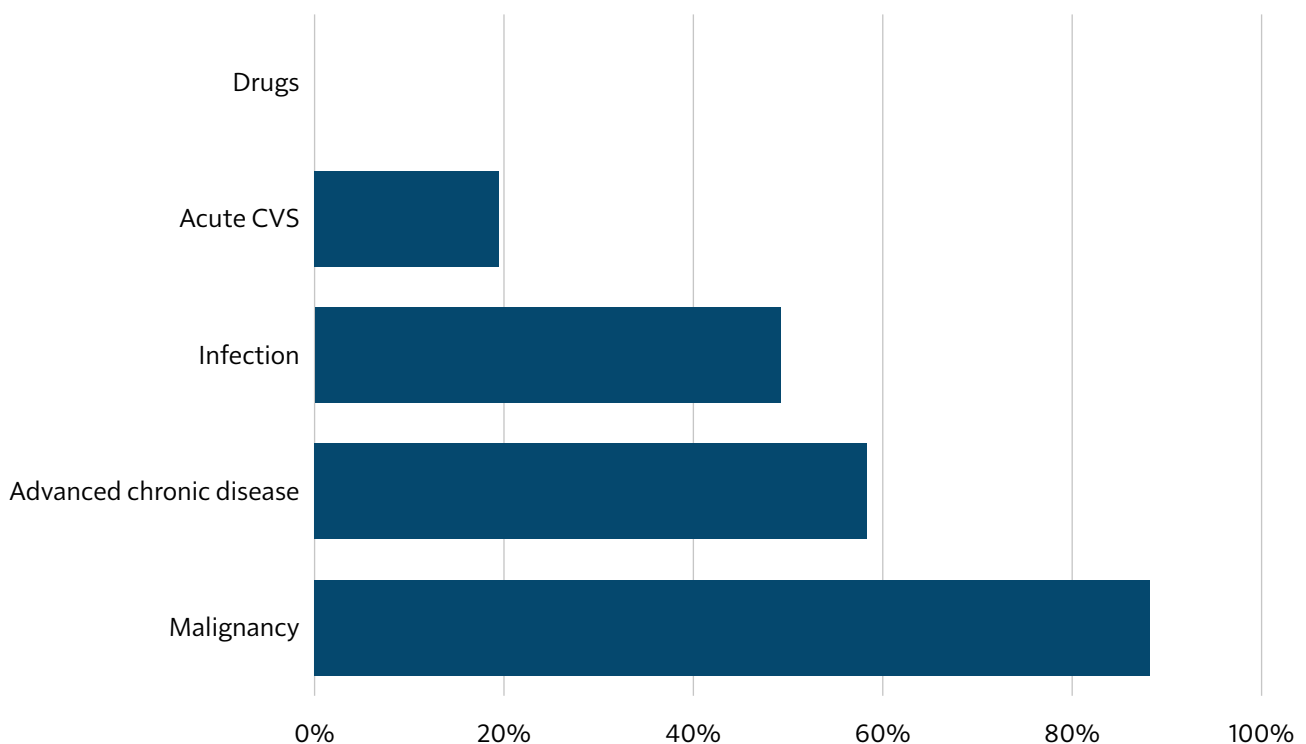
Case study: advance care planning

This case study is from Hospice UK 'Dying behind bars 2021'²². Following a patient's terminal cancer diagnosis, prison staff managed to arrange transfer to a specialist palliative care suite in another prison. The patient refused, as he wanted to stay in a prison with which he was familiar. Prison staff respected this, creating a care plan to enable him to stay. This included enlisting support from a rapid response team from Marie Curie in case the patient required medical attention outside of healthcare hours, the prescription of anticipatory medicines to manage end of life care and a social care assessment to support his increased care needs.

As the patient's illness progressed, a specialist nurse practitioner from the hospice assessed his needs and together they completed an advance care plan in which a Do Not Attempt Cardiopulmonary Resuscitation Order was put in place. The patient said that his preferred place of care was the prison or a hospice and that his preferred place of death was a hospice. His wishes were respected and 2 months later, the patient spent his final days in the hospice.

A review of deaths in prison in 2019 and 2020 identified that individuals with malignancy were more likely to have an advance care plan with a documented decision about resuscitation than individuals with other causes of death (figure 2).

Figure 2: proportion of people in prison with an advance decision about resuscitation and cause of death, review of natural deaths in prison in 2019 and 2020



Source: National confidential enquiry into patient outcome and death (NCEPOD), 2024, Inside Healthcare²³

Advance care planning in prisons brings additional challenges. Due to detention, it may not be possible to meet individual preferences such as dying at home with their family. Anecdotally, people in prison often see prison as their home and their fellow prisoners as their family and wish to die in their prison 'home'. Any developments such as providing prison end of life care by moving individuals to hospital, hospice or other prisons for end of life should be carefully considered with early, open and honest conversations about achievable care, which can help avoid unplanned emergencies and distress.

End of life in prison is also unique in the separation of patients from their families.

During end of life care many prisons offer enhanced arrangements, including extended visits, access to dedicated family spaces and in some cases, in cell or overnight visits. Despite these developments, the perspective of these families and their support needs is largely unstudied²⁴.

Compassionate release

Compassionate release is a process by which people in prison may be eligible for early release on the grounds of health or social care needs, where the person is incapacitated or has health conditions such that the experience of imprisonment causes suffering greater than the deprivation of liberty intended²⁵. However, compassionate release for people in prison with a life-limiting diagnosis is extremely rare, with a total of 7 people released early on compassionate grounds in 2023 and 109 people between 2013 and 2023²⁶.

Application for compassionate release is most effective when the people in prison are identified as a palliative patient as early as possible to enable assessments to be completed. In their review of natural deaths investigated by the PPO, Hospice UK identified that there was no consideration or delayed consideration of compassionate release in 15 out of 95 cases²⁷.

Some people in prison do not wish to apply for compassionate release. The length of their sentences and the nature of their offences may mean they have no supportive network outside prison and as a result all their significant relationships are with other prisoners and prison staff. Current policy states that applications for compassionate release should be made even in the case where the person wishes to stay in prison, if it is believed to be in best interests²⁸. This can lead to prison and healthcare staff feeling pressured to apply in the belief that it could attract criticism by either the PPO or coroner. The application process is lengthy and involves not only an assessment of the health of the applicant, but a risk management plan including their offence, the victim perspective, their behaviour in prison and their family²⁹. HMPPS identified that barriers to a successful application include the lack of suitable accommodation to manage risk or refusal of community accommodation for people in prison. This means that while people present a lower risk of physical offending, they are often assessed as higher risk for compassionate release due to the inability to mitigate risks, for example for people with sex offences you may not be able to prevent access to children in a care home. Information that was known about at the time of sentencing cannot be used as grounds for compassionate release, meaning that the number of historic offenders entering custody with known health conditions would not meet the criteria if the presentation hasn't changed.

Clear guidance is needed on how long the compassionate release process takes to complete assessments and indication of the likelihood of a successful application in order for health and prison staff to have informed and ethical conversations with prisoners and their families about making an application. Guidance on completion of applications is also required.

Care that is co-ordinated within and across different services and organisations

NICE states that adults approaching the end of their life should receive care that is co-ordinated between health and social care practitioners within and across different services and organisations. Outside of prison, end of life care is a multidisciplinary, multi-organisational process typically involving patients, their family and friends, GPs, district nurses, hospital teams, physiotherapy, occupational therapy and social care, as well as specialist palliative care teams. In prison there is further involvement of the prison service, probation and potentially parole boards.

Security requirements of prison pose specific challenges to delivery of palliative and end of life care. Prison regimes involve periods where individuals are locked up in their cells. When a prisoner is in the last days of life, local arrangements and specific authorisation is required to ensure they do not die behind a locked cell door. The PPO has repeatedly made recommendations about the use of restraints during hospital visits for severely unwell patients from prison³⁰. A clear policy framework is in place requiring an individual risk assessment that considers the current medical condition and their escape risk. Healthcare staff must be involved in the risk assessment process to ensure decisions are clinically informed and proportionate³¹.

Practice example: use of restraints

This example is taken from Prisons and Probation Ombudsman, Policy into practice, 2022³².

In February 2020, an individual in Category C noted as a wheelchair user with severe lung disease and relying on oxygen to help him breathe, was restrained by a chain to an escort. The PPO raised concerns that all staff involved in the risk assessments, including healthcare, appeared to be under the impression that people in prison with poor health and/or mobility issues should be restrained using an escort chain. In this case there was no evidence of any consideration to not use restraints given his condition.

Practice example: joint working

At HMP Littlehey the security governor and healthcare team have worked together to create a shared document of people in prison with healthcare recommendations for no restraints. This includes information on whether individuals have a terminal diagnosis, their clinical frailty score, any cognitive impairment, risk of falls and any high risk to pressure ulcers from use of restraints.

The prison estate is ageing and generally not designed for the needs of elderly or disabled individuals, this is explored in chapter 5. While there is existing policy and operational guidance to ensure that essential resources for end of life care, such as hospital beds, additional pillows and portable oxygen are provided where required, in some cases it can be challenging to arrange this.

Coordinating care for individuals due for release during their end of life period can be complex, particularly where housing is unstable or the person is without a fixed address. Some accommodation options, such as approved premises, may not be suitable for people at the end of life who generally have complex health and social care needs. Additional co-ordination between services including community offender managers, local authorities and health and social care teams is required to ensure continuity of care and access to appropriate accommodation and support packages prior to release. There are existing policy frameworks to support this joint working, but it can take considerable time.

Case studies: planning for release

A 78-year-old man was approaching his release date. He had metastatic cancer and a prognosis of only a few weeks after his release date. In prison he had carers 4 times a day funded by NHS Continuing Care. Multiple multi-agency public protection arrangements (MAPPA) meetings were held to secure him care home accommodation on release. Initial difficulties were finding which integrated care board (ICB) was responsible for his funding on release as his sentence was very long, so it was many years since he had been registered with a community GP. Once the ICB was identified they had significant difficulties identifying a care home which would agree to accept a sex offender. One care home agreed only on the condition that 1 to 1 care was funded for him. Eventually a care home was found but only after having his release date postponed to allow further searches.

An 84-year-old man with severe dementia was going through the parole process. Both the healthcare team and probation team agreed he would require a care home with nursing on release as he was fully dependent on others for all activities of daily living. The Parole Board required a known address in order to approve his release. However social services, who are funding his care, require a release date in order to start commissioning a care home. A year later, he remains in prison.

Prisons where end of life or frailty are rare events may not have day-to-day contact with local social services or community healthcare provision. This can lead to delays or lack of provision of equipment and care.

Local community specialist palliative care teams generally do not see every end of life patient but only those with complex symptoms, as district nurses and GPs are highly experienced in end of life care. However, in prisons where populations are typically younger, support for end of life is less frequently required and healthcare teams may not be confident to manage an expected death. Early liaison between healthcare and specialist palliative care teams before a patient need is identified can help overcome boundaries. Early identification of people in prison

at risk of natural death also helps identify potential problems in advance. The dying well in custody charter states that each prison should have a palliative end of life register to identify individuals, and enable care, support and holistic needs to be met, with individuals involved in planning their care³³. Engagement identified this was a beneficial tool to facilitate joint working where in place.

Case study: involvement of community specialist palliative care teams

An 84-year-old man arrived in prison with a long prior history of self-neglect and frailty. On arrival it became clear he was suffering from dementia. Shortly after, he fractured his femur and required nursing in bed. The prison was able to accommodate him as they had a 24 hour healthcare facility, but it was a difficult environment for end of life as the other patients all had complex and severe mental health needs. He was referred to the local community palliative care team. They were able to assist the prison with an application for Continuing Healthcare Fast Track funding, symptom control and provision of pre-emptive medication, delivery of long-term oxygen and creation of a personalised care plan to avoid admission to hospital.

There can be multiple barriers to accessing medication for end of life in prison. These include ability for people in prison to self-administer opioid pain relief in possession, access at times healthcare is closed and diversion of often prescribed end of life medications such as opioids, benzodiazepines and gabapentinoids which are highly tradeable and valuable commodities in the prison environment³⁴. These barriers require a multidisciplinary approach involving primary care, pharmacy, prison security governors, prison senior managers and residential staff and local palliative care teams. Each solution will vary according to the needs of the individual person and the local provision of primary care and prison regime. Potential prescribing solutions are presented in the appendix.

Access to support

NICE recommends that adults approaching the end of their life, and their carers should have access to support 24 hours a day, 7 days a week. The needs of frail and palliative care patients can change rapidly, including overnight. Outside of prison, it is taken for granted that a person can self-medicate with their own medication, call directly for advice from NHS 111 or ring for a district nurse, or call an ambulance. If they are frail and need help with their activities of daily living, this can be provided by family and friends, or by a care package. If necessary, they can be admitted to a care home. While many of these can be facilitated in prison, they are all significantly more complex.

Pre-emptive prescribing of subcutaneous (superficial injection under the skin) medications for pain, breathlessness, nausea, secretions and agitation is a core practice of end of life care. In the community these medications would be available in the home, to be administered by district nurses if required. A typical care package at end of life in the community would consist of 4

visits a day and none overnight, even with NHS funded Continuing Healthcare. Ability to call for help overnight can be provided by friends and family and technology.

Prisons are often concerned as to whether they can meet the needs of an end of life patient due to the absence of nursing staff overnight. A care package in prison can include social services providing 4 visits and regular visual checks by a prison officer with an open-door policy. Research and clinical experience have identified that approximately 2 out of 3 patients in the community or prison require a subcutaneous medication at end of life, only a small proportion would benefit from a syringe driver for more regular administration³⁵. Most deaths in prison will need general medical care rather than specialist palliative care. Most will have less complex medical needs than those usually known to a specialist palliative care team in the community: it is the prison setting which adds complexity to their care.

Although every prison provides primary healthcare, in-patient 24 hour healthcare facilities are predominantly within reception and high security prisons. In some prisons, specialist accommodation is available to support people with complex health and social care needs, staff are trained to escalate care appropriately and demonstrate compassionate and responsive care. In other establishments, healthcare is provided on a primary care model with no on-site nursing or medical staff commissioned overnight and no specialist accommodation. This means that prison officers are required to call the commissioned 111 or 999 service, as it would be in a person's home outside of prison. Training of prison officers understandably does not focus on supporting patients with frailty, disability or at the end of life. Many prison officers are young and may have no prior experience of death and dying in their own lives. People in prison may not trust either the officers, or prison healthcare, seeing them as representatives of the prison regime rather than being concerned for their best interests³⁶. Ensuring officers know where to call for help overnight is an essential part of planning end of life in prisons.

Case studies: medication needs at end of life

An individual with advanced cancer was admitted to hospital from prison. On planning for discharge, it was clear he needed access to opioid pain relief on an as required basis 24 hours 7 days a week. This was discussed with prison healthcare who explained that this was not done at their prison (Category B) due to the local security risk assessment. In order for him to receive the care he needed he was transferred to a neighbouring prison with a 24-hour in-patient facility. This resulted in him losing touch with the friends who had supported him for his last 10 years in prison.

An elderly individual with severe frailty was admitted to hospital from prison with a urinary tract infection. Following successful treatment, his care needs were assessed before his return to the prison. He returned to a cell adapted to meet the needs of people with a disability, with a hospital bed and 4 times a day care package from social services. The cell was located on the wing he had lived the last few years and he could be visited by his friends. Although the prison did not have 24-hour healthcare, assessment was made before his return to prison that he did not have care, or medication needs overnight so he could return safely. He did require opioid medication for pain and this was kept in a locked location on the wing. A flow chart was created for officers to use should he become unwell overnight, and information kept on the wing to provide to paramedics, so they were aware that he was receiving end of life care. He died peacefully on the wing in the presence of his best friend.

Support for carers

NICE recommends that carers providing end of life care to people at home should be supported to access local services that can provide assistance. Family members of people in prison are separated from their loved ones and may be unable to provide the care in person they might wish. Significant care is provided by people in prison themselves, particularly in the role of prison ‘buddies’, helping frail people in prison with laundry, meals, cleaning and other tasks.

Prisons and health and social care providers should be aware of the impact of expected death and end of life care in the prison, especially on officers, prison buddies and other people in prison on the same wing. Existing policies outline structured support through chaplaincy, employee assistance programmes and family liaison officers. It is considered good practice to appoint family liaison officers at the point a person is identified to need palliative care.

Lived experience: support for carers at the end of life

This panel is taken directly from a paper by Turner et al³⁷.

In the community, carers providing end of life care to people at home are supported to access local services that can provide assistance and support. Palliative and end of life care in prisons is unique in that the majority of support is provided, not by friends or family or professionals in health and social care but by other people in prison and prison officers. This can have a significant impact on staff and other people in prison³⁸:

“I don’t think that the staff don’t care because, to be honest with you, I think the staff do care, a lot of them do care about you, but I think it’s just there’s no... there’s no system in place for anybody who is in real bad pain.” (Person in prison)

“I think people probably do come into the Prison Service and don’t expect to face end of life situations... particularly with older people. I don’t think they’ve got any idea that we have such an elderly community in prison”. (Governor)

Practice example: training and family liaison

Officers working on the 2 older people's wings regularly experience people that are frail, unwell and at the end of life in prison. The palliative care clinical nurse specialist developed training for all new officers working on the wings, including written materials to explain care provided at end of life, what dying looks like, out of hours action plans for any people in prison on palliative care who wish to die on the wing.

Even if not present in person, the families of people in prison can often remain their carers. While prisons appoint a family liaison officer (FLO) at the point of death, it is not routine practice for them to be appointed prior to death. At HMP Norwich, HMP Whitemoor and HMP Littlehey it is now policy for a FLO to be appointed when a person in prison is identified as being at risk of expected death. This allows the individual person in prison to develop a relationship with the FLO for support, families to build a relationship of trust with the FLO and to be kept accurately informed of any changes in their loved one's health.

Summary

In summary, expected natural deaths are becoming more common in prisons both in the UK and globally due to longer life expectancy and longer sentences. Multiple reports have made for end of life care for people in prison in the UK and identified examples of both excellent and inconsistent practice. The dying well in custody charter and self-assessment toolkit provides a framework for implementation of all the quality standards for end of life care, bespoke to a prison environment. However, its implementation has been patchy and often dependent on the presence of committed individual staff members from both the prison service and healthcare. Some prisons demonstrate that compassionate, personalised end of life care in prisons is achievable.

Additional recommendation

Prison policy on appointing family liaison officers should be reviewed to consider early appointment for frail or end of life prisoners, to improve support and communication for them and their families (HMPPS).

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7 Data and information sharing for health in the criminal justice system

Authors: Jake Hard, Donna Gipson, Angelique Whitfield

Contributors: Jonathan Bickford, Steve Willner

Background

There are 2 overarching issues which will be considered in this chapter and which have relevance within the wider report: personal data for individual care and aggregate data for surveillance and research. Together these types of data are essential for safe, high-quality care and research and planning of health services. This chapter describes the current extent to which data is available and shared, implications of this and what needs to change. Ultimately, there are substantial challenges which are unique to this setting and are not equitable with the community.

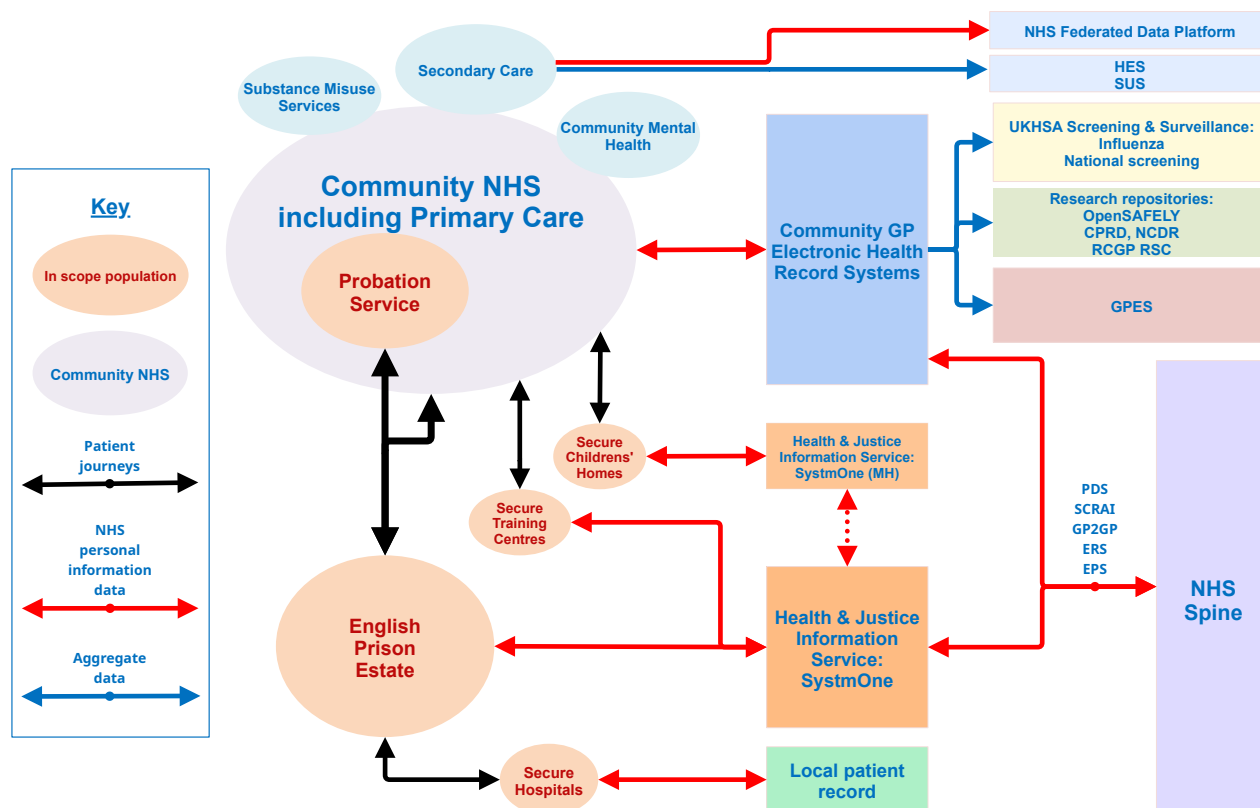
Personal data for individual care is information that relates back to an identifiable individual, either directly such as by their name or NHS number, or indirectly, through combining multiple pieces of information. Personal data may be shared for individual care and treatment, for example between a GP in the community and a hospital providing secondary care¹.

Aggregate data for surveillance and research is information that is collected from multiple sources or individuals and compiled into a data summary. Aggregate data can be used for research and planning, such as identifying what care and treatment a group of patients may need and planning the services to deliver those treatments. Where aggregate data consists of compiled personal data and individuals cannot be identified (either directly or indirectly), then it is not considered personal data in law².

The journey of an individual through the criminal justice system can be complex and will include areas such as police and court custody which are outside the main focus of this report. This chapter will consider people in contact with prison healthcare services, people who are being supervised by the probation service in the community (including but not limited to following release from prison) and some consideration for people who are detained within the NHS secure hospital estate in England.

The criminal justice landscape is a complex system of numerous geographical, commercial and legal boundaries and responsibilities. There are many IT systems which sit across multiple government departments and organisations (including the: Department of Health and Social Care (DHSC), Ministry of Justice (MoJ), Home Office, NHS England, individual NHS providers and UK Health Security Agency (UKHSA)) and many of these systems cannot talk to one another. This is demonstrated in figure 1.

Figure 1: patient journeys and information flows with movement of a person into, within and out of the justice system



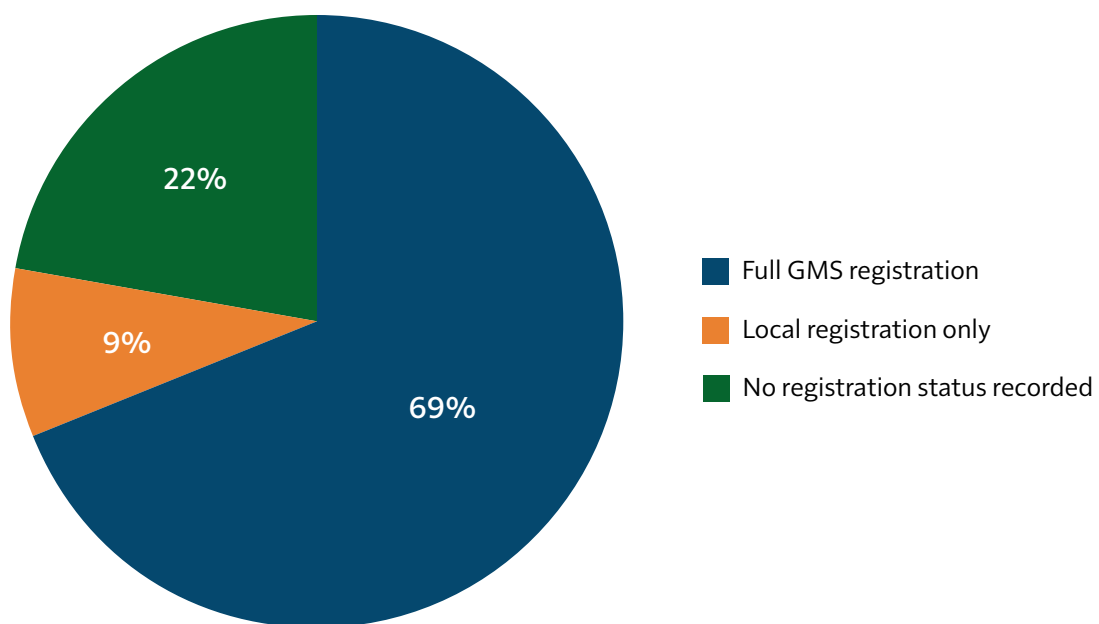
There are several factors which have contributed to the complex landscape relating to data and information-sharing for health purposes in the criminal justice system. The responsibility for the commissioning of health services in prisons was transferred from the Home Office to the Department of Health in 2003. This move led to a wholesale shift and subsequent improvement in some elements of the standard of care provision for people in prison by ensuring the care was more in line with the wider community. As a result of the Health and Social Care Act (2012) prison healthcare services then became the responsibility of NHS England. This has led to several distinct differences and disadvantages when considering the movement and availability of health data. If left unresolved this will present a significant barrier to further integration of health data limiting care, health surveillance and research opportunities. Below, we describe the current system and ongoing challenges, highlight how some of these barriers could be overcome to provide a better understanding of health needs, reduce variation and improve health outcomes. Improvements are needed in the care being provided to people in contact with the criminal justice system. The system needs to be more integrated and in line with the advancements and innovations being made in the wider community.

Personal data for individual care

Personal information sharing from GP to GP

In February 2022, primary care registration for the male prison estate was enabled within the Health and Justice Information Service (HJIS) programme (the advances prior to 2022 are described in more detail in the appendix). For those who complete primary care registration on entry to prison, their lifelong community health record is transferred from the community to the prison GP service. This transfer takes place securely via GP2GP through the NHS Spine and includes information relating to long-term conditions, medication history and clinical consultations. A person entering prison is given a choice as to whether they wish to complete primary care registration or not. Registration is not mandatory for all people in prison. When compared to the historic paper-based and 'closed' electronic systems, this represents a significant advance in electronic health records within the prison estate. Within the female prison estate, there was an initial pause in implementing the primary care registration process while awaiting the introduction and deployment of the NHS Cervical Screening Management System (CSMS), which subsequently went live in May 2024. Registration was then enabled in the female estate in July 2024.

Figure 2: proportion of people in prison that opt for primary care registration



Source: NHS England

Approximately 1 in 3 people in prison do not have their full electronic health record available to prison healthcare staff (figure 2). Two thirds (69%) of people within the prison estate have opted for full registration to transfer their health record into prison (as of December 2024). Of the 69% of patients who opted to complete primary care registration, 60% have also opted for their data to be uploaded to the summary care record with additional information (SCRAI). This is a summary of important minimal information such as allergies and medications. A further 9% have opted to have only the SCRAI uploaded and less than 1% of registered patients have

dissented from any data being uploaded to SCRAI. The fictional example below provided by the authors gives an example of how vital it is for the full health record to be available to prison healthcare staff to enable safe, high-quality individual care.

Case study: the importance of data sharing on individuals care

Mr A is a 67-year-old man who had been in prison 15 years previously and arrived at HMP Highwall, a Category B local remand prison, at 21:00 on Friday evening. During reception screening with the nurse, Mr A reported that he was diabetic and that he had seen his GP recently. Mr A had a bag of medicines with him, including some unlabelled tablets and some inhalers. With his permission, the nurse was able to locate Mr A on the NHS Spine Personal Demographic Service and confirmed that he was registered with Greenleaf Community NHS GP practice. Mr A agreed to complete primary care registration with HMP Highwall by completing the registration form and consented to uploading information from his record to summary care record from the prison.

The summary care record included the following coded diagnoses: Type 2 diabetes, Chronic Obstructive Pulmonary Disease, Hypertension, Heart Failure and Atrial Fibrillation. Additional information confirmed Mr A was on 11 repeat medications and their doses. The prison GP on duty reviewed the electronic health record (SystmOne) and prescribed the required medications. The nurse made a GP appointment for the following day. The following day, the prison healthcare administrative team commenced the GP2GP record transfer from Greenleaf Community NHS GP practice and this was now visible within the Health & Justice Information Service SystmOne record in the prison.

During the GP appointment the GP was able to review the information received from the community GP practice, the information gathered during the reception screening process and to have a face-to-face discussion. He was able to see when Mr A had last visited the GP in the community and his last blood test results. He was able to have a clear picture of Mr A's healthcare needs and together made a detailed plan including, booking blood tests for annual diabetic review, booking in with the long-term conditions nurse for his diabetic foot check and lifestyle advice for diabetes, review of the chronic obstructive pulmonary disease and sending a notification to the nurse lead for the national screening programmes as he required both abdominal aortic aneurysm and bowel cancer screening.

There has been considerable progress toward improving the transfer of records between community primary care and the prison healthcare record system, but there remain significant barriers in regard to the uptake of this approach. For example, people on remand may not choose, or be encouraged, to complete primary care registration as it is not clear how long they may be staying in prison or they may not fully understand how this benefits their continuity of care. Guidance made available for the roll-out of registration within prisons recommended primary care registration for people who were likely to stay in prison for more than one week and who had significant medical problems, regardless of whether they were sentenced or on remand. The extent to which information is shared and implications of this may be poorly understood by both patients and staff. Further concerns limiting the uptake of primary care

registration have arisen because of the difficulties in people being able to register with a community GP practice following release from prison.

Lived experience: perspectives on data sharing

The following engagement was undertaken by Empowering People: Inspiring Change (EP:IC) lived experience consultancy.

Engagement with people in prison indicates that most view data sharing positively when the process and its benefits are clearly explained.

“I do think it’s a good idea to share data and for prisons and NHS and doctors [to] all share information with each other because in my experience when I’ve gone to prison, whatever meds I’ve been on outside prison, it’s such a long process to get what you would normally take in the community in prison.”

However, there are several important factors to be considered. The journey into prison can be highly stressful for many reasons. In some instances, being detained in custody is unexpected and the ‘entry shock’ can result in confusion and distress.

“The car was at the court, the kids needed to be picked up from school. It didn’t cross my mind I’d end up in prison. I was in complete shock, my immediate thoughts went to the kids, the car, my job, my mum.”

The complexities associated with people arriving in prison are substantial and widely acknowledged, including literacy and communication needs, immediate health needs, including serious mental ill-health, injuries or withdrawal from opiates or alcohol. However, it is at this point, on the first day of custody, patients are asked to provide informed consent to their data from community services to be shared. This raises ethical concerns around requesting consent from patients experiencing significant distress or acute health needs, despite the necessity to do so; or how this can be achieved in a trauma informed or trauma-responsive way. The reality is that patients often lack full understanding of the extent and mechanics of how personal health information, including medical records, are transferred between community healthcare providers and prison healthcare services.

When delays to treatment occur due to reduced access to healthcare records this often results in frustration and in some cases, needs not being met in a timely way. There is often an expectation from patients that prison healthcare services can access historical health records immediately, even when consent is not obtained from the offset.

“It can take weeks you know, and if you’ve got mental health and physical health [problems], it just doesn’t work.”

This was true on transfer between prisons, as well as between prison healthcare and community health providers.

“Information isn’t always shared well to special departments in the outside hospitals, information is relayed too late to us.”

There is currently no mechanism by which prison healthcare providers can ‘electronically’ or automatically pre-register a patient with a community GP practice prior to their release from a prison to ensure that the record is transferred back to the community on the day of release. Following release, a person must complete primary care registration with a GP in the community so the full lifelong record, including the care episodes from within the prison will transfer via GP2GP back to the community GP practice. In preparation for release, people in prison are encouraged to attend pre-release clinics. There is variable attendance at pre-release clinics and some patients may be released unexpectedly (for example via court). The focus of pre-release clinics includes prescribing medication and identification of a community GP practice that the person could register with, depending on where they will be located following release. This location may be different to the area they were residing prior to arrival in prison. Some GP practices should (and do) accept registration requests prior to a patient’s release. They need to be informed of the expected release date, after which they can complete the primary care registration in order to avoid transferring the healthcare record out of the prison system prematurely. Many practices opt to wait until the patient contacts the surgery (either in person or by telephone) to complete the registration to ensure that the patient has been released. Where patients who have left prison do not complete primary care registration with a community GP practice after release, the medical records can become ‘siloes’ within the prison system. If requested, prison healthcare teams can send a printout of the patient record to a community GP practice, a process which can result in various inconsistencies. The deployment of the Electronic Prescribing Service within prisons, enables people who completed primary care registration in prison to be able to collect their medicines through their local pharmacy following release from prison. Many of these themes about primary care registration and the ability of IT systems to share information were recognised in the recent Health Services Safety Investigations Body (HSSIB) review of data sharing and IT in prisons³.

Personal information sharing between healthcare providers and health organisations

There is currently no mechanism by which the relevant data within the person’s clinical record can be routinely and directly shared with other relevant care providers. This includes community mental health teams, substance misuse services or social care providers. Knowledge of the patient’s NHS number and access to the summary care record within these services would be helpful.

Despite Caldicott principle 7⁴, the duty to share information, the sharing of information between different healthcare providers and across the legal and commercial boundaries is hindered by lack of staff confidence and lack of clarity on what should be shared and with whom. This persists despite the improvements to the technical capabilities. For example, barriers in sharing of personal information creates challenges for case-finding, follow-up and contact tracing for infectious diseases on entry or exit to the secure estate. It is often the case that secondary care hospital teams looking after a patient who has been admitted from prison will be reluctant to share information with prison healthcare teams which restricts handover and safe discharge planning processes.

The sharing of personal data across the various organisations is a complex area. The inception of the Information Sharing Advisory Group (ISAG), co-chaired by HMPPS and NHS England acts as a central forum for raising and discussing routine and general queries related to the sharing of health-related (special category) information. ISAG includes representation from the Prison and Probation Ombudsman (PPO), the Independent Advisory Panel on Deaths in Custody, the Ministry of Justice Data Protection Team and regional probation leads. The group is consulted on internal and partnership challenges, supports the development of new initiatives and reviews guidance as appropriate. However, this group has no responsibility for addressing the use of aggregate data, which is discussed later in this chapter.

Personal information sharing between health services and justice systems

Personal information is not automatically or routinely shared between health and justice organisations. Currently, demographic data and high-level risks such as risk of self-harm and/or suicide risk are only available through inefficient manual extraction and uploads to the clinical system.

Essential personal health information is not automatically or routinely shared with probation services. This is the case for those following release from prison, or for people serving a community order under the supervision of probation. This has implications for supporting continuity of healthcare, for example, if an individual has started a course of treatment for Hepatitis C, probation may be unaware and therefore unable to support the person with the continuity of this following release from prison. One example of an approach to address this issue is in the Probation Notification and Actioning Project (PNAP). PNAP aims to enhance the sharing of data to enable probation offender managers to be aware of prison leavers who are in treatment for substance misuse and have been referred for community treatment so that they can support them to engage. Probation teams report ongoing challenges with understanding and supporting wider health needs, including mental health, due to the absence of routine data and information sharing. Ensuring that people who are under the supervision of the probation services are registered with a community GP practice and improving the mechanisms to support the better sharing of health information would help improve continuity of care. It is necessary to establish joint oversight, responsibility and agreeing and improving the sharing of essential health-related information between organisations.

Lived experience: data sharing on leaving prison

The following engagement with people in prison or with recent experience of the criminal justice system was undertaken by Empowering People: Inspiring Change (EP:IC) lived experience consultants.

We know that on release from prison accessing healthcare services isn't always easy for people, especially when someone is released homeless. Those who remain on probation licence following release, often have multiple meetings to attend before considering registering with a GP and is likely to prioritise these over health, for risk of returning to prison. Even where there is a keenness to access community services continuity of care can be problematic and some people remain unaware of the need to register with a GP.

"I wasn't sure if I had been deregistered when I was in prison and therefore, I wasn't sure if I needed to go back to the doctor I had before prison and no one explained that to me, and no one at probation ever mentioned it to me either."

Issues around continuity of care can be further exacerbated by the often-transient nature of prison leavers with multiple short periods in temporary accommodation. This results in challenges registering with new services; and pain in telling their stories multiple times.

"We need more consistent support from services. I moved a lot because I could only get temporary accommodation but wanted to meet regularly with the same person. The moves meant I had to keep explaining my life/situation to different people all the time, which is depressing."

This highlights some of the genuine challenges faced by people when they leave prison, in particular, the barriers in registering with a GP in the community and the subsequent delays to data sharing and potential interruptions to treatment.

Personal information sharing between health providers in the secure NHS estate

The secure NHS estate was not included within the scope of HJIS. They rely on separate electronic health record systems which are 'closed' to connection with other systems and have no connection to the prison systems. Patients in secure psychiatric hospitals are unable to complete primary care registration with a community GP practice and must receive their primary care through internal arrangements. Additionally, the full care record from the secure hospital is not transferred back with the person on remittal to the prison estate meaning that prison healthcare teams must rely on limited discharge summaries. Following discharge from a secure hospital, patient records are archived and clinical data is not recorded on the NHS Spine. As patients within the secure hospital estate are unable to complete primary care registration, they do not appear on national screening databases, with the result that hospitals must manually sift through their patient cohort for eligibility for the relevant national screening programmes. This is time consuming and liable to human error.

Practice example: secure hospital information flows

When a patient is admitted to a forensic mental health setting, the NHS Trust must provide all care because these patients cannot attend or are very limited in their attendance to primary care services. Registration with local practices mitigates the problem but adds administrative burden for these practices and relies upon their goodwill. The GP practice team cannot attend a forensic mental health ward and the patient cannot attend the practice. This presents several gaps in information and disparities in care compared with the wider community.

The hospital is not a GP practice, therefore there is no GP2GP transfer of the health record so the practitioner must rely upon a referral letter, the National Care Records Service or the patient if they are well enough to do so. In the course of their admission, they are commonly removed from GP registration. This occurs on transfer from the prison healthcare service or if they have been admitted from the community and as a consequence of searches undertaken by Primary Care Support England that detect changes in the patient's demographics. If the former GP practice does not receive confirmation from the patient in 6 months, they are removed from the list. This has significant implications, in particular because there is no active primary care record into which the patient's healthcare data, correspondence and history can be recorded. The gap persists until the patient re-registers on discharge which can be after several years.

At the same time, the primary care team will have an incomplete history and the patient may be excluded from systems of care, for example, a diabetes review, if this diagnosis is unknown. During their admission without an active GP registration, referrals cannot be made by the NHS e-referral Service leading to unclear or unsafe referral pathways such as endeavours by telephone or email, sometimes with significant delays along with no provision of choice. NHS screening for bowel cancer requires GP registration hence patients do not receive invitations. Then finally, on discharge there is no GP2GP transfer of their record. The admission should be an opportunity to narrow the health inequality these patients experience but their exclusion from digital systems as a consequence of their removal from GP registration risks widening it further.

Personal information sharing: what needs to change

There is a need to improve uptake and continuity of electronic records between community GP and prison healthcare services. Increasing levels of primary care registration in prison will help to increase the availability of information in the electronic health record in the prison and will increase the information uploaded to the summary care record (SCRAI), allow use of NHS e-Referral Service⁵ and the electronic prescribing service⁶. This will in turn assist community NHS services (who have access to SCRAI and the patient's NHS number) to have visibility of some of the person's health information relating to their recent period in prison and in the event that they have not yet completed primary care registration with a community GP practice.

People leaving prison could be better supported to be aware of and use the NHS App which will help awareness of the NHS number, register for a community GP and locate NHS services.

Further work is needed to make it easier for people to register promptly with a community GP practice at the time of or following release from prison. Mechanisms are also needed to ensure that records do not remain siloed within prisons and transfer of the record to an appropriate community GP practice takes place. This could be achieved by ensuring closer working with ICBs to enable pre-registration and registration and support the transfer of prison healthcare records to appropriate community GP practice at the point of release.

Interoperability between the numerous justice and health IT systems needs to be improved to ensure that important health and risk information can be seamlessly shared. This is a priority area for NHS England Health and Justice and progress is anticipated. As an example, the automatic sharing of basic demographic information relevant in the prison setting such as the cell and wing location, would assist healthcare staff in various aspects of care provision (for example medicines management and identification of contacts with infectious diseases).

System interoperability by design will assist in ensuring data can be shared. This could be addressed by ensuring that all IT systems are developed to sufficient national interoperability standards as part of their non-functional requirements. The Health and Justice Information Service is already compliant with modern NHS interoperability standards. Subject to re-procurement, there will be a specific focus on the development of further interoperability capabilities within the new solution with one aim being better interoperability with justice data systems.

Agreement on the use of unique identifiers would enable improvements in information-sharing processes for individual care. The NHS number is seen as a potential solution. This would support interoperability between systems. Although the NHS number is not routinely gathered by criminal justice organisations within their IT systems, it is now recorded within approximately 97% of prison health records. The NHS number is essential for NHS Spine integration and other health information platforms and could be an appropriate starting point for use as an identifier across the criminal justice pathway - as opposed to the development of a new unique identifier.

The quality of recording of health data needs to be improved. Prison healthcare providers do not generally have embedded clinical coders or record summarisers and have not been incentivised in the same way as the community general practices (for example via the Quality and Outcomes Framework (QOF)). This disparity along with other factors has led to relatively rudimentary clinical coding levels, poor data quality and inconsistency of health data-recording, when compared with wider community primary care data. Factors such as prisoner 'churn' (patient turnover) can also affect the overall data quality picture and needs to be taken into account in order to ensure comparability. Improvements to clinical coding will require a rolling programme of regular training for clinical and administrative teams.

Aggregate data for surveillance and research

There are challenges in accessing the multiple existing systems. There is currently no single system used by which aggregate health-related data for people in contact with the criminal justice system is routinely captured and analysed for health surveillance or research purposes. As a result, there is a significant paucity of research which would help provide a better understanding of the factors driving health inequalities and for improving health outcomes. Resolving these issues will be critical to avoid the further marginalisation of this population and in line with the 10 Year Health Plan to move from analogue to digital.

Health related and criminal justice data in aggregate data repositories

Health-related and criminal justice data residing within the criminal justice system has been largely excluded from the large aggregate data projects. For example, there are several large-scale primary care health data repositories which are available in the wider community, but data from TPP's SystmOne prison records is currently not included in these. OpenSAFELY⁷ is a secure analytics platform for NHS electronic health records, although it includes TPP as one of the collaborators, it does not currently benefit from inclusion of data from the prison population. Other examples of datasets which do not include prison SystmOne data are Clinical Practice Research Datalink (CPRD)⁸, the Royal College of GPs Research and Surveillance Centre (RCGP RSC)⁹ and Health Data Research UK (HDR UK)¹⁰. This inhibits research and comparison with, or inclusion in, wider community primary care studies, which would be necessary and beneficial for epidemiological analysis and research for patient benefit purposes. Unless this is addressed, the inability to undertake or develop meaningful research opportunities will result in further marginalisation and disparity for this patient population relative to the wider community.

Health data from prisons is not currently routinely included or visible in the national extracts, such as Mental Health Services Dataset, vaccinations and immunisations and the NHS population screening programmes (such as bowel and breast cancer screening and screening for abdominal aortic aneurysms among others). This could be resolved by the inclusion of health data from the prison SystmOne records in the various primary care and General Practice Extraction Service (GPES) extracts. A 'flag' could be a method to help identify people within the prison population and enable comparative analysis for demonstrating equity of access to screening services. The means by which the 'flag' was removed following release from prison would need to be considered.

Health-related and criminal justice data residing within the criminal justice system has not been readily accessed by external users or otherwise integrated into large-scale data projects. Research for patient benefit requires access to anonymised aggregate data. Current barriers to accessing the SystmOne primary care data include complexities in the understanding of the responsibilities for data control. Access to anonymised data via the approval processes is often complex and limited by understanding and capacity within the organisations to undertake the work necessary. Historically, as an alternative, proxy data (for example, Hospital Episode Statistics, Secondary Uses Service and postcode) have been used to bypass these processes which otherwise limits comparison with wider community populations. A recent study

describing cancer incidence and outcomes for people in prison was dependent on historical hospital records and therefore lacked data on the care received in the prison¹¹. This meant that generalisations had to be made in respect of the poor outcomes highlighted in the study.

People who are under supervision by the probation services cannot be identified within aggregate health data. People under probation supervision should be registered with a community GP practice, although this cannot be mandated. For those who are registered, their health data may appear in some of the various aggregate data projects. However, this data would not be distinct from the wider population highlighting that they are in contact with the criminal justice system. This limits the ability to understand the needs of this population. Some primary care practices code probation involvement within clinical records as a solution.

Health related and criminal justice data for surveillance

Population surveillance activities require timely access to large-scale data and analysis of important health issues relevant in this population. Near real-time data for surveillance and screening purposes is currently unavailable. Without access to this data, the surveillance function served by UKHSA for the secure and detained population is considerably limited. For example, currently, the monitoring and progress toward elimination of Hepatitis C and relative immunisation status within the secure estate (relevant for reducing the risk of outbreaks in this vulnerable population) is unavailable. The inclusion of prison health data within the platforms used in sentinel surveillance programmes would enable national monitoring of acute respiratory infections in the prison population.

Health related and criminal justice data for service planning

The procurement process for prison healthcare services are often dependent on health and social needs assessments (HSCNA). These assist both commissioners and providers in the tender process and for designing service delivery. HSCNAs are often undertaken by third-party organisations who do not have access to the 'whole' population-wide SystemOne data, meaning that current comparisons between establishments may be inaccurate. It is recognised that these 'needs assessments' are often quickly 'out of date' following publication, as population and other changes arise within the estate (for example, changes in category of establishment and/or population size, patient complexity and so on). The significant limitations to data quality and access to large-scale aggregate data, means that regular and routine analysis of the population needs and trends cannot be readily evaluated on a site-by-site, cluster-wide or national basis. Real-time comparison of patient groups and projections of patient need and associated cost is not currently available but is arguably essential for adapting service delivery to the changing patient need. To enable more comprehensive analysis between different groups of people within the estate and comparison with the community, the development of comparative health indicators would be beneficial.

The inability to identify people under the supervision of probation in community health records limits the ability of integrated care boards (ICBs) and local authorities to allocate resources to create better pathways of care. The NHS Federated Data Platform¹² (NHS FDP) is an example of a recent innovation supporting the better analysis of data at an integrated care board (on behalf

of ICSs) level. Currently, health-related data from the prison system will not be incorporated owing to the current segregation of systems. The NHS Federated Data Platform¹³ has enabled ‘privacy enhancing technology’ (PET) which provides a secure encrypted approach to the utilisation of the NHS number as a unique identifier for anonymisation and de-anonymisation purposes. It should be highlighted that in line with the limitations described above, the SystmOne health-related data within the secure estate is currently not included within the local or national instances of the NHS Federated Data Platforms.

Linkage of health related and criminal justice data

Data linkage between established healthcare and justice datasets would provide important opportunities to build a more comprehensive picture of care pathways, understand disease burden, map risk factors, evaluate interventions, measure health inequalities and assess health outcomes. Accurate data linkage requires 2 or more datasets to have information relating to the same person which would result in combining information from 2 or more sources and the data accuracy and completeness of these data influence the success of data linkage. Agreement on the use of the NHS number as an appropriate unique identifier would be a pragmatic approach.

Data linkage across government departments is rapidly increasing and it is vital that health and justice data are included within these developments. The data being considered in this chapter is located across several government departments and ensuring that these are included in the cross-government data linkage projects will further enhance our understanding of population needs. As identified above, the lack of use of an agreed unique identifier hinders the potential for more informed data linkage research projects and cross-organisational case tracking.

The NHS number¹⁴ could be considered as an appropriate unique identifier, although another alternative would be for the agreement on use of common identifiers which could allow probabilistic linkage. It has been considered that, subject to the appropriate consideration of Information Governance (IG), General Data Protection Regulation (GDPR) and Data Protection Impact Assessments (DPIA), capture and use the NHS number could provide an appropriate unique identifier within data linkage projects. While there is approximately 97% capture of the NHS number within prison health records, the NHS number is not currently routinely captured within the other criminal justice data sets.

MoJ have several data linkage projects, including the use of aggregate data through Data First¹⁵ (which links to Administrative Data Research UK (ADR)¹⁶) and the use of personal data through Better Outcomes through Linked Data (BOLD)¹⁷ (linked data is used for analytical and operational purposes but has not included health-related use cases). These projects have been helpful in improving administrative and justice-related data-linkage across government departments. Application of health-related data remains limited, which if developed further would help with better analysis and understanding of population needs and outcomes (for example, through data linkage with Hospital Episode Statistics, Office for National Statistics (ONS) and UKHSA surveillance data). One example of this type of data linkage from the BOLD programme was in the publication of the pathways between probation and addiction treatment in England report which, was a joint experimental statistics publication by MoJ and the Office for Health Improvement and Disparities (OHID), (which is part of DHSC).

Practice example: West Mercia Data linkage pilot

Background: In order to identify patterns of unplanned non-elective hospital use in people on probation, West Midlands Probation Service, NHS Herefordshire and Worcestershire ICB, NHS Shropshire, Telford and Wrekin ICB, NHS Midlands and Lancashire commissioning support unit (CSU) and Worcestershire Public Health collaborated to develop an innovative data linkage pilot.

Activities: A poster campaign was conducted to collect NHS Numbers on consent during probation appointments targeting willing participants. Necessary information governance protocols were followed with co-signed Data Sharing Memorandum of Understanding and Data Protection Impact Assessment embedding protocols under Section 9 (2) (a) of the UK GDPR and Section 9 (2) (h) Health & Social Care. Before data sharing via the CSU as the custodian, the aggregated data were pseudonymised and handled in accordance with the relevant data protection regulations in Moj, relying on public task lawful basis in Article 6(3) of the UK GDPR.

Outcomes: Out of the 280 records, only 173 records (98 for Herefordshire and Worcestershire and 75 for Shropshire, Telford and Wrekin) were matched in the ICB Master Patient Index as 117 patients were found not registered with a GP. The analysis focused on emergency department (ED) attendances and non-elective admissions from April 2022 to March 2025.

In Herefordshire and Worcestershire, 69% had at least one emergency department (ED) attendance and 30% had at least one non elective admission. In Shropshire, Telford and Wrekin, 68% were found to have at least one or more urgent care attendance with a total of 196 attendances, predominantly to either an emergency department or minor injury unit.

In Herefordshire and Worcestershire 85% of ED attendances were in the 25 to 49 age group, 34% attending ED five or more times and 48% with one or more long-term condition. Similarly, the non-elective admissions data highlighted 15% having at least one long-term condition, with 6% living in the top 20% most deprived areas.

Practice example: importance of data linkage for continuity of care

One of the key benefits of data linkage is the ability to link across a patient's journey, ensuring continuity of care and treatment as a person moves between service providers for example, prison to community. These insights support clinical care with (re)engagement and inform service development.

Using the surveillance of chronic Hepatitis, which is linked to several established healthcare datasets, we review how data linkage is currently being used to characterise populations, identify where additional support is needed in the patient pathway, support clinical care and to better understand and provide data to improve the continuity of care.

Testing and positivity

The introduction of ‘point of care’ testing has resulted in gaps in surveillance data as point of care testing is not consistently recorded. This can make interpretation of trends in testing patterns and prevalence of infection difficult. The triangulation of testing data through different data collection tools optimises our ability to estimate the number of individuals tested for and diagnosed with chronic Hepatitis.

Continuity of care and treatment

Records for those with diagnosed chronic Hepatitis are routinely linked to treatment data to enable us to estimate the proportion of people linked into care, the proportion initiating treatment, and the proportion who have successfully cleared their Hepatitis infection. Through data linkage we can identify gaps in the care pathway and the associated factors to inform the development of interventions and support resource planning. Similarly, linkage to established healthcare datasets allows for outcomes associated with a chronic infection to be identified and the associated factors among those with or without these outcomes, such as hospitalisations related to end stage liver disease and hepatocellular carcinoma, liver transplants and death.

Characterising populations, identifying where additional support is needed in the patient pathway

Finally, data linkage feeds into our efforts to better characterise populations disproportionately affected by viral Hepatitis. Data linkage provides an opportunity to enhance surveillance data to better understand who is at risk, who is being tested, who is living with chronic Hepatitis, alongside demographic and associated risk factors. Ultimately, we hope this information will inform the development of interventions and diagnostic methods to facilitate effective and efficient early access to care and treatment reducing morbidity and mortality and onward transmission.

Aggregate data for surveillance and research: what needs to change

Cross departmental leadership is needed. One of the key issues that has been highlighted is that there is currently no specific team that has been identified to take the lead role and responsibility for overseeing and managing the various legal and practical aspects of data processing across the relevant government departments. These issues have often been considered to be the responsibility of individual departments and organisations and as such, this lack of integration has contributed to the segregation of data. These barriers can be considered to be too complex to resolve and this otherwise limits the potential for national level cooperation to improvements in data integration and comparison.

There is a need to create a centralised, cross-departmental team who are enabled with the appropriate permissions and responsibility for overseeing data governance, data controllership, data-sharing, data linkage and data analysis for the criminal justice population. In conjunction, this will require the team to be able to oversee the development of the interoperability capabilities that will be necessary for the integration of the various systems. Through analysis,

the team would also be responsible for assessing and driving the work required to improve data quality which will be essential for ensuring better inclusion and integration of this data. This aligns with mission-led government priority to move from analogue to digital and deliver a NHS fit for the future. It will be important to ensure that health and justice data relating to people in contact with the criminal justice system is included in the development of a UK national data library.

It is recognised that given the sensitivity of health-related data, that cross-departmental leadership would best sit with 'health' as the primary lead. A 'health' lead would also be best placed to address the data capture and data quality issues highlighted above.

Additional recommendations

In addition to the recommendations highlighted in the executive summary, the cross departmental team, led by DHSC should:

- ensure that the digital transformation agenda of the NHS 10 Year Health Plan is incorporated into prisons and justice settings to ensure equitable access to digital tools and IT as they develop in the community
- explore the mechanism for automatic pre-registration of patients with a community GP practice prior to their release from a prison to ensure that the record is transferred back to the community on the day of release

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8 Mental health of people in prison and in contact with criminal justice system in the community

Authors: Dr Sunil Lad and Dr Matthew Tovey

Contributors: Professor Seena Fazel, Rebecca Dado, Glyn Thomas, Dr Eva Stigaard Laird, Dr Peter Stevens, Dr Ruth Scally, Angelique Whitfield

Introduction

Mental health needs are more common among people under criminal justice system supervision than the general population¹. Approximately 13% of people in prison meet diagnostic criteria for depression and 4% meet the criteria for more severe diagnoses such as schizophrenia and bipolar disorder². This is approximately double the prevalence of depression in the general population and four times the prevalence of psychoses³. Together, this means that around 1 in 7 people in prison have a treatable mental disorder. Post-traumatic stress disorder (PTSD) and Complex PTSD are also common; affecting up to 1 in 10 people in prison⁴. In men, diagnostic criteria for personality disorder can be difficult to translate into a prison setting, partly because the criteria can overlap with reasons for entering prison. Some research studies report very high prevalences, whereas high quality studies that use clinically based diagnoses report the prevalence of personality disorder in English men in prison to range from 7% to 10%⁵. Among women in prison, approximately 1 in 5 are estimated to meet criteria for emotionally unstable personality disorder.

For many people with a mental disorder, this is recognised before they enter prison^{6,7} but the experience of imprisonment can trigger or exacerbate significant emotional distress. Behaviours leading to imprisonment can often relate to an untreated mental health needs, which can then be exacerbated by the distress of being imprisoned. The relationship between mental health problems and offending is complex. While there is a small increased likelihood of committing violence associated with psychosis, the absolute risk is low and such individuals are much more at risk of being the victims than perpetrators of violence. Evidence suggests that the better someone's mental health is in prison, the lower the probability of reoffending on release⁸. Similarly, improvements in mental health after release from prison has been found to reduce the risk of reoffending⁹, as well as benefitting the individual¹⁰.

Comorbidity is common – around half of those with a serious mental disorder have a co-occurring substance use disorder. Mental health problems can often also co-occur with other risk factors such as trauma and neglect. Mental health needs can vary significantly in severity between individuals and over time within a diagnosed individual. For some, a clear diagnosis of

a mental disorder leads to an established pathway of available interventions, while for others, their mental health needs can be more diffuse and not neatly fit within diagnostic criteria. Both groups are prevalent in the criminal justice system.

This chapter explores the relationship between these life experiences and mental health in the prison and probation populations. It identifies challenges to improving the mental health and wellbeing of the wider prison population, then examines organisational challenges that occur when supporting people with mental health needs along the pathway from before custody, in prison and after release.

Experiences that contribute to high proportion of mental health needs in prison

Many people in prison in the UK have experienced childhood trauma such as neglect, abuse or domestic violence¹¹. Half of care leavers have a criminal conviction by early adulthood¹². The true prevalence of traumatic histories among those known to criminal justice services is unknown, because of fear of disclosure and low trust in systems of authority. In the general population, traumatic experiences are known to be associated with the development of mental health conditions like post-traumatic stress disorder (PTSD), depression, and anxiety¹³. Similarly, among adults in prison, a history of childhood trauma increases the risk of mental disorders¹⁴. Exposure to a greater number of adverse childhood experiences including physical and sexual abuse can also impact a person's ability to regulate emotions, relax, or deal with problems effectively¹⁵. Some use self-harm and illicit drugs to regulate distressing emotional states. These responses often develop as a strategy to cope with unpredictable and unsafe environments from a young age^{16 17}. These in turn can impact on their ability to develop a sense of safety and build trust with others, creating barriers to receiving and accessing help and support before, during and after contact with criminal justice services.

Many people in prison have low levels of literacy. Over 70% of adults in prison are assessed on entry to prison as having at, or below, GCSE level Maths and English. This can significantly influence people's ability to communicate effectively with prison staff, access mental health services and information about mental health.

In custody, half of people have an identified substance misuse need and 22% have an identified alcohol misuse need¹⁸. Mental health problems and substance use are often interlinked. The reasons for addictive behaviours are complex, but substances can be used to distract from or escape the reality of painful emotions or situations. There is often a cycle where substances are used to reduce emotional distress, however ongoing use can lead to deterioration in mental health which makes problems more entrenched. Prison is often a stressful, under-stimulating and isolating environment¹⁹, which itself can lead to substance use to numb feelings and mask underlying mental health difficulties. Psychoactive substance use is a well-documented concern among UK prisons and it is known that their use can cause wide-ranging physical and mental health harms, including psychosis. There were nearly 50,000 adults in alcohol and drug treatment in prison between April 2023 to March 2024, a 7% increase on the previous year, and 14% higher than 2020 to 2021²⁰. More than 1 in 4 (28%) were identified to also have a mental

health need. This proportion was consistent across people with opiate, non-opiate, non-opiate with alcohol and alcohol only dependency. People with addictions, including gambling, are at risk of experiencing increased debt, stress, and difficulty managing the environment leading to victimisation, bullying and exploitation (both of individuals and their families) by organised criminal groups. Compared to the general population the prevalence of gambling is higher in those who are incarcerated²¹.

Adverse childhood experiences can include experiencing violence and trauma and be associated with impulsive and risk taking behaviors that increase the risk of a traumatic brain injury and entering the criminal justice system. People with extensive adverse childhood experiences have been shown to have poorer outcomes with long-term cognitive and emotional difficulties²².

Stigma around mental health is also a significant barrier to mental wellbeing in prisons. Many people in prison feel that there is a cultural stigma associated with seeking mental health support, which can lead to underreporting of mental health difficulties²³. Many men in prison may view seeking help for mental health issues as a sign of weakness or vulnerability, which can be seen as dangerous or socially unacceptable in masculine cultures that can exist in prisons. Those who might benefit can therefore be deterred by the risk of bullying or judgement from others. For women, 40% of those leaving prison noted a decline in their mental health due to the stigma and impact of imprisonment²⁴. Low levels of trust in staff and environmental challenges such as difficulties accessing confidential spaces may be a further obstacle to help-seeking. This is heightened in Black and ethnic minority groups where there is significant mistrust of mental health services and challenges accessing and engaging with services²⁵. One in 3 Black people in prison in England and Wales report a mental health problem, compared to half of all other ethnicities, with Black people reporting it felt less acceptable to be open about mental health difficulties²⁶. HMPPS and NHS England have commenced an investigation to explore and respond to drivers of this inequality between ethnic groups.

Together these experiences can significantly influence the mental health of a person throughout their journey in the criminal justice system and significantly impact service needs and engagement as demonstrated in the fictional case study, based on true experiences, below.

Case study: experiences that contribute to mental health and service needs

Ms C is a 33-year-old woman serving a 6-month sentence for theft. Ms C witnessed her mother being subject to domestic violence and was herself sexually abused by one of her mother's boyfriends. She struggled at school, with frequent moves and was bullied for being unkempt. She stopped attending education at 11 when she became part of a 'bad crowd', spending her time drinking alcohol, smoking cannabis and engaging in petty crime.

Ms C had her first child when she was 16, who was subsequently taken into care due to concerns about neglect and domestic abuse by her partner. She went on to have a further 2 children by different fathers, both of whom were taken from her care. At 19 her partner introduced her to heroin and crack cocaine. She has used these habitually since, funded by shoplifting and sex work. She has had several short custodial sentences for shoplifting.

As a teenager she began to self-harm by cutting, which she described as a means of releasing emotional distress through physical pain. She describes hearing the voices of the man who abused her as a child and her first boyfriend telling her that she is useless and that she would be better off dead. She has vivid dreams of past incidents when she has been assaulted and is hypervigilant, fearful she will be attacked.

She finds it hard to trust professionals; it takes time to develop a relationship, which is interrupted by her brief periods in custody. Her self-injurious behaviour increases in prison when she is unable to take drugs which she finds 'numbs the pain'. Her focus on prescribed medication as a relief for her symptoms causes tension with clinicians. Both Ms C and her team are frustrated that the psychological interventions she requires are not offered in prison due to her short sentences and due to her being unable to find permanent accommodation after being released from custody she is not able to engage with a community team either.

Mental health of the whole prison population

Supporting people in prisons to improve their mental health and wellbeing is a fundamental part of rehabilitation, resettlement, reengagement into community. Using the opportunity to address mental health challenges in prison means we can better protect the wider public by reducing reoffending while also supporting people in prison to successfully integrate back into the community. Yet there are many challenges to delivering effective, efficient and robust mental health services due to the nature of having a prison sentence and the prison environment.

Criminal justice environment

Social isolation

The prison environment is characterised by separation from family and friends. At its core it is for public protection and punishment by removing a person from their community. Sometimes people in prison can be placed far from family, reducing access to support networks, and this separation and isolation can lead to increased distress and hopelessness. The risk of reoffending is approximately 40% less in those who receive regular family visits²⁷.

Long-term confinement and segregation also affect on mental health as they have been shown to exacerbate feelings of isolation. An individual in prison may be placed in segregation for multiple reasons including for their own safety (segregation policy cited in the appendix). A joint pilot in the north of England from 2021 to 2023 between HMPPS and NHS England using a

multidisciplinary approach found an improved experience for staff and people residing in the segregation unit with improved relationships and collaboration and greater understanding of the healthcare needs of the population in segregation. This joint approach is not yet implemented nationally.

Overcrowding and staff shortages mean that individuals in prison spend less time with staff and undertaking meaningful activities. Social interaction can be restricted, which may lead to feelings of loneliness and despair. For example, only 1 in 4 male prisons were rated positively by HM Inspectors in 2021 to 2022 for their provision of purposeful activity and half (49%) of people in prison reported being in their cell for more than 22 hours a day, rising to around two-thirds (67%) at weekends²⁸. Staff shortages in HMP Bronzefield (female prison) led to people being locked in their cells for up to 23 hours a day virtually every weekend in 2023 to 2024²⁹.

Interventions

Purposeful activity in prisons refers to a broad range of activity aimed at addressing risk or needs related to re-offending or resettlement, enhancement of personal wellbeing, physical or mental health and enhancement of inter-personal, social or life skills. Each prison regime sets out the purposeful activity a prison plans to deliver. Prisons gain credit for attendance at a wide range of measured activities. Currently attendance at healthcare appointments is not consistently measured and not credited. Therefore, while HMPSS recognises that healthcare is fundamental to meet an individual's needs and will support further engagement in purposeful activities such as education or employment, within some prisons access to healthcare is not given the same priority in the prison regime as other purposeful activity.

Access to on-site healthcare is dependent on the prison service facilitation (enablement), for example providing prison escorts to allow individuals to move from residential, work and education areas to healthcare (including mental health and substance misuse support). When prison staff are unavailable, access to healthcare appointments are compromised. Working in partnership with HMPPS and Ministry of Justice (MoJ) system partners, we want to ensure that access to health care services available in the prison grounds is given the same priority as education and employment.

Threat

Threat of violence negatively impacts mental wellbeing. Rates of violence within custody are high and increasing³⁰. Tension in the prison environment can lead to an increase in violent incidents and people living in a state of hypervigilance, which negatively impacts mental wellbeing. There are many factors contributing towards violence in prison including bullying and gang membership, illicit drug use and feeling unsafe. People who have a mental disorder, learning disability and/or a neurodevelopmental condition are at higher risk of physical victimisation than those without³¹, which also means that the environment is not conducive for therapeutic interventions and treating mental disorders. While there is policy to support safety and violence reduction³², in prison there are limited opportunities to avoid the risk of violence; be that fear of victimisation or witnessing violence towards people in prison or staff.

Bullying in prison, whether it involves physical violence, verbal abuse or social exclusion, increases states of anxiety and social isolation³³. To avoid further bullying victims may isolate themselves from others which can lead to depression, loneliness and a sense of disconnection from the outside world, especially if they are being told to put pressure on their families to engage in illegal activity. Overcrowded conditions may increase the likelihood of bullying and poor mental health³⁴ as limited resources and close living conditions can intensify interpersonal tensions.

Lived experience: mental health and the prison environment

This panel is summarised from engagement by EP:IC (Empowering people: inspiring change) lived experience consultancy.

People with lived experience reflected that emotional needs can be heightened on arrival to prison or transition between prisons while adapting to the new environment³⁵:

“Worst at first then improves, it’s a rollercoaster at the beginning, it’s the initial shock. You need help with that.”

“I didn’t expect to move prisons, I wasn’t told I would be transferring. I had my own room, and then came here and had to share, there was a mix up with my property, and lost all my friends, it was like coming to prison for the first time again.”

The fabric of the building, separation from family and feelings of safety can all impact their mental health:

“I have PTSD and bipolar disorder because of everything I’ve been through, sometimes the loud noises and other women in prison set me off, but the officers have got to know me and help me when they see me starting to go.”

“When women first come into prison it’s the family ties and fear of the unknown that emotionally charge you. As time passes and you settle into prison life it’s more guilt and past trauma that control emotions.”

“It’s not the prison that makes me feel unsafe, it’s the actions of other people and their behaviour”

“Being alone in my cell for so many hours a day makes me feel so afraid”

Type of prison sentence

The type of prison sentence an individual receives can impact on their mental health. Self-inflicted death is a wider definition than suicide as it also includes any death brought about by an individual’s own actions, regardless of intent³⁶. People in prison on remand (in prison before trial) have higher rates of self-inflicted deaths than people who are sentenced³⁷ (chapter 10). While there is limited research evidence on the relationship between incarceration on remand and mental health, engagement for this report identified that being on remand can cause immense stress and anxiety due to the uncertainty of what will happen at court or not knowing

when they will be released, and thus uncertainty about their life in the future as well as being away from family. People can also lose accommodation, employment, benefits and access to children while on remand, which impacts on wellbeing. This can also foster beliefs of helplessness and hopelessness in some people. Uncertainty about the time that will be spent in prison makes it difficult to commence certain treatments and build therapeutic relationships. Some services (such as the Offender Personality Disorder pathway described below) are only commissioned for people who have been sentenced.

Imprisonment for public protection (IPP) sentences were introduced in 2005 and abolished in 2012. People serving this sentence could remain incarcerated indefinitely – even after serving their minimum term – if they are deemed to pose an ongoing risk to public safety. As of 31 March 2025 there are 2,544 people in prison serving an IPP sentence and all but 6 have passed their tariff date³⁸. There is evidence that people on IPP sentences have higher rates of self-harm than people on other sentences (explored in chapter 10). However, there is no known large-scale study that has used conventional diagnostic methods to ascertain the prevalence of mental illness in the IPP population. Written evidence to Parliament by the charity United Group for Reform of IPP (UNGRIPP) noted 6 studies which investigated the experiences of people serving an IPP and noted common feelings of injustice, perpetual anxiety, hopelessness and despair³⁹.

Lived experience: reflections on the role of IPP sentences on mental health

This panel is summarised from a report by Empowering People: Inspiring Change (EP:IC) and Fair Justice.

Engagement with 52 men with lived experience of the IPP sentence identified a pervasive fear about parole and recall which peppered their days with anxiety:

“Once I get a parole date, I feel like sitting in my cell for 3 to 4 months to keep myself away. Then I won’t get into trouble.”

“I stay in most of the time, even though I’m off my licence now. I drive past probation and think, oh my God, do I have an appointment? Then I remember I’m not even on it anymore. But I still don’t go out. I feel like I’m still on licence.”

For many distress and depression were ever present, some entered IPP system struggling with mental health issues:

“It’s stressful seeing other people leave. Of course, I am pleased for them. But they’ve done a lot worse than me, and off they go. The injustice of it sits badly in the gut.”

Identification of mental health needs

On arrival to prison (reception) people are routinely screened for immediate mental health concerns. This is a brief assessment and resulting action depends on accurate disclosure of the

extent of mental health needs, availability of services and knowledge and experience of those undertaking the screening. Arrival in prison can be overwhelming and this can impact disclosure. Health information can also be accessed from electronic records as described in chapter 7.

Staff and health care teams may also identify mental health issues that arise for people during their stay in prison and individuals may self-report these. Prison officers on residential wings should receive basic training on mental health needs. However, in 1 in 3 prisons inspected in 2019 to 2020 officers had not undergone adequate mental health awareness training⁴⁰. It is essential for all staff to have the skills and knowledge to recognise and act promptly on mental health concerns without stigma. In engagement for this report, we identified staff who were often going the 'extra mile' to support people in prison's mental health. Some staff disclosed the impact on their own mental health from working in an environment with acute distress. This vicarious trauma and the support to mitigate it is explored in chapter 17.

Support for the whole prison population's mental health

A range of non-clinical support is available including from prison chaplaincy, key workers and peer support services, which have a growing evidence base⁴¹. There is evidence that sports-based interventions, horticultural interventions and mindfulness can improve psychological wellbeing in prisons, including distress, anxiety and depression⁴². Chapter 14 explores further evidence and examples of practice. In the children and young people's secure estate a whole prison approach is usually implemented which systematically identifies the mental and social needs to formulate a trauma informed care plan with the individual and the professionals. There is no equivalent approach in the adult estate.

The Female Offender Strategy reported that women are twice as likely to report mental health problems compared to men in prison⁴³. Women in prison have reported higher rates of trauma and complex needs (chapter 4) and therefore it is vital this is recognised in the development and provision of women-specific services including evidence based talking therapies and non-clinical interventions. This was an important recommendation from the 2023 review of health and social care in women's prisons.

Given the high levels of trauma across all people in prison, there is a need for the whole prison to use a trauma informed approach and work in a multidisciplinary way that considers mental health in combination with social and physical needs, including co-occurring substance dependence.

Mental health intervention in the criminal justice system

Community interventions

Liaison and diversion

Liaison and diversion (L&D) services aim to identify people who have mental ill-health, learning disability, substance misuse or other wider vulnerabilities when they first come into contact with the criminal justice system and divert them to appropriate services in the community instead of prison. L&D services are co-designed by those with lived experience. L&D services are 'all age', supporting those from the age of criminal responsibility and upwards.

Services are delivered to:

- all police custody suites
- all magistrates' courts and youth courts
- the 50 highest footfall Crown Court centres
- outreach function, working holistically with individuals in community setting during the currency of criminal proceedings

L&D services are comprised of a multidisciplinary workforce, underpinned by a career and competency framework. L&D services work with over 150,000 individuals a year in England which has increased over time. The proportion of people who may potentially benefit is unknown. L&D services consistently secure engagement rates in excess of 80%⁴⁴. In depth review of liaison and diversion services was not within the scope of this report due to the recency of an internal cross-government 'deep dive' review, conducted by the Home Office Co-Lab research team.

Mental health treatment requirements (MHTR)

Mental health treatment requirements (MHTR) are a type of community sentence treatment requirement used in the UK criminal justice system in England and Wales. They are designed to ensure that people who have committed an offence that are eligible for community or suspended sentence order and have mental health condition such as depression, anxiety, personality disorder, trauma and/or drug or alcohol use disorder, access appropriate treatment and support. NHS England commissions MHTR. They screen, assess and provide psychological interventions⁴⁵.

Primary MHTR support people with lower level mental health needs in the community who do not reach the threshold for secondary care services. Evaluation has identified positive outcomes and improvements in mental health following completion of the order⁴⁶. MHTR recipients had a lower reoffending rate than those on a short custodial sentence (by 9%), and lower than those on a community sentence without a treatment required (by 8%)⁴⁷. Engagement for this report

identified that primary MHTR services are still being rolled out at pace across regions. While there are sites with good practice, there is variation between regions.

People with complex mental health needs, for example those who are psychotic, or who pose a high risk to themselves, are not eligible for primary MHTR. This group may also face barriers accessing community mental health teams due to previous poor engagement and/ or substance misuse histories of substance use disorder. Therefore, there can be a treatment gap for this group of people, as there is also a significant treatment gap in community service provision for severe mental illness. This may prohibit individuals having their mental health needs addressed.

Secondary MHTR are provided and overseen by secondary care providers for individuals who can only be supported by specialist services. This is similar to interventions offered by community mental health services⁴⁸. These currently are only operating at very limited number of pathfinder sites as part of an ongoing evaluation⁴⁹.

Challenges in prison

Models of care in prison

For people with mental illness requiring care in prison (including those awaiting transfer to hospital and all lower-level illness requiring care), there are various clinical models being used. HMP Grendon operates wholly as a therapeutic community for people with a confirmed personality disorder diagnosis, with evidence suggesting reduced reoffending, disruption, self-harm and improved wellbeing^{50 51}. Outside of the unique therapeutic settings, there are also some prisons such as HMP Durham and HMP Hull that have opened bespoke mental health units within the prison to deliver evidence-based care and treatment to people in prison with acute and/or severe and complex mental health needs who are able to consent to treatment and who do not reach the threshold for detention under the MHA. To be considered for wider use there would need to be evidence of efficacy and safety, consistent staffing models, resource and defined outcomes for monitoring. Intensive support mental health teams and greater in reach of community mental health teams and outreach training by specialist services are also in use. One prison healthcare provider engaged for this report had access to mental health nurses 24 hours a day, 7 days a week who were able to assess mental health needs on arrival to prison and complete referrals to mental health teams. The availability of mental health services varies between prisons and was not always proportionate to need.

Personality disorder

The Offender Personality Disorder (OPD) Pathway is a jointly funded partnership between HMPPS and NHS England and also makes provision for Wales. It is a long-term change programme that commissions treatment and support services nationally for people in prison and probation with some of the most complex mental health problems linked to serious sexual and violent offending, specifically for a population that would likely satisfy a diagnosis of 'personality disorder'. A large number of people in the criminal justice system present within the

diagnostic criteria of ‘personality disorder’, however the number who receive the OPD intervention is small and assessment and approval processes can be lengthy.

An evaluation of OPD’s Psychologically Informed Planned Environments (PIPES) found that people in prison reported better social and relational outcomes, improved staff-prisoner relationships and improved pro-social behaviour⁵², however reoffending data was limited. A trial of mentalisation based treatment (MBT) for men on probation reduced reoffending⁵³. Studies have varied in their methods and rigour and there are still many gaps in the evidence base. However, a recurring theme is that the ‘relational approach’, the way of delivering and developing services that promote relationships as the foundation upon which effective interventions are made, is an important factor in achieving positive outcomes. There is limited evidence to identify whether the main components of this practice could be relevant within the wider custodial estate.

Medication

Psychotropic medications are used to influence the brain chemistry, for example to treat psychosis, depression or epilepsy. Research data from 2014 shows that 1 in 5 men and 1 in 2 women in prison are prescribed psychotropic medications⁵⁴, which is higher compared to the general population⁵⁵.

The way that the prison regime (timetable) is managed and the availability of health care staff, means that medicines are usually administered twice per day at approximately 8am and 4:30pm. This includes many medications for certain mental disorders which have sedative effects. This can lead to feeling tired during the day and consequently disrupted sleep patterns. This can then contribute to a poor medication concordance and thus worsening of mental health. While it is empowering and helpful for some medications to be in someone’s possession, there are many factors including trading, bullying, poor concordance, risk profiles and overdose history which have to be taken account to overcome this administration challenge by increasing in person possession. Some prisons had good examples of work to increase appropriate use of in possession medication.

Digital

There are digital barriers relevant to providing optimal care to people with mental disorders. For example, the current legal position around schedule 2 and 3 controlled drugs requires a physical signature. This increases the workload associated with printing and signing of prescriptions. This is particularly pertinent given the significant rise in stimulant medication prescriptions for the treatment of ADHD and is explored in the chapter on neurodiversity. In the community there are growing advances in the use of digital programmes to support mental health⁵⁶. Currently the incarcerated population cannot benefit from these advances.

Hospital Transfer from prison to hospital under the Mental Health Act

Prisons are not a suitable environment for someone with acute mental illness. Some individuals in prison with acute mental illness that meet the threshold for detention under the Mental Health Act (MHA) need to be transferred from prison to a secure NHS hospital. The number of people transferred has increased over the last 10 years. The transfer process is complex and involves multiple teams and organisations including the prison mental health team, the prison, the responsible commissioner, the receiving mental health hospital, and the Mental Health Casework Section. The 'NHS England Good Practice Guidance 2021 – The Transfer and Remission of Adult people in prison under the MHA 1983'⁵⁷ sets out required standards for referral, assessment and transfer for sentenced people in prison under sections 47 to 49 and remand people in prison under sections 48 to 49. The expectation is that the period from referral to assessment will not exceed 14 days, and the period from assessment to transfer will not exceed 14 days, running concurrently to a maximum of 28 days.

In 2024 HM Inspectorate of Prisons (HMIP) published 'The Long Wait', a thematic review on delays in transfer of mentally unwell people in prison⁵⁸. They found that in their sample of those waiting for psychiatric hospital admission across 21 prisons, only 15% were transferred within NHS England guidelines of 28 days⁵⁹. The average waiting time for transfer was 85 days. Unpublished insight data from NHS England provided for this report suggest that these figures have improved in 2024, but still only a minority achieve the expected 28-day transfer, with no difference by sex. Reasons for these delays are multifaceted⁶⁰, including the timeliness of referrals, understanding and communication between teams and organisations and oversight of the process. While many of these issues are currently being addressed, there remain significant structural issues across mental health inpatient provision that must be attended to in order to meet the 28-day transfer time limit for all people in prison. These include the need for significant investment in hospital estates, an increase in appropriately qualified workforce and addressing the mismatch between variations in demand and capacity exacerbated by a reduced flow into community-based mental health and social care provision.

The Mental Health Bill going through parliament in 2025 will include a statutory requirement that 'seeks to ensure' that the 28-day expectation from the time of referral to date of transfer from prison to hospital is upheld. However, this will require significant resourcing of destination hospital placements and more streamlined interface between prison health providers and inpatient mental health teams. There is a need for greater clarity and guidance about the best way to support the mental health of people who are awaiting transfer to a secure hospital.

Practice example: Cheshire and Merseyside Prison Pathway team model

A new Prison Pathway Team model pilot launched across Cheshire and Merseyside in April 2024. The aim was to significantly improve the prison transfer and remissions processes and expedite transfer timeliness in line with the 28-day expectation. The model provides:

- a single point of contact between adult forensic services and prisons in the area and builds networks with prisons and service providers outside of the local area
- an enhanced offer of support to people in prison and prison teams
- support for remission back to prison at an appropriate time after treatment is completed ensuring patients are receiving the treatment in the least restrictive and most clinically relevant environment

Early findings have been very positive, and while support for national roll out is strong, the necessary resource required to enable roll out has not yet been identified.

Place of safety under the Mental Health Act

There are examples of people who, despite having a court order to hospital under the Mental Health Act (MHA) (1983), are nonetheless sent to prison. This is because prisons remain a legal 'place of safety' which can be used while an individual is awaiting a hospital bed for treatment or assessment⁶¹. The Mental Health Bill is removing prison being used as a 'place of safety' for those who require assessment or treatment under the MHA.

Remand for own protection under the Bail Act

The criminal justice environment is not a suitable place for someone who has acute mental health needs. Yet prisons report that this is a persisting challenge. To partially address this issue, the Mental Health Bill is also removing the separate power to remand individuals to prison for their 'own protection' solely on mental health grounds. For this cohort, alternative provisions need to be found to keep people safe and give them access to appropriate treatment and care, unless this provision is available the aims of the MHA will be difficult to operationalise.

Post custody

Through the gate

It is not uncommon for people in prison to be released at very short notice, either because the case against them is dropped or because they have been to court and any sentence imposed has been served through their time on remand. This creates considerable challenges when there is imminent release of an individual that is awaiting transfer to a secure NHS hospital. Section 3 is used to detain individuals in hospital for treatment, but it is only valid once they are actually admitted to the hospital. It cannot be used to hold an individual in prison for treatment. In this

scenario a civil part II MHA assessment, undertaken by an approved mental health professional (AMHP), could be considered. If the person is deemed not to require detention under the MHA then they will be released. Given that the notice of release is short, this often causes significant difficulties in identifying the appropriate community mental health team, as many are not registered with a GP and 13.1% of all prison leavers in 2023 to 2024 were released homeless⁶².

If a person is deemed appropriate to be detained under section 2 of the MHA for a period of assessment, then again, an appropriate hospital must be identified. This is dependent on knowing the 'ordinary residence' of the person and a mental health facility being available. Both factors present considerable challenges in the context of national bed shortages⁶³. The individual at this point should be released from prison into the community. They could voluntarily agree to accept crisis team support or alternative treatment but this can be challenging to arrange if people are of no fixed abode and they would not be compelled to engage in treatment. This treatment gap is similar to that for people in the community, however, healthcare and operational staff in prison described the real challenge of knowing they are obliged to release someone without having an immediate pathway for support.

If the risks are felt to be high at the point of release, sometimes police can be asked to consider their section 136 powers outside the prison. This would have the effect of detaining the person at a place of safety for 24 hours to prompt yet another assessment by an AMHP and a doctor. During engagement for this report, we heard of individuals being released from prison and taken to emergency departments. This offers no controls or safeguards to either staff or the individual as there is no legal power to prevent the person leaving but reflects the sheer challenge of facilitating this process. This complexity is described in the case study below.

Case study: challenges arranging care for people with acute mental health needs and sudden release from prison

Mr B was remanded to prison for a series of minor non-violent offences. In prison, he was taken to the segregation unit following an unprovoked assault on a prison officer. It became apparent he was unwell with a psychotic illness. He was hearing voices and believed he was under government surveillance.

Mr B was referred to hospital under section 48 of the Mental Health Act (MHA). He was referred initially to psychiatric hospital, however a historical marker for possession of a firearm in his youth meant that the referral was forwarded to secure services. An admission was planned to a medium secure hospital. Due to the geographical location of the patient's GP, the hospital was in a different part of the country to the prison. The prison mental health team wrote to the court, located in a third part of the country to let them know that Mr B was being referred to hospital. Regardless, the court processed the charges in Mr B's absence. The prison mental health team was notified that the patient should be immediately released. The mental health team contacted the secure unit to let them know that the bed was now required urgently. There were no beds, and hourly updates were sought.

At the same time, the AMHP were called to convene a civil MHA assessment as it was no longer valid to hold him in prison when the patient was no longer a prisoner. The patient was assessed and section 2 medical recommendations were completed, however by the evening, no bed had been found despite widening the search to out of area beds. The prison mental health team contacted the police to let them know of the patient's impending release. The patient was released. The police attended the prison at time of release and conveyed the patient to the section 136 police place of safety suite. Work to arrange admission was ongoing.

Continuity of care

Community mental health teams are essential for bridging the gap between prison healthcare and the community. They provide psychological therapies, medication management and social support. Although there is an absence of data, engagement for this report identified wide challenges in provision of community services on release. It is widely acknowledged that there is insufficient capacity in the NHS community mental health and crisis services to meet demand for the general population.

When there is sufficient time to plan for release community mental health teams can collaborate with prison healthcare teams to arrange continuity of care. A joint thematic inspection in 2021 identified that there are substantial challenges with continuity of mental health care from custody into the community⁶⁴. Mental health services may also have higher thresholds in the community than in a prison. This is likely appropriate given the complexity of experience, environment and challenges with diagnosis, yet it means that patients may not meeting the strict clinical thresholds on release. Waiting lists for services in the community are also long, leaving very vulnerable people with gaps in their support at a time of significant change. The community offer will vary between geographies making it challenging to know what is available. This all makes effective risk management planning a challenge for probation as it is not clear who will be working with a person on release. There are examples of innovation in this space, for example in the east of England the probation office is working in partnership with their integrated care boards to commission a pilot on-site mental health support for the approved premises in Bedford. In other regions probation offices have commissioned their own mental health nurse to work with positive uptake and engagement.

Summary

Mental-health needs are common across those under the criminal justice system compared to the general population⁶⁵. Around 1 in 7 people in prison are identified as having a treatable mental disorder⁶⁶. Not all prisons have mental health services sufficient to respond to need and there are significant challenges in the pathways to secure NHS hospitals, and for continuity of mental health care. People on probation may also have higher mental health needs than the general population. There are challenges with accessing community mental health services and crisis services at times of deterioration, as there are for the general population.

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9 Supporting neurodivergent people and those with neurodevelopmental conditions within prison and on probation

Author: Neisha Betts

Contributors: Callum Allison, Dr Alexandra Lewis, Dr Varinder Panesar, Dr Peter Stevens, Dr Ruth Scally, Dr Matthew Tovey, Lucy Chadwick, Dr Sunil Lad, Professor Seena Fazel

Introduction

Research demonstrates that the prevalence of neurodivergent people within the adult prison population is higher than in the general community population^{12 3 4 5}. This is also thought to be the case for a number of diagnosable neurodevelopmental conditions^{6 7 8}. Not all of these people arriving into prison will have a confirmed diagnosis. Many may have struggled to access health and other support or education systems before going to prison. Once in prison, many may have challenges communicating or conveying any specific areas of difficulty and support requirements. They may also have a range of other health needs and possible trauma.

Certain neurodevelopmental conditions also have associated common physical and mental health needs that may require treatment^{9 10 11}. People with a learning disability are more likely to have some long term health conditions such as type 2 diabetes¹² and die at a younger age than the general population¹³. Also, it is well established that people with conditions such as learning disabilities and autism are less likely and often less able, to access healthcare services and therefore engage with healthcare treatment^{14 15 16}.

Speech, language and communication difficulties are known to impact a significant proportion of the adult prison population^{17 18} and are a common feature of many neurodivergent and neurodevelopmental conditions, requiring adapted and easy to understand communication methods and resources.

Generally, there is increased organisational and staff awareness within the criminal justice system concerning the high number of people who are neurodivergent and the potential support needs they may have. In December 2020, the then Lord Chancellor and Secretary of State for Justice commissioned HM Inspectorate of Prisons and HM Inspectorate of Probation, with support from HM Inspectorate of Constabulary and Fire and Rescue Services, to undertake an independent review of adult neurodiversity within the criminal justice system¹⁹ which produced clear recommendations for the respective criminal justice agencies.

The review highlighted the importance of cross-government, agency or partnership working to support neurodivergent people in the system, as well as improvements in the approach to

screening, information sharing, data and recording, awareness and training, and reasonable adjustments. This did not include the respective (justice-based) healthcare services directly. However, there had also been a national learning disability based joint inspectorate of prison and prison healthcare previously²⁰.

There is a range of publications from charities and advocacy or user-led organisations on the topic of being neurodivergent within the criminal justice system, providing readers with insights into the lived experience issues, backgrounds, concerns and also hopes people have for the future of the justice system²¹.

This chapter sets out to provide a high-level overview of the current situation for those individuals with known or suspected neurodivergence, or neurodevelopmental conditions, who find themselves within prison or on probation. This builds upon previously published work, such as the 2021 independent inspectorate review²², with an additional focus on the role of the respective healthcare services that are aligned with the prison and probation stages of the justice system. It promotes the idea of a more 'neuro-inclusive' justice system, whereby everyone can fully understand, engage and benefit; both in terms of improved health and support and to help reduce reoffending.

Lived experience: the need for a more neuro-inclusive justice system

Quotes from members of the lived experience team, Revolving Doors neurodiversity policy position²³

"As soon as you enter prison, you're swimming against the current because you're neurodivergent. The lack of understanding between the churn in the criminal justice system and those who work there, it really does have an impact on your progression through prison."

"You are expected to fit the system. But it can't work like that, you need to see the individual."

Definitions

There are many definitions that can be used to describe neurodiversity, the following are examples.

Neurodiversity: the term neurodiversity is a combination of the words 'neurology' and 'diversity'. The term originated from a social justice movement via online forums of autistic people in the 1990s. It is used to describe the variety and variability of neurological functions operating within the minds of groups of people. This term is a descriptor for variability in groups, rather than for use to describe individuals.

Neurodivergent or neurodivergence: a person or group who fall outside parameters of the most common ways of thinking may be referred to as neurodivergent. The range of disorders this

term can be used to encompass varies; there is no universally agreed definition of the conditions it covers. However, it typically includes autism, attention deficit hyperactivity disorder (ADHD), specific learning difficulties (such as dyslexia, dyscalculia and dyspraxia) and Tourette’s syndrome. The Ministry of Justice (MoJ) and HM Prison and Probation System (HMPPS) have adopted a broad definition that includes conditions such as acquired brain injury.

Neurodevelopmental disorders: a neurodevelopmental disorder is a diagnostic classification or term and refers to behavioural and cognitive disorders that arise during the developmental period, that involve significant difficulties in the acquisition and execution of specific intellectual, motor, language or social functions. The 2 main diagnostic classification systems in use are the World Health Organization’s ICD-11 and the American Psychiatric Association’s DSM 5. Some examples include disorders of intellectual development, developmental speech or language disorders, autism spectrum disorder, developmental learning disorder, developmental motor co-ordination disorder and ADHD²⁴. Some people object to the word ‘disorder’, as it is deficits-focused and prefer to use the term ‘condition’ instead, as this acknowledges that aspects of the neurodevelopmental disorder can be an area of strength for the individual. However, the classification systems use the term ‘disorder’.

Lived experience: neurodiverse conditions explained by service users

Quote from the UserVoice 2023 neurodiversity report²⁵, from people with experience of neurodiversity in the criminal justice system:

“There are some things I don’t understand about myself even now, like, I want to understand why my brain tells me to do that, rather than do this. Why don’t I think before I act? I don’t know...” Male, 19, with ADHD, learning difficulties and/or disabilities, dyscalculia and self-diagnosed autism.

The needs of neurodivergent people within prison

The prison environment can be difficult and stressful to navigate and can often exacerbate the difficulties experienced by a neurodivergent person or someone with a neuro-developmental condition. This can be due to individuals experiencing specific sensory needs, overstimulation, inflexible routines, inaccessible communication or insufficient quiet spaces.

All staff operating within prison and probation services have a duty to understand and provide reasonable adjustments for the individuals they work with under the Equality Act 2010^{26 27}. This is to ensure people are not disadvantaged by areas they may struggle with and therefore have equal access to the information, support, education and opportunities available.

HMPPS take a needs-led approach to supporting people in prison, including those with neurodiverse related needs, to ensure their needs are identified as soon as possible, which then allows for appropriate reasonable adjustments to be put in place.

By making adjustments to the physical prison environment and improving accessibility generally to accommodate neurodiversity, a person's ability to engage with staff and services could be significantly improved. This may improve overall wellbeing. A few prisons now have a dedicated neurodiversity wing, one has an autism wing, some have sensory rooms, or resources such as fidget or sensory walls. Their impact has not yet been independently evaluated.

Practice example: HMP Pentonville's neurodiversity wing

This is an initiative whereby a self-selecting group of motivated officers are supported by clinicians from the prison's mental health provider to meet the needs of prisoners with a range of suspected or confirmed neurodevelopmental conditions and acquired neurological disorders on a specifically designed wing of the prison. The wing also provides environmental adaptations including a therapeutic regime and sensory room to enable residents to escape stressful contexts for somewhere calmer than they would have had access to on normal location. The service hosts open days and has received positive national media attention.

Various actions and initiatives have been taken in response to the independent inspectorate review's recommendations²⁸, including the recent roll out of prison neurodiversity support managers and a planned 'additional learning needs' screen called the "Do It Profiler" to be offered to all adults in prisons. Prison healthcare services should work closely with the new prison neurodiversity support managers and with prison education, to collaboratively meet the various needs that neurodiverse people or people with neuro-developmental conditions may have while in prison. For example, agreeing local information-sharing processes, multidisciplinary meetings and what appropriate referrals to healthcare would entail.

Practice example: neurodiversity support managers in prisons

HMPPS introduced the neurodiversity support manager (NSM) role, trialling it in 2021 to 2022 before rolling it out across the prison estate by 2024. NSMs are responsible for providing training and guidance to prison staff to equip them to better support neurodivergent individuals. They also improve processes to identify and support prisoners to enable access to education, skills and work opportunities within the prison, and ensuring that reasonable adjustments are made to prison environments to make it more supportive of neurodivergent needs. Their impact has not yet been evaluated.

Lived experience: positive encounters with prison staff

Quote from the UserVoice 2023 neurodiversity report²⁹, from people with experience of neurodiversity in the criminal justice system:

“One of the staff members here, Mr X, he told me about his son who has ADHD. He is the only one who comes up occasionally and just talks, you know, whenever he can. He actually realises the problem. He realises how hard it can be.” Male, 35 with ADHD and post-traumatic stress disorder.

The role of prison healthcare in supporting neurodivergent people

It is expected that all types of healthcare delivered within prisons operate with an awareness of the potential support needs neurodivergent individuals may have and the ability to adapt and meet these, as appropriate. For healthcare services, a large proportion of these reasonable adjustments are centred around adapted communication methods and resources.

Prison healthcare services also have an important role in terms of providing clinical screening, where appropriate, for neurodevelopmental conditions and acquired brain injury. These services also help individuals with any physical or mental health issues related to their neurodevelopmental condition. While there are some good examples of this working well, there are also a proportion of services with challenges in this pathway as described below.

Where specialist staff are employed within prisons, such as learning disability nurses, speech and language therapists and occupational therapists, the respective care pathways typically have more in-house support options available. However, prison healthcare services are affected by the national shortage of such specialists, as well as facing other barriers to recruitment. For example, there is a lack of awareness of the opportunities for these professions within prison settings and the impact of significant delays due to security vetting can be off-putting.

Practice example: neurodevelopmental conditions pathway

HMP Forest Bank has a neurodevelopmental conditions pathway involving specialist multidisciplinary clinicians (provided by Greater Manchester Mental Health (GMMH) NHS Foundation Trust). It includes specialists learning disability nurses, consultant level nursing, psychology, psychiatry and administration. It provides a pathway model of care, designed to be responsive to the needs of the individual with diagnosed or clinically suspected autism, learning disability or ADHD. People are referred from the wider healthcare teams of HMP Forest Bank and there is an extended offer to neighbouring GMMH prisons for consultation and/or advice.

Support, whether it be by further assessment, formulation, advice on adapted intervention, or recommendations for practical support, are provided to both staff and the patient in question. The pathway may sign-post to a range of charity or prison-based initiatives for wider neurodiversity based support. The specialist secondary clinicians working on the pathway can offer external agency working for release planning, clinical risk assessments, medication management, care co-ordination, staff support packs, care-plans, and others, as required. They also support and provide awareness training for their healthcare and prison colleagues on neurodevelopmental conditions. The service is very clear that healthcare support is just one piece of the multifaceted jigsaw when meeting the needs of this cohort within prison.

Some neurodevelopmental conditions, such as ADHD, have medication options for those people who may benefit, as well as other psycho-social treatment options. Engagement with stakeholders for this report has revealed some issues regarding ADHD medication within prisons. For other neurodevelopmental conditions, there are also important medication related considerations for prison healthcare and pharmacy services (for example, the impact of over-medicating people with learning disabilities or autistic people)³⁰.

It has been found that pharmacological ADHD treatment can help reduce reoffending rates^{31 32}. Plus, in the general population there is evidence that medication lowers mortality³³ and improves other behavioural and neuro-psychiatric outcomes³⁴. However, recent research found no benefit in behavioural outcomes for prisoners diagnosed with ADHD taking medication³⁵. It is therefore important to undertake further work to understand which prisoners and people under the supervision of probation might benefit from this intervention and then ensure the medication is available for those who need it.

As people in prison move in and out, and between, prisons and therefore between prison healthcare and community GP services, access to ADHD medication can be potentially affected in various ways. For example, those prescribing the medication need to feel confident about the credibility of a diagnosis for any new patient, especially given concerns about the potential 'tradability' of ADHD medication (most being classed as a controlled drug). Other factors include the combined effect of other medicines and a potential lack of access to ADHD specialists able to carry out the National Institute for Health and Care Excellence (NICE) recommended 12-month medication review³⁶. This may lead to delays in receiving prescriptions.

Identifying neurodiverse or neurodevelopmental conditions within prison

Within the first 24 hours of arriving in prison, prison healthcare services undertake an initial health screen for all patients, followed by a full health assessment within the first 7 days. These provide opportunities for identification of known conditions or needs, as well as capturing any required reasonable adjustments.

However, some individuals may be unaware that they may have a specific condition or unable to fully communicate their level of support needs at this point or may 'mask' any difficulties initially. In addition, not all staff may be trained in neurodiversity and neurodevelopmental awareness to a level that can help with identification.

Not all neurodiverse conditions come under the remit of prison healthcare services in terms of clinical screening. Healthcare covers screening for neurodevelopmental disorders and acquired brain injury (ABI), as appropriate. Screening for specific learning difficulties, such as dyslexia, is the responsibility of Prisoner Education Services.

HMPPS education departments offer a screen for possible areas of need to all those coming into prison. This helps identify any additional needs a person may have that potentially impact their ability to engage with the prison regime and to navigate the environment and opportunities within the prison. From October 2025, on entry to prison all adults in prison will be offered an additional learning needs screen in the form of the 'Do-IT profiler'³⁷, via prison education providers. This tool will identify individual strengths and any additional learning needs, including those associated with neurodivergence. It will also suggest practical support strategies and offer guidance relating to potential areas of strength and need. Work is also underway to ensure the outcome of such screening is shared with partner agencies, such as prison healthcare where appropriate (and with consent) and to help ensure any referrals to healthcare are appropriate, given limited capacity issues.

Prison healthcare services should be able to provide additional clinical screening, where they discern this is clinically appropriate, based on the presenting evidence and information. Healthcare will also consider the impact of other co-morbid conditions, intoxicated states, trauma and gender, which can affect how an individual presents and screening outcomes.

A positive screen enables staff to ensure an individual is on the appropriate care pathway, to further assess and tailor support requirements and to help address any presenting needs, including any associated mental or physical healthcare issues that are identified. It does not mean an individual will automatically receive a diagnostic assessment or confirm a diagnosis.

The national shortage of staff trained to undertake diagnostic assessments for neurodevelopmental disorders impacts prison healthcare, as it does the wider community. If a prison healthcare team does not have access to this expertise, then the decision to undertake a neurodevelopmental diagnostic assessment is dependent upon the judgement of the lead clinician and the discretion of the local commissioner, as this does not form part of the standard prison healthcare contract or commissioning framework. Other agencies operating within the prison may also organise or commission a diagnostic assessment for an individual, for example where there is a non-clinically related need for a diagnosis, such as a parole request.

Prison healthcare services operate under a 'principle of equivalence'³⁸ with community services, whereby prison health primary care services can refer to community secondary care services and waiting lists. However, as part of evidence gathering for this report, this does not appear to be happening or possible within most prisons with regards to accessing community neurodevelopmental assessment waiting lists or assessments. This means that the majority of individuals who screen positive for certain conditions, do not receive a diagnostic assessment

when in prison and experience delays being able to join community waiting lists for assessments (that is, they are able to join when they leave prison, prolonging their waiting times).

There appears to be a need for more consensus and understanding as to the role of the respective agencies and details concerning how this can and should happen when there is no one qualified via prison healthcare to deliver this, which is common. There are also reports of individuals being removed from community neurodevelopmental waiting lists when they enter prison, possibly as record changes are taken to mean they have permanently moved out of the area. People in prison should have equivalent access to any service they are clinically assessed as needing and being in prison should not be a barrier to accessing services, regardless of who commissions or provides them.

For many, where the appropriate awareness and needs-based support is provided by all agencies within a prison, this lack of diagnosis does not significantly impact their ability to engage with justice and healthcare systems. However, for others, this can be an obvious barrier to accessing interventions, such as medications, that could have a significant impact upon their health, wellbeing and ability to cope and engage with these systems.

Lived experience: what a diagnosis means

Quote taken from a paper by Empowering People: Inspiring change (EP:IC) lived experience consultancy in the Prison Service Journal³⁹.

“I think receiving a diagnosis of neurodivergence in prison would go a long way to decreasing rates of recidivism [reoffending]. For years I thought I was stupid... I was too impulsive to hold a job or get on with others in the work environment. Selling drugs was something I was good at; I was self-employed. So, to know that I am neurodivergent has been liberating. Turns out I’m not stupid. Even if it doesn’t change the condition, knowing that means I can be less hard on myself, more compassionate.” Individual with lived experience of the justice system.

The needs of neurodivergent people on probation

For neurodivergent individuals and those with neurodevelopmental conditions, the period leaving prison and moving to being under the supervision of probation services as they resettlement back into the community can present additional difficulties and challenges.

It may also mean the level or type of support a person needs may change and a number of key actions are typically required to help ensure they are not disadvantaged by unmet needs. For example, ensuring all staff are well aware of how to support individuals with neurodivergent related needs, the provision of the appropriate reasonable adjustments and also adapted versions of standard offending behaviour programmes to ensure these are fully accessible for all.

A ‘diversity and inclusion form’ is used at the earliest point of contact with the probation service, to gather personal information related to an individual’s protected characteristics and

associated needs. Probation practitioners use this form to start a conversation about needs for people with disabilities. This provides an early opportunity for people on probation to discuss any reasonable adjustments they may need in relation to their sentence management.

A lack of a confirmed diagnosis should not be a barrier to probation services providing required reasonable adjustments, including those required to address barriers to understanding and benefiting from offending behaviour programmes. While some programmes offer adapted versions, not all are suitable for all types of difficulty or information processing.

Probation staff also have a critical role to play in generally assessing individuals at the courts stage and providing recommendations or notes for the judge (via pre-sentence reports) concerning an individual's ability to comprehend and interact with the various stages of the criminal justice system (given any known difficulties the person may have).

Lived experience: concerns about continuity of care

Quote from a prisoner via interviews by A Better Life (ABL)⁴⁰:

"I am going to an approved premises, so I'm worried staff won't be trained to support me. I am on medication in custody at the moment, I hope I can get my prescription sorted for outside"

Meeting the health and social care needs of neurodivergent people on probation

People on probation are served by community health and social care services. Some people may be supported by local community teams, for example learning disability or autism services. Ideally there is a co-ordinated relationship and communication between such services and an individual's probation officer, to facilitate the best possible outcome. Improvements in data and information sharing, recommended in chapter 7, would help to facilitate this. However, often individual's leaving prison are not eligible for community specialists services due to differing thresholds for treatment.

For people leaving prison, ensuring they are registered with a community GP is vital. Where a neurodivergent or neurodevelopmental condition is suspected but not confirmed, the community primary care services are the vehicle by which probation staff can steer individuals towards the waiting list for a further assessment.

Some individuals leaving prison may also be referred to their local 'RECONNECT' service⁴¹. This service seeks to improve the continuity of care of people leaving prison with an identified health need. Staff work with people before they leave to support their transition to community-based services, thereby safeguarding health gains made while in prison. The goals and mechanisms of RECONNECT are explored in chapter 15.

Figure 1: neurodiversity pathway principles



Depicts the neurodiversity pathway principles designed by people with lived experience for the national RECONNECT programme. Ensuring people could trust the service was reported as key to its success as well as well trained staff that treat people as individuals.

Summary

The prevalence of neurodivergent people and diagnosable neurodevelopmental conditions within the adult prison population is estimated to be higher than in the general population. Prison can be difficult and stressful to navigate and can often exacerbate the difficulties experienced by a neurodivergent person or someone with a neuro-developmental condition. Both prison operational staff and prison healthcare have important roles. Healthcare undertake screening and secondary care can support with management and medications. There are challenges over the clarity of responsibility for diagnostic assessments for neurodevelopmental disorders for people in prison, and continuity of care as people move in and out of prison. Movement can also interrupt access to ADHD medication.

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10 Self-harm and suicide in prison

Authors: Professor Seena Fazel

Contributors: Dr Matthew Tovey, Dr Sunil Laad, Gavin Entwistle, Stephen Firth

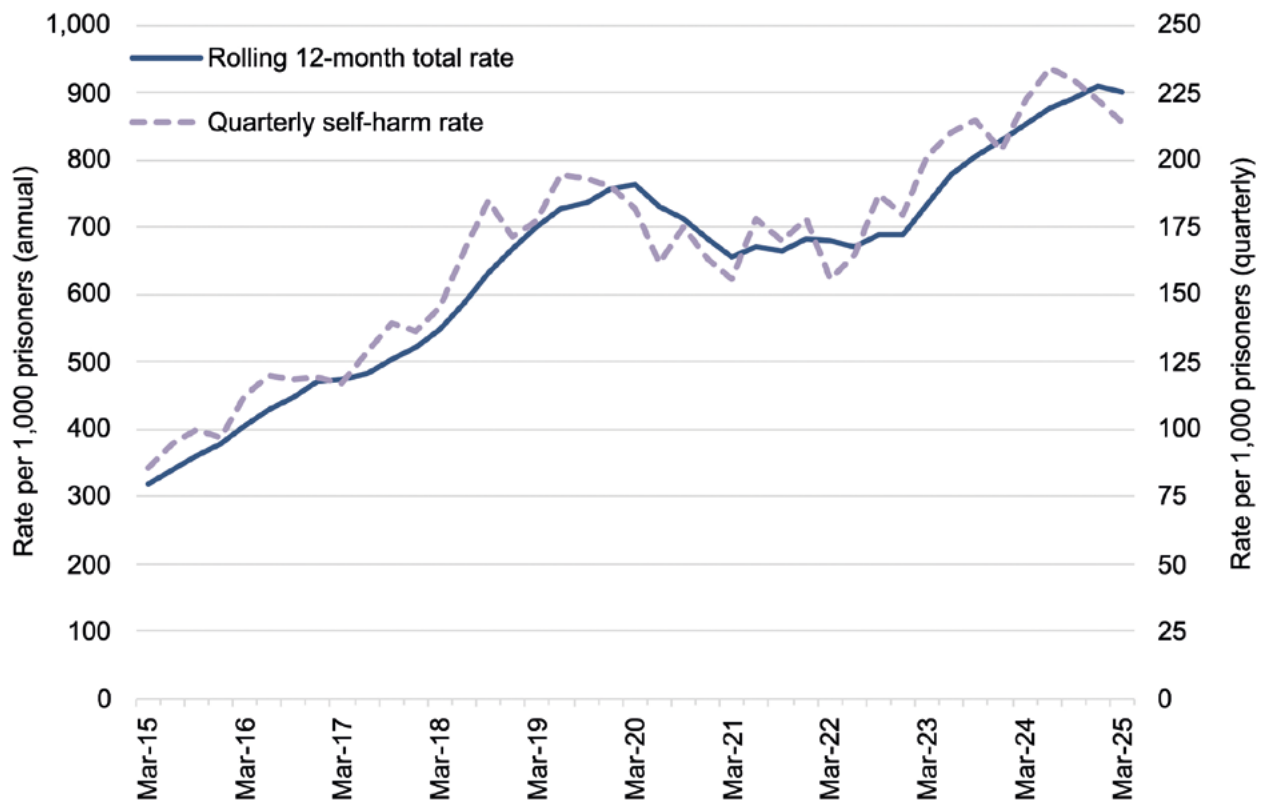
Trends and implications

Self-harm

Self-harm rates and incidents in English and Welsh prisons have increased year on year since 2013, except for a reduction in 2019 to 2021 (figure 1)¹. The rate of self-harm incidents in prisons in England and Wales was 899 per 1,000 people in the 12 months to March 2025 (77,898 incidents), an increase of 6% compared to the year before².

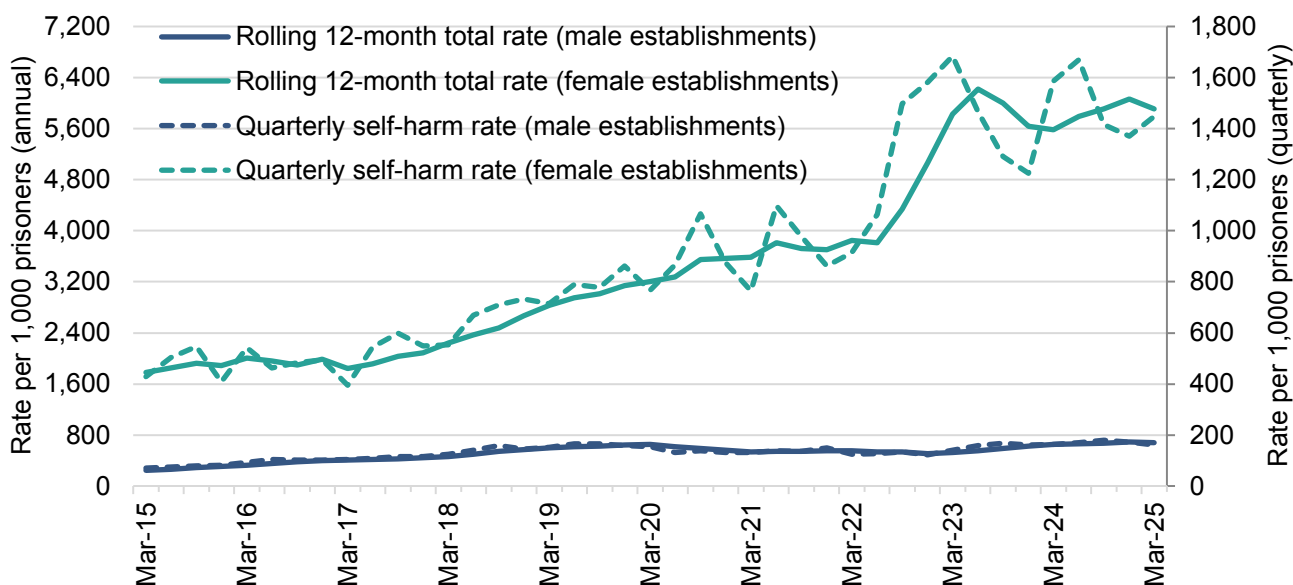
Although the number of self-harm incidents are lower in the female estate, the rates are more than 8 times higher than that in the male estate (5,906 incidents per 1,000 prisoners, in comparison to 684 incidents per 1,000 prisoners in the male estate in the 12 months to March 2025) (figure 2)³.

Figure 1: quarterly 12-month rolling rate of self-harm incidents per 1,000 people in prison, 12 months ending March 2015 to 12 months ending March 2025, with quarterly rates



Source: Ministry of Justice and HM Prison and Probation Service Safety in Custody Statistics⁴

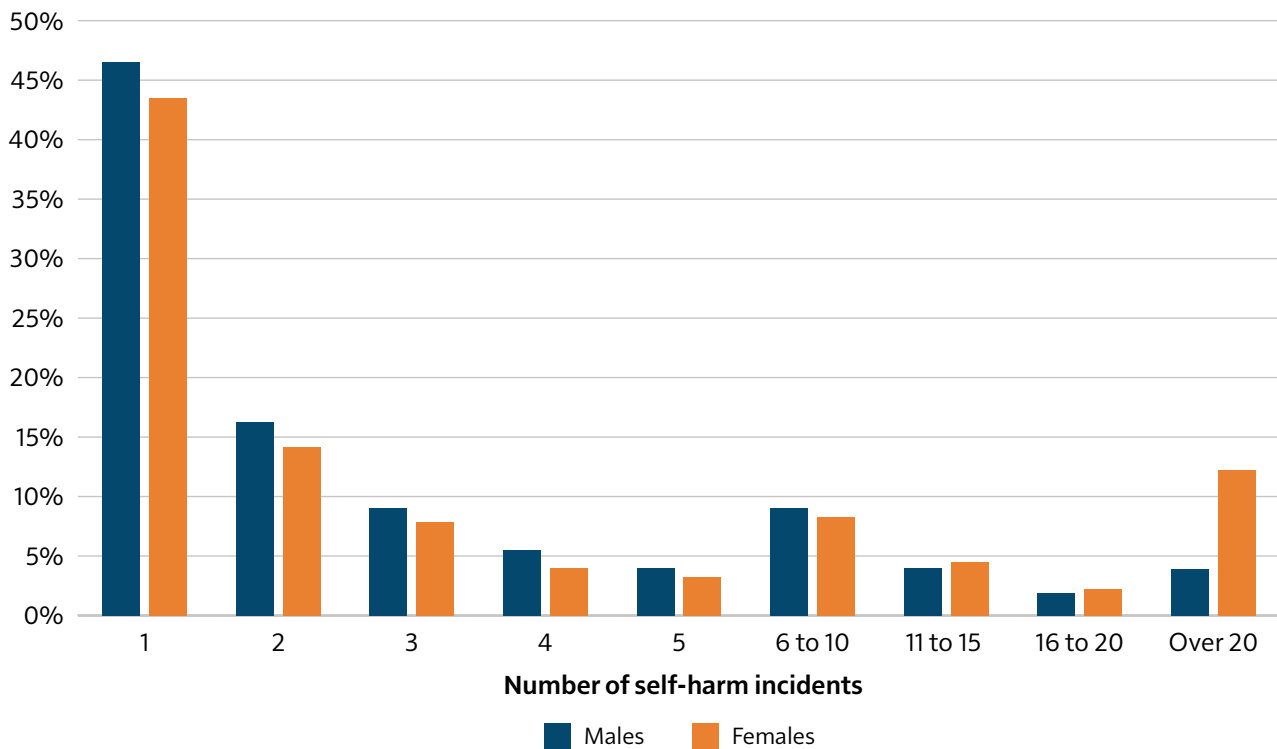
Figure 2: quarterly 12-month rolling rate of self-harm incidents per 1,000 people in prison by gender of establishment, 12 months ending December 2014 to 12 months ending December 2024



Source: Ministry of Justice and HM Prison and Probation Service Safety in Custody Statistics⁵

In the 12 months to December 2024 the average number of incidents of self-harm per individual was 5.7. The average number of incidents per self-harming individual was 4 times higher in the female estate compared to the male estate (18.7, compared with 4.5 incidents per self-harming male in the male estate in the 12 months to December 2024). A small number of individuals who repeatedly self-harm have a disproportionate impact on this figure, with just over half of people in prison who self-harmed in 2024 doing so more than once, and 495 (3.9%) males and 142 (12.2%) females self-harming more than 20 times (with 84 females self-harming 50 times or more) (figure 3)⁶.

Figure 3: proportion of individuals self-harming by frequency of self-harm incidents in 12 months ending December 2024



Source: Ministry of Justice⁷

In the 12 months to December 2024, 3475 self-harm incidents in prison led to hospital attendance^a, predominantly to accident and emergency without requiring inpatient admission (96.5%). Self-harm in prison leads to substantial morbidity and financial and operational costs⁸. It is also associated with higher rates of suicide mortality in prison⁹ and on release¹⁰.

The rate of self-harm incidents can vary between prison population group. For people on remand (which can be prior to conviction or to sentencing) the rate is higher than for sentenced prisoners (1,016 per 1,000 prisoners compared to 833 per 1,000 prisoners in 2024). Within the sentenced population, the rate was higher for recalled prisoners (1,466 per 1,000 prisoners) and prisoners on imprisonment for public protection (IPP) (1,198 per 1,000 prisoners)¹¹. For many people, their first experience of prison is on remand. People may be detoxing from drugs and experiencing removal from their families and support networks. The remand population is currently at its highest level in at least 50 years. People are being held on remand longer. Those on IPP sentences do not have release dates and can be detained indefinitely if the Parole Board decides it is not safe to release them. When released, a person serving an IPP sentence will be on licence, subject to conditions. The licence will be in force until it is terminated.

^a Need for hospital attendance is dependent on the healthcare facilities available at the prison

Suicide and self-inflicted deaths

In England and Wales, there have been around 88 self-inflicted deaths per year on average over the last decade. The rate has remained fairly stable at around 1 death per 1,000 people in prison. Self-inflicted death is a wider definition than suicide as it also includes any death brought about by an individual's own actions, regardless of intent¹². There is no such thing as an acceptable level of such deaths.

From a wider European perspective, over an 18-year period, prison suicide rates in England and Wales have been higher than the European average. The incidence rate was 96 per 100,000 person-years of imprisonment in England and Wales compared with a median rate of 75 in all European countries (including the UK nations). English and Welsh suicide rates for people in prison were not different to Scotland and Northern Ireland, and lower than in France, Norway and Denmark¹³.

People in prison on remand have higher rates of self-inflicted deaths (1.8 per 1,000 people in prison in 2024) than those sentenced. In each of the last 10 years, people in prison on remand accounted for between 27% and 40% of all self-inflicted deaths¹⁴. HM Prison and Probation Service (HMPPS) does not routinely report the rate of self-inflicted deaths by other sentenced subpopulations as the numbers are small and vary year on year. The Independent Advisory Panel for Deaths in Custody (IAPDC), using official data, reported that the rate of self-inflicted deaths for people in prison on IPP have varied from 0.6 to 1.7 per 1,000 people in prison¹⁵, comparable to the overall rate published by HMPPS of around 1.0 per 1000 over the last decade. However, IAPDC and The Prisons and Probation Ombudsman note that IPP sentences "could lead to hopelessness, which is associated with an increased risk of suicide"¹⁶.

Impact on prisoners and staff

Lived experience: self-harm in prisons

Engagement with stakeholders for this report found that some incidents of self-harm in custody can be very serious and complex to manage, for example extended periods of food and fluid refusal, extensive cutting or self-strangulation. Engagement by Empowering People: Inspiring Change (EP:IC) consultancy reflected on this:

"The biggest health need in here is mental health, probably self-harm. I work for the biohazard team and some self-harm, ... there was this one and the blood was everywhere. How she wasn't dead I don't know." (Female – Women's Review Report)

Frequent exposure to traumatic events can impact on the health and wellbeing of other people in prison:

"You see a lot in prison, self-harm, someone cutting up, you don't even blink – you just get on with it – ain't right." (Male – Drug Recovery Wings Report)

"In prison you see people get hurt, self-harm, lose everything, no one can undo all that shit, you just have to get on with it." (Male – Wellbeing Report)

Exposure to traumatic events can also impact on both healthcare and prison staff. Compassion fatigue has been defined as the reduction in ability to provide empathic care following exposure to multiple or even single traumatic events¹⁷. Research from 36 mental health nurses and prison officers in a large local remand prison in London, published in 2019, identified frequent exposure to suicide and self-harm, with around half having medium or high levels of burnout and around 1 in 3 reporting medium levels of compassion fatigue¹⁸.

“One nurse said to me when I self-harmed “stop it, where’s it going to get you?” They don’t understand the root of the problem. It’s not a case of me saying “oh OK then I better stop, I hadn’t realised it wasn’t getting me anywhere”. It’s not trauma informed. They don’t really know what they’re doing.” (Female – Women’s Review Report)

“You can cut up all day and you get f*** all.” (Male – CSU Report)

“Another issue I would like to raise is how nurses deal with self-harm. I have been in custody 13 months, so I am a frequent self-harmer, and unfortunately the duty nurses get called quite often. However, some of them make me feel guilty for doing it, like they’re wasting their time... It’s just got to the point where I usually self-harm after I’ve seen a nurse, so they come half-heartedly, dress it and I do it again because I am made to feel worthless and like I am less than nothing.” (Female – Women’s Review Report)

HMPPS and healthcare teams have implemented a range of approaches to reduce the impact on staff. These include:

- Wellbeing and Support leads who focus on wellbeing of staff following an incident in the workplace
- Trauma Risk Management training (TRiM) (a peer-led support scheme for frontline staff who have experienced a traumatic event) in all establishments. As of January 2025, there are 1,750 TRiM practitioners
- a proactive offer of support to staff from care teams (a peer support initiative comprising of prison staff) in any establishment where there has been a self-inflicted death

Risk factors for self-harm

There are a wide range of replicated risk factors for self-harm across clinical, prison-related, historical and sociodemographic domains¹⁹. Two key findings emerge from a systematic review of this work – first, that the magnitude of effect that these risk factors have on self-harm varies considerably between these overall domains. For example, strong risk factors have been reported in the clinical domain, including for major depression and psychotic disorders (such as schizophrenia-spectrum and bipolar disorders). Substance misuse and anxiety disorders are also linked to self-harm in prison. Prison factors include separation from other prisoners, disciplinary infractions, experiencing sexual or violent victimisation while in custody, and being threatened with violence²⁰. Not having social contacts or visits and not engaging in purposeful activity (such as work or education) in prison is also associated with higher self-harm rates²¹.

Some of these are modifiable and can therefore be targeted as part of prevention approaches. Adverse childhood experiences including abuse and having been in local authority care are linked with self-harm in prison. Engagement for this report with a wide range of clinicians and professionals identified other contributing triggers for self-harm, for example self-harming in order to precipitate a move into segregation as protection from violence. Unlike in the general population, systematic review evidence has not found difference in the effects of risk factors effects by gender for people in prison²².

One of the possible explanations for increasing rates of self-harm is that people who have been entering prison more recently bring with them more historical and clinical factors than those coming into prison in the past. This may be due to alternatives to prison being used in those with fewer psychosocial difficulties, resulting in a more disadvantaged and marginalised population coming into prison. Longitudinal data on the prevalence of these background risk factors in successive cohorts of people in prison could support this hypothesis, but this work remains to be conducted in the UK. By examining responses to questionnaires²³ from the HM Inspectorate of Prisons, one risk factor that has been trending upwards is the proportion of women reporting drug problems. Another possible explanation for increasing self-harm rates is that the particular prison conditions that impact on mental health have worsened. This is a complex area as environmental factors are interrelated and also interact with individuals in prison. Despite this, there are reports of an overall decline in some aspects of the prison regime, such as less experienced staff and more absenteeism, with likely knock-on effects on social support and the amount of time people in prison spend out of their cell engaged in meaningful activity. Although there has been increasing awareness of neurodevelopmental disorders in criminal justice settings, there is little evidence of links with self-harm in custody. Neurodiversity is explored further in chapter 9.

Evidence and initiatives to improve outcomes

Interventions with people with identified mental health conditions (secondary prevention)

On the basis of the evidence of risk factors, the strongest of which are clinical and modifiable, primary care and mental health services have a major role to play in reducing self-harm rates in prisons. The identification and treatment of clinical depression, psychotic disorders, personality disorders and other mental disorders will be central to this. Practice challenges and opportunities for supporting people with mental disorders is explored further in chapter 8, including health services, and the Mental Health Bill that aims to speed up access to specialist inpatient care and ensure faster access to specialist inpatient care.

Interventions to reduce risk of self-harm (primary prevention)

A recent review that examined suicide prevention strategies in prisons internationally highlighted the lack of robust trial data, but usefully pointed to approaches that have not been effective²⁴. This evidence synthesis found there was very limited high quality research evaluating dialectical behaviour therapy, and that individual psychological treatment trials have

used poor methods. Peer support programmes also lack robust evidence from research trials. However, there are promising findings from group-based interventions, which need to be adapted for people in prison and not transplanted directly from the community. Although most of the research is conducted in male prison populations, there is no indication that different approaches should be used for women in prison.

In medicine more generally, a model of prediction and prevention has become part of a wider approach to more personalised healthcare. Here the approach is that risk stratification models can inform which individuals should receive what therapies, not to deny standard care, but to facilitate efficient allocation of resources. Self-harm is one such example where not everyone can receive a gold standard approach of psychological treatment with regular follow-up and booster sessions. This is due to considerable resource that would be required to deliver and enable it. National Institute for Health and Care Excellence (NICE) (2022)²⁵ and NHS England (2025)²⁶ guidelines state that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm and that risk should not be stratified into low, medium or high risk categories to determine treatment or discharge. This guidance is based on research with older and mostly unvalidated tools, many of which were developed as symptom checklists rather than prognostic models for adverse outcomes and are based on tools that classify people into risk categories. However, new tools developed by the chapter author since NICE guidelines publication have used novel approaches to improve accuracy, use probability scores (which allow for more personalised decision-making), have cost-effectiveness findings in support and can be used to support clinical decision-making and consistency in the assessment of risk between and within services. Importantly, guidelines clarify that everyone who self-harms should receive a basic level of clinical care and denial of care on the basis of tools is not acceptable (nor is it on the basis of unstructured clinical decision-making). Therefore, this new evidence suggests that structured approaches, particularly in those who have self-harmed²⁷, can assist with better targeting of resources, liaison with mental health and prison psychology, and more consistent risk assessment between and within services. Unstructured approaches can also risk denial of care to people, lack transparency and not take into account potentially modifiable risk factors.

Currently risk is assessed in the early days of custody as this is known to be a higher risk period for self-harm and/or suicide. This is undertaken by digital ‘flags’ of risk information and interviews with all incoming prisoners. There is also guidance to support prison staff to recognise and respond to the heightened level of risk of self-harm and suicide among IPP prisoners, who are identified as one group who may be at raised risk of self-harm and suicide. The guidance can be used to support IPP prisoners during high-risk times such as during recall to prison or parole reviews. Specialist support is also provided to women’s prisons including training for new officers and recruiting psychologists to support women with complex needs.

There has been progress in improving family contact to people in prison. Since 2020, all prisons across England and Wales can offer social video calls with approved family members and friends, in addition to existing means of contact including social visits, phone calls and letters. As remanded prisoners are not required to undertake work in prisons, they are entitled to hold more private cash and have a higher spend limit to help maintain relationships with family and

friends through phone calls. To support contact with these sources of support, remand prisoners can send more publicly funded statutory letters and are eligible to receive more social visits.

Making completed suicide more difficult

Reducing access to means is a key part of suicide prevention programmes in the community, and in prisons, how to remove ligature points should be regularly reviewed in each prison and on a national level in a systematic way. In 2024, ligatures were used in just over 80% of self-inflicted deaths²⁸. Evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health shows there were approximately 20 to 30 deaths per year by hanging or strangulation in the secure hospital estate between 2008 and 2014. However, following ligature reviews, this number has fallen to between 15 and 20 since 2015²⁹. New prisons have been largely fitted with ligature resistant cells, where ligature points have been removed in the cell design and installation of fittings and furniture. The aim is that every site has a small number available for use by prisoners at the highest risk of ligaturing and prison governors can apply for funding for this. A few such cells per prison will not be sufficient – increased effort is needed to target those prisons with most ligature-related deaths and funding to remove ligatures in all cells in these prisons should be allocated accordingly³⁰.

In England and Wales, the case management of suicide and/or self-harm is currently undertaken by prison staff under what is called the Assessment, Care in Custody and Teamwork (ACCT) process. This is a process that is started when someone self-harms or is at risk of self-harm. An ACCT can be opened by any member of staff (custodial or healthcare). They involve an initial assessment of risk and needs, how they can be met, and an agreed plan for observation frequency and regular multidisciplinary reviews that involve other staff, including healthcare staff. The ACCT is ‘closed’ when the individual prisoner is no longer considered to be at risk. This may typically be days to weeks. While previous versions of the policy have been qualitatively evaluated with professionals and people with lived experience³¹, its effectiveness in reducing self-harm or suicide has not been independently evaluated. Mental health, on the other hand, is managed by the NHS commissioned health care providers in prisons as part of mental health in-reach teams, having previously been run by the prison service. Improving the care of people who self-harm may need closer liaison between custodial and mental health staff.

Partnership working

The main services for people who have self-harmed in prison are run by different organisations. Joint working can potentially lead to a shared focus in addressing risks. However, in some cases, it can result in tension when the priorities of healthcare and other related services are not aligned with the prison service whose focus is security and safety and lacks a public health lens with which to tackle self-harm. As many key modifiable factors in reducing self-harm are clinical, treatments are psychosocial. In a prison setting, this requires multidisciplinary risk assessment and management to incorporate the wider systemic and environmental interventions. In the broader perspective, multiagency suicide prevention panels can be an important step forward to address suicide before and after release in addition.

Practice example: partnership working initiatives

In 2021 the Ministry of Justice, HMPPS and NHS England jointly commissioned an Enhanced Support Service to provide specialist support to the most violent and challenging individuals in each prison who are at risk of harming themselves or others. Eight prisons across the adult male and female estates are currently commissioned to deliver ESS. Each site providing this service typically works with the top 10 to 15 challenging individuals throughout the establishment who have previously refused or not accessed meaningful intervention, and that staff have found difficult to manage. Prisoners supported by the project do not fit set criteria but are likely to have high risk of violence scores and may present with a range of complex mental health emotional and behavioural issues. The service is delivered by a small multidisciplinary team including a psychologist, mental health professional and a prison officer, and the team proactively manage and address the causes of the prisoner's behaviour at an individual level, delivering bespoke interventions.

Independent evaluation identified that this service is helpful for reducing violent behaviour. Ongoing internal quality assurance and performance management of services suggests it may also be helpful for reducing self-harm, but independent scrutiny is required.

For effective implementation of this initiative there needs to be a strong commitment from all parties including the governor, the NHS commissioners and health providers and the ability to provide a psychologist. There are resource and personnel issues with all 3 staff roles, given the difficulties across HMPPS and the NHS in the recruitment and retention of skilled staff.

Research priorities

Research is key to providing a robust evidence base to inform clinical practice. However, undertaking research in prisons is complicated by practical problems (chapter 18). For example, given the organisational complexity of prisons and prison services, and uncertainty regarding clinical equipoise, randomising participants for a research trial may not be feasible or ethical for some interventions. Furthermore, there may be difficulties with recruiting large enough sample sizes to detect meaningful differences for self-harm (and even less feasible for suicide as an outcome given its much lower incidence). Studies that follow people up over time are also difficult and resource intensive. One solution is to use routinely collected linked datasets (for example, linking prison and criminal justice records with healthcare and mortality registers). This is a robust method for accurately and efficiently following up large samples over time. Such linked data can also reliably be used to examine health service use following self-harm in custody, stratify risk of future self-harm at reception to prison and following release, and repeat self-harm in prison. Currently prison service (including self-harm within prison) and health records are not linked, which should be a central part of initiatives to improve prison health. The importance and challenges around data linkage are further explored in chapter 7.

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11 Complex care in the criminal justice system

Authors: Dr Caroline Watson

Contributors: Dr Lucy Wainwright, Donna Gipson, Gayle Francis, Marjorie Gillespie, Kathryn McVicar, Laura Spowage, Dr Nicola Lang

Introduction

People in contact with the criminal justice system experience disproportionately high levels of physical and mental ill-health, often compounded by social exclusion, trauma, and systemic barriers to care. The prison environment presents both challenges and opportunities for addressing complex health needs, particularly for people living with long-term conditions (LTCs), multimorbidity and multiple disadvantage. This chapter defines long-term conditions and multimorbidity, outlines their prevalence and the drivers of progression and examines the challenges of delivering effective care in prisons and after release. It also highlights opportunities for improvement within both primary and secondary care. It is closely linked to and can be read with chapter 5 on older people in prison and chapter 6 on palliative and end of life care in prison. While we recognise that the health and social care needs are closely connected, detailed discussion of social care is outside the scope of this report.

Definition, prevalence and risk factors

Long-term conditions and multimorbidity definition

Long-term conditions are health issues that can be managed but not cured, such as diabetes, hypertension, chronic respiratory disease, cancer, chronic pain, dementia and mental ill health. Multimorbidity is defined as the presence of 2 or more long-term health conditions in an individual (NICE NG56)¹.

Baseline prevalence and additional risk factors

The prevalence of long-term conditions and multimorbidity increases with age. In England, the prevalence of long-term conditions and multimorbidity is rising as the general population ages. Currently around 56% of the population live with one long-term condition and around 15%² with multiple long-term conditions. The prison population is ageing more rapidly than the general community. The fastest growing cohort is people aged 60 or over, which has increased by 82% in the last decade and by 243% since 2002³. This has been and will continue to be a significant contributor to increasing prevalence of long-term conditions and multimorbidity in prisons. However, ageing alone does not explain the much higher health burden in prisons. Compared to the general population, there are additional risk factors leading to earlier onset,

faster progression and greater levels of multimorbidity and complexity seen in the prison population. These include:

- higher rates of lifestyle risk factors for long-term conditions, including physical inactivity, poor diet, substance misuse, smoking and harmful drinking prior to prison⁴. Described in chapter 14 and chapter 16
- overrepresentation of serious mental illness, substance use disorders and neurodiversity
- overrepresentation of socio-economic disadvantage and minority ethnic groups, in whom long-term conditions are more common

Research and data limitations

International research suggests a higher prevalence of long-term conditions for people in prison than the general population. National prevalence data in prisons in England is limited. Table 1 is a summary of research estimates (predominantly regional cohort and needs assessments) and the prevalence of conditions recorded in the Quality and Outcomes Framework (QOF) register of 55 prisons where healthcare is provided by Practice Plus Group (PPG). Infectious disease prevalence and conditions associated with the older prison populations are covered in chapters 12 and 5 respectively. It is challenging to compare prevalence to the general community as:

- the prison population is younger and some conditions such as cancer and cardiovascular disease are substantially driven by age
- screening for conditions can differ between research studies, the prison population and the general population
- coding of long-term conditions in electronic health records in prison can vary, with low rates of compliance QOF⁵ and lower recording of indicators for long-term conditions compared to community general practice⁶

Table 1: summary of relevant research prevalence of long-term conditions, QOF register from Practice Plus Group prisons and the general population

Prison population research summary		Practice Plus Group QOF register for average prevalence between 1 October 2024 and 31 March 2025	General population in England 2023 to 2024
Cardiovascular	Overall, 21.8% (13.8 to 37.3%) have pre-existing cardiovascular comorbidity such as hypertension (12.9%), diabetes (8.5%), and cardiovascular disease (5.6%). This is similar to the proportion in the community, but the age of the prison population is 10 years younger ⁷ .	Hypertension: 4.8% Chronic heart disease: 1.4% Heart failure: 0.3%	Hypertension: 14.8% ⁸ Coronary heart disease: 3.0% ⁹ Heart failure: 1.1% ¹⁰
Type 1 and 2 diabetes	4.4% ¹¹	3.1%	7.7% ¹²
Epilepsy	2.8% ¹³	0.9%	0.8% ¹⁴
Respiratory illness	COPD and asthma combined: 8.0% ¹⁵ to 16% ¹⁶ in Scotland, Asthma estimated to be 10.2% in England ¹⁷ .	COPD: 1.3% Asthma: 5.6%	COPD: 1.9% ¹⁸ Asthma: 6.5% ¹⁹
Cancer	The prevalence of cancer in prisons is unknown as health data is not linked. The incidence of new diagnoses of cancer to people in prison has been lower for many types of cancer than for people the same age in the general population ²⁰ . However, survival was also lower suggesting the need for improved cancer diagnosis. Despite this, cervical cancer was diagnosed twice as often in prison as in the general population ²¹ .		

Regional work in the Midlands has explored the prevalence of patients with very complex physical and/or social care needs in their 28 prisons. They concluded that approximately 0.4% of their total prison population, 53 people, had very complex needs whose care in the general population would normally be provided by a care home or extensive package of care and/or require long-term equipment to accommodate their needs.

Further insights are available from mortality data. The standardised mortality rate for people in prison in England is 50% higher than the general population²². In 2024 to 2025, most deaths in prison (66%) were due to naturally occurring diseases, such as cardiovascular disease or cancer, rather than self-inflicted causes or homicide. The Independent Advisory Panel on Deaths in Custody report that many deaths from natural causes, such as cardiovascular disease or cancer, are premature or avoidable²³. The Prison and Probation Ombudsman (PPO) has reported that over the last 5 years, an average of 0.93% of deaths each year in prisons were due to sudden unexpected deaths epilepsy (SUDEP), compared to 0.15% of deaths in the general population in the UK. The PPO undertook a deep dive of deaths of people in prison with epilepsy. It was unpublished at the time of writing but key findings include:

- many of those who died had co-morbid mental health and or substance misuse issues, which can contribute to poor compliance with medication and health care appointments
- the stressors of the environment, logistical pressures of prisons and reduced ability to self-advocate can also impact on the quality of care
- improved staff understanding and management of epilepsy may be required, for example in the need for welfare checks and emergency responses

Multiple disadvantage, life experiences and drivers of complexity

Much of the complexity in prison healthcare results from 'multiple disadvantage' – the combination of homelessness, substance misuse, mental ill-health, justice system involvement and experiences of violence or abuse²⁴. For example:

- 15% of people in prison report being homeless before custody²⁵ and 34% of the rough sleeping population have spent time in prison²⁶
- 50% of people in prison have substance misuse needs and 22% have an alcohol misuse need²⁷. Drug use patterns have changed to include new psychoactive substances such as synthetic cannabinoids and opioids, which have cardiac, psychiatric and neurological adverse effects and can trigger underlying mental health issues²⁸. The risk of drug-related death is 7.5 times higher in the first 2 weeks after release²⁹
- around 1 in 7 people in prison have a treatable mental disorder. 1 in 10 have post-traumatic stress disorder (PTSD) or complex PTSD³⁰. 1 in 5 women in prison are estimated to meet criteria for emotionally unstable personality disorder, and 1 in 10 men for a personality disorder³¹
- 70% of people in prison have or more mental health disorders³² and around half of those with a serious mental disorder have a co-occurring substance use disorder

- 57% of women in prison report past abuse³³ and 60% have experienced domestic abuse³⁴

Life experiences such as adverse childhood experiences (ACEs), trauma, and social exclusion have a profound influence on health behaviours and access to care. Many individuals in contact with the justice system have experienced negative interactions with health and social care professionals and other authority figures, leading to mistrust and disengagement from services. This is further complicated by:

- cognitive and neurological consequences of trauma, which may impair decision-making, memory and emotional regulation
- stigma and discrimination in healthcare settings which can deter people from asking for help
- barriers to self-care, including low literacy, language challenges and digital exclusion which make it hard to navigate and engage with health systems effectively

This explains why people may present in prison with undiagnosed or poorly controlled long-term conditions and may struggle to engage consistently with healthcare that is offered, leading to progression and complications of illness that may be otherwise straightforward to manage.

Primary care for long-term conditions and multimorbidity

Current processes

Most long-term condition care for people living in prison is provided onsite by the multidisciplinary primary care team, with support from secondary care specialists where required. Care is often led by nurses with additional training in prescribing and management of one or more long-term conditions, or by pharmacists with expanded roles incorporating clinical consultations, prescribing and structured medication reviews. General practitioners will usually contribute to long-term condition care through assessment and investigation of undifferentiated symptoms, management of multimorbidity, complexity and polypharmacy and pharmacy technicians contribute to drug monitoring. Allied health professionals will often work across a cluster of prisons to provide, for example, physiotherapy or podiatry input. Prison mental health teams, including nurses, psychiatrists and psychologists, will support people with mental health long-term conditions and multimorbidity.

Health and wellbeing coaches, physical education instructors, catering staff, psychosocial substance misuse teams and neurodiversity leads also play a valuable part in the holistic care of people living with long-term conditions and multimorbidity, supporting modification of risk factors such as obesity, physical inactivity, poor diet or smoking. In some prisons, with more static populations, health champions are trained to support their peers with, for example, blood pressure monitoring.

Effective communication between members of the multidisciplinary healthcare team, prison staff and hospital specialist team is essential for effective personalised planned long-term condition care.

Outcomes

Monitoring and assessment of long-term conditions in prisons fall below community standards. Research into primary care and the management of long-term conditions in prisons has identified poor coding in electronic health records, low rates of compliance with national quality outcome monitoring (QoF)³⁵ and lower recording of indicators for long-term conditions compared to community general practice³⁶. The 2024 National Confidential Enquiry into Patient Outcome and Death report (NCEPOD) highlighted improvement in healthcare assessments and the monitoring of long-term conditions as one of 6 priority areas for improvement³⁷.

Cancer outcomes in prisons are worse than the community. Research into cancer in prisons in the UK has shown lower overall survival and likelihood of receiving curative treatment than in the general population and has identified barriers and enablers of care attributable to both healthcare and prison factors^{38 39 40}.

Challenges and opportunities

Data, IT system and digital capability

Prison healthcare faces major challenges with data visibility and digital infrastructure. As described in chapter 7, prison health data is poorly linked with local integrated care system (ICS) datasets, limiting the ability to assess health needs at a population level in real time. In addition the SystmOne module in prisons is basic compared to community primary care software, as described in the appendix on data and information sharing.

Digital tools widely available in the community — which improve efficiency and outcomes for people with long-term conditions — are not readily accessible in prisons. Examples include:

- clinical software to support triage, referrals, record keeping (for example Docman) and optimised prescribing
- medicines safety and monitoring systems (for example, Eclipse Live)
- digital social prescribing solutions, such as online weight-loss or lifestyle programmes

The absence of these tools in prisons restricts the quality and consistency of long-term condition management.

Workforce design, capacity and skill mix

Engagement workshops for this report highlighted persistent staffing problems in both prison and healthcare teams. These include shortages of permanent staff, reliance on agency staff, high turnover, and lengthy recruitment and clearance processes.

When combined with high patient volumes and rapid turnover – particularly in remand prisons – these challenges mean that long-term condition management is often de-prioritised. Instead, services become largely reactive and crisis-led, with most time devoted to reception checks, medication administration, and responding to urgent incidents on the wings.

Healthcare staff described the need to adapt their staffing capacity and competence rapidly to meet changing population needs due to operational decisions. Examples were given of the increase in older people seen at HMP Channings Wood following the closure of HMP Dartmoor, and the re-role of Holme House from a Category C to a reception prison. With good clinical and operational leadership, the right skill mix and capacity, and effective team integration, it is possible to deliver equivalent long-term care. For some patients, prison provides an opportunity to address unmet needs and reduce health inequalities.

Lived experience: prioritisation of long term conditions

For this report we held a workshop with frontline healthcare professionals working in prisons. Healthcare staff reflected that prison enablement challenges included the need for data, time and joint working between prison and healthcare to support people with long-term conditions. This was especially challenging in reception prisons:

“...it’s not that bad, it’s just the turnover is really, really high for the remand prisons. We’ve picked up that we have a lot of diabetic patients in prisons. We invested in nurse-led diabetic sort of an interim between primary care and secondary care where we run clinics. We attended Desmond training, so we are delivering diabetes education programmes within the prison....There is no time to do this... It’s one of the things that we talk about can actually be done on the ground. If I tell you to eat a healthy diet, but the prison can only afford to feed you ‘x food’, has the diabetes education programme been useful? if one prisoner can afford to buy and another one can’t afford to buy from the canteen to vary their diet to meet this advice?”

Prison enablement

Arrival and early days in custody

Large numbers of people arriving in prison, NHS England procurement constraints and provider availability can all contribute to challenges with initial long-term condition assessment, care planning and management. Small clinical teams are required to rapidly screen and assess large cohorts of new arrivals from court, who may have poorly controlled long-term conditions, complexity and unmet need. While the initial prison reception process is intentionally efficient and not intended for screening new long term conditions, some long term conditions can cause acute deteriorations in health if there are even moderate delays to administering medication. New receptions may start to arrive during the day but often continue late into the evening and can arrive in large cohorts. Some health providers have a prescriber availability cut off time of 10pm and others require the prescriber to stay late but with a requirement to complete hurried consultations. There is an expectation by HM Inspectorate of Prisons (HMIP) that the prison

process will be efficient and although there is no target time, the HMP and YOI Doncaster HMIP report referred to delays 'over 3 hours'⁴¹. When these factors are combined, the prescriber is required to take on risk that may not be appreciated where care is later scrutinised, for example at inquest.

Lived experience: identifying long term conditions on arrival in prison

For this chapter, a 2 hour focus group was held by Empowering People: Inspiring Change (EP:IC) lived experience consultancy, attended by people with lived experience of the justice system with long-term health conditions. Focus group participants universally reported that they felt rushed through reception and that more staff were needed. They perceived that in reception, both prison and healthcare staff were very busy, meaning that they focused on managing risk and getting people through rather than on long-term health conditions. Some said that when they arrived in reception they felt too tired or stressed to go into detail about their health conditions and others found it difficult to immediately trust staff. They said that the likelihood that they would try to access healthcare in prison began from their experiences with staff in reception.

Staff reflected that they had limited time for comprehensive assessment:

"I saw 32 patients in 4 hours between 6 and 10pm and I thought I was going to pass out! That wasn't the start of the shift, and it didn't include the prescribing for patients experiencing drug and alcohol withdrawals. I'd been there since the morning. The prison will declare the number of spaces but that isn't matched to the number of staff available. There's a lot of goodwill there to try and just cover that."

These views concurred with responses from people in prison, reported to EP:IC consultancy during their engagement for the Women's Health and Social Care review in prisons, 2024:

"You come to prison, you feel like shit, you're anxious, worried, scared, you don't know what's going to happen next and the nurses ask you a load of questions and the officers rush you through – no one really cares about what's really going on."

"Care goes a long way in prison, especially in the first few hours."

Additional challenges for long-term condition management

Prison regimes and security processes create further barriers to effective management of long-term conditions, including:

- limited times for patient movement to appointments which can impact both on review appointments and monitoring
- restricted medicines administration times leading to drugs intended for dosing over a 24 hour period being administered over a 7 to 8 hour period

- limited time out of cell where attendance at healthcare or health related activities may not be counted as purposeful activity and may therefore be viewed as in competition with paid work or education
- limited dietary options available to reduce risk factors and limit progression of long-term conditions
- security restrictions limiting the use of app-based mobile devices for long-term condition monitoring
- restricted internet access to web-based health advice or digital treatment programmes
- costly phone contracts used by prisons with lack of telephone or group support facilitated by clinical nurse specialists

Secondary care for long-term conditions: current care, challenges and opportunities

Current processes

Most secondary care for long-term conditions is provided by community NHS trusts. Prison governors and staff are responsible for facilitating attendance at appointments, including providing officers to escort prisoners. Some prisons have secondary care in-reach, either virtually or in person. Examples include:

- virtual in-reach: such as the virtual ward at HMP Frankland which allows hospital consultants to provide remote care
- in-person in-reach: such as specialist urology clinics in the Sheppey Cluster and hepatology clinics led by clinical nurse specialists at HMP Peterborough, which provide assessment, investigation and treatment for Hepatitis C

Challenges

Staff shortages or safety incidents can lead to cancellation of hospital appointments⁴². Males and females in prison in 2024 missed 43% and 48% of outpatient appointments, higher than in the community (26% for both sexes). While the proportion of these appointments that were for long-term conditions is unclear, people with long-term conditions are likely to be overrepresented.

The quota of prison officer escorts available to accompany people to outpatient clinics are fixed and vary between prisons. A recent investigation identified the ratio of possible outpatient appointments to prisoners varied between prisons from 1 appointment per 164 people to 1 per 365 people⁴³. These ratios are not always based on clinical need, leaving health care professionals to choose which individuals can attend appointments. This is a particular problem for prisons with older populations with high levels of complex needs and multiple hospital appointments, as acute needs may be prioritised over management of long-term conditions.

When escorts are facilitated, patients are given little or no warning of their hospital appointment due to potential security risks. They therefore may choose not to attend if they haven't had access to a shower or they do not wish to be taken to hospital with restraints⁴⁴. When hospital appointments are missed due to a combination of these factors, the ability to rearrange is dependent on understanding and good will from NHS staff, not formal agreements⁴⁵.

Opportunities

Telemedicine offers a practical solution to reducing missed hospital appointments as it removes the need for hospital transport and escorts. Telemedicine has been shown to be beneficial in management of diabetes and dermatology conditions and reduced the need for face to face ophthalmological appointments⁴⁶. Research has identified that telemedicine is cost effective when a minimum threshold of patient appointments were achieved⁴⁷. During engagement for this report we identified successful models of telemedicine being used as virtual wards across a cluster of prisons. Data provided by Prison Partnership Group who provide healthcare to 55 prisons in England showed that 2.0% of all secondary care appointments between April 2024 to April 2025 were undertaken with telemedicine, across a range of specialities including with endocrinology, dietetics, rheumatology, trauma and orthopaedics.

While some difficulties with access to hospital care can be overcome through the use of telemedicine, current use is low. Barriers to telemedicine include poor digital infrastructure and secure Wi-Fi, limited availability of dedicated telehealth spaces and inconsistent engagement from community services. Hospitals often have a preferred video software platform and HMPPS has approved alternative platforms in response to this potential barrier, however, engagement with community NHS health services remains a challenge. Other telemedicine barriers include overrunning clinics or an incident on the wing which may prevent prisoner movement to the healthcare clinic to access the video equipment. These are explored fully in a recent report by the Health Services Safety Investigations Body⁴⁸ which recommended that NHS England, through regional commissioning teams works with HMPPS to identify barriers to using telemedicine for outpatient appointments and implements local solutions to overcome these. An example of this is the use of the virtual ward in HMP Frankland, where virtual links with the local hospital have facilitated consultant in-reach for patients receiving bowel investigations, or end of life care, with remote hospital support and are reducing emergency hospital attendances.

Research has also explored the role of specialised healthcare equipment in prisons to manage chronic diseases and prevent or reduce hospital attendance, with examples of haemodialysis⁴⁹ and peritoneal dialysis⁵⁰ being successfully used. Providing glucose meters can slightly improve glucose control in patients with diabetes in prison⁵¹ and have been approved for use in custody. Educational interventions and staff led specialist services also improve chronic disease management.

Continuity of care

Continuity of care is disrupted by inconsistent communication and by movement through the prison estate. An example of this is provided in the fictional case study below, which is based on true experiences.

Case study: long-term conditions with movement through the prison system

A 60 year old patient was remanded into a local London prison (A), and transferred to another prison (B) 5 days later, after his first court hearing. While in prison (B), he was referred on the 2-week wait pathway with suspected cancer. He was transferred from prison (B) to prison (C) while on medical hold, part way through his investigations.

He was re-referred on the local 2-week cancer pathway from prison (C) where he underwent duplicate investigations in the new local hospital. Still on medical hold, he was transferred again, back to prison (A), for his court hearing. Investigations remained incomplete 4 months after his original 2-week wait referral with suspected malignancy.

People with complex health needs require strong joint planning between health and justice services to ensure continuity of care. This planning is generally more effective in training prisons, where longer sentences allow time to prepare for release. By contrast, it is far more difficult in reception prisons, where individuals often serve short sentences, are recalled unexpectedly, or are released directly from court without advance notice, at which points, the risk of care falling through the cracks is especially high.

Despite planning and the processes for referring people back into community care, outlined in chapter 15, people may experience inconsistent access to specialist treatments, such as long-acting injectable buprenorphine for opioid dependence and loss of continuity on release, especially where treatment pathways are complex or a person is released to a different area. Several recommendations were made within the 2024 HSSIB report into continuity of care directly relevant to long-term conditions.

Improvements needed include:

- standardised communication protocols for appointments and discharges, especially for people with multimorbidity
- access to local integrated care board (ICB) tools, including electronic referral systems and proformas, to streamline connection with community and specialist services
- wider use of health navigators, who play a key role in detecting needs, supporting GP registration, and improving engagement with community healthcare after release

Promising examples of integrated care for people on probation are explored further in chapter 16.

Practice example: Early Detection of Liver Disease and Cancer programme

The Early Detection of Liver Disease and Cancer programme in East of England uses health navigators embedded within a general practice outreach team (nurse and GP), or connecting to local GP practices, to engage, advocate, improve health literacy and agency, and provide basic health checks for people experiencing homelessness (which includes people connected with justice system). This increases not only detection of liver disease and cancer but, using the Making Every Contact Count approach, supports registration with GP, and detection of hypertension, atrial fibrillation, severe mental illness medicines monitoring and facilitates attendance at screening appointments⁵².

Summary

Research evidence suggests that people in contact with the criminal justice system experience much higher levels of physical and mental ill-health than the general population. These needs are often compounded by social exclusion, trauma, and systemic barriers to care. The prison environment and regime presents both challenges and opportunities for addressing complex health needs but also offers opportunities, as custody may provide consistent access to healthcare for people who have struggled to engage in the community. We have shared opportunities for good practice that are being achieved in some prisons and could be more widely implemented to improve outcomes and reduce health inequalities.

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12 Health protection in prisons and probation

Authors: Dr Chantal Edge, Dr Nicola Dennis, Steve Willner, Holly Goss, Dr Lucy Thomas

Contributors: Professor Andrew Hayward, Lewis Colwill, Angela Haughton, Memona Paracha, Dr Leonora Weil, Dr Nick Watkins, Dr Shona Arora

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Introduction

“People come to prison and find out they have things. My old pad mate got treatment and wouldn’t have known about it if he wasn’t in jail”. Individual in prison

Health protection is a core aspect of public health, focused on protecting individuals and populations from threats such as infectious diseases, environmental hazards and chemical or radiological risks². Prisons are particularly vulnerable to the spread of infectious diseases due to factors like overcrowding, the movement of residents, shared facilities and the connection between staff and the community^{3,4}. Prison populations tend to have poorer health overall, with higher rates of chronic diseases and factors like drug use, sex work or homelessness, which increase both the risk of contracting infectious disease and experiencing associated poor health outcomes^{5,6,7,8,9,10,11}.

Living or working in a prison environment exposes people to a higher risk of both acute disease (for example seasonal outbreaks of influenza and norovirus) and longer-term or even life-long chronic infectious disease (for example TB and viral Hepatitis B and Hepatitis C). Given the high level of movement and connection to the community, people living in prison as part of a custodial sentence, people entering prison for other reasons (such as staff and visitors) and people living in the general community are all impacted in different ways by infectious disease in prisons.

The health protection risk to people living in prison changes over time. Prison residents are more likely to contract chronic infectious disease or be impacted by environmental threats such as radon the longer they stay in prison. Prison visitors and staff can also be at risk of infection. Prison staff and people in prison can often have high levels of contact, for example when staff restrain people or provide ‘bed watch’ at hospital, increasing the risk of transmission to both staff and people in prison. For example, there has been known transmission of TB from people in prison to staff in prison and staff injuries from sharp objects can also occur, risking the spread

of bloodborne viruses (BBVs). Visitors coming into prison can be exposed to disease through outbreak situations, for example measles or influenza. When prison residents and staff interact with the general community, either on release or family life outside of work, unmanaged infectious disease has the potential to be spread to and within the public. Equally, outbreaks in the community can be introduced into prison settings by staff and visitors and may be hard to control once present. Reducing levels of infection among people in prison, for example Hepatitis, can therefore also reduce the risk of the public contracting infectious disease. This is also known as a 'community dividend'.

Outbreaks of infectious disease in prisons can disrupt operations and affect both the health of prison residents and staff. Although measures are in place to test, treat and manage infections, these are often insufficient, leading to delayed diagnoses and potential outbreaks. Lack of staff training in recognition of infectious diseases, difficulties with contact tracing and limited understanding of infection prevention and control measures can delay identification of infectious diseases and increase risk of spread¹². Prisons are also exposed to environmental risks like extreme heat or poor air quality.

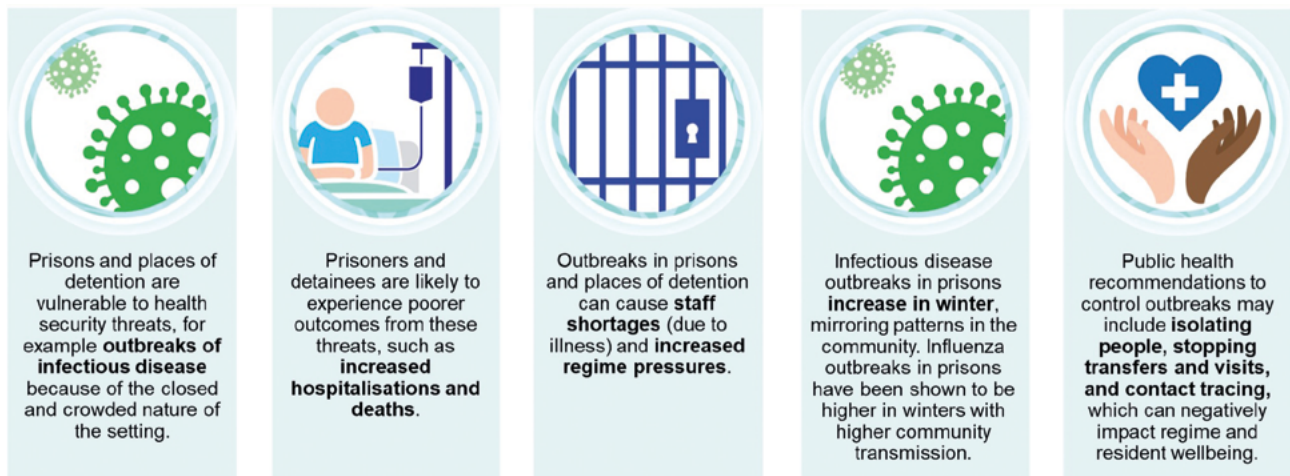
Despite this, prisons also present an opportunity to improve health outcomes. They can serve as settings for targeted health interventions, such as testing for infectious diseases, increasing vaccination rates and providing access to treatments that individuals in the community may not otherwise seek out. Prisons are run by HM Prison and Probation Service (HMPPS), but healthcare is commissioned by NHS England. Various partners, including HMPPS Prison Governors and the UK Health Security Agency (UKHSA), play roles in ensuring access to healthcare and managing health protection issues.

This chapter will focus on 2 key health protection areas: communicable disease control and environmental public health, providing an overview of data, current management strategies and recommendations for improvement¹³. The information presented primarily covers the English prison population unless otherwise noted. Information on data sources and populations is available in the appendix.

Communicable disease control in prisons

Communicable disease control involves the prevention, investigation, control and management of infections¹⁴, including cases and outbreaks of disease within prisons and probation. Figure 1 summarises some of the main risks associated with infectious diseases.

Figure 1: prison settings and the risks of infectious disease

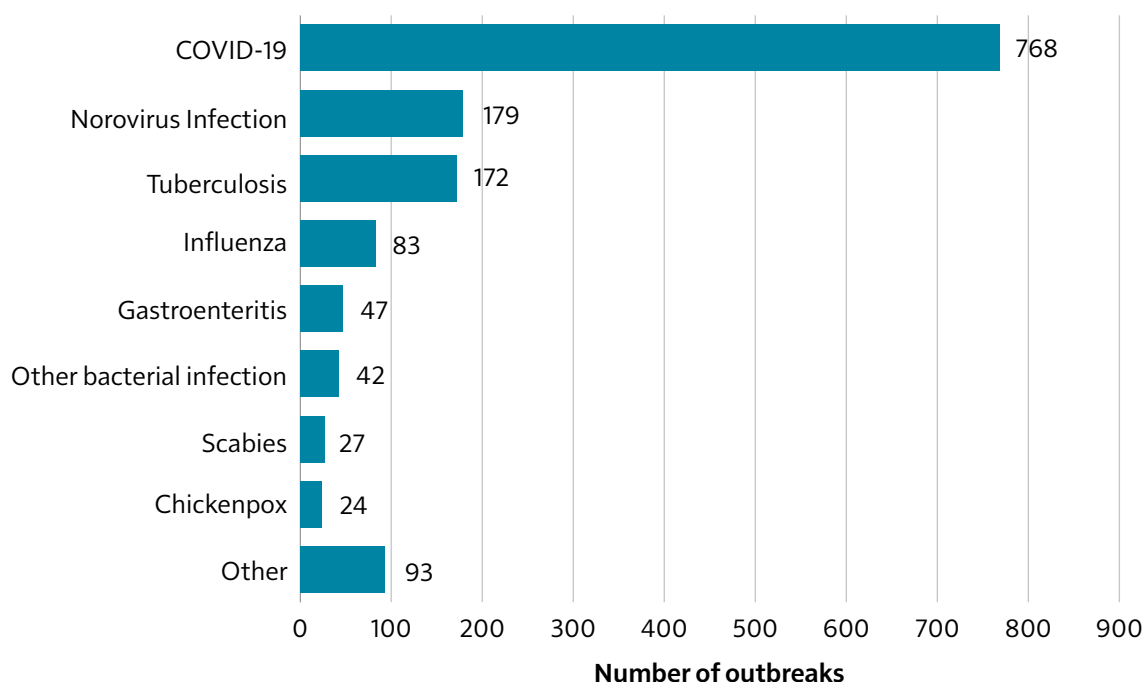


At all stages of disease management, people in prison are reliant on adequate access to healthcare teams in the prison, facilitated by prison officers. If a patient requires hospital treatment or admission, then the prison must provide prison officers to escort the patient; this can be difficult due to staffing pressures in the prison system^{15 16}.

Infectious disease risk in the prison and probation setting

An outbreak is defined as an incident in which 2 or more people affected by the same infectious disease are linked by time, place or common exposure, or a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred. Figure 2 shows all outbreaks in English prison settings notified to UKHSA between 2011 and 2024. In this time, 1,435 outbreaks were notified and managed. Of these, 768 (54%) were COVID-19 outbreaks occurring between 2020 and 2024. Of the remaining 667, the largest burden was from norovirus infection (179; 27%) and TB (172; 26%).

Figure 2: number of outbreaks in prisons in England by pathogen, 2011 to 2024



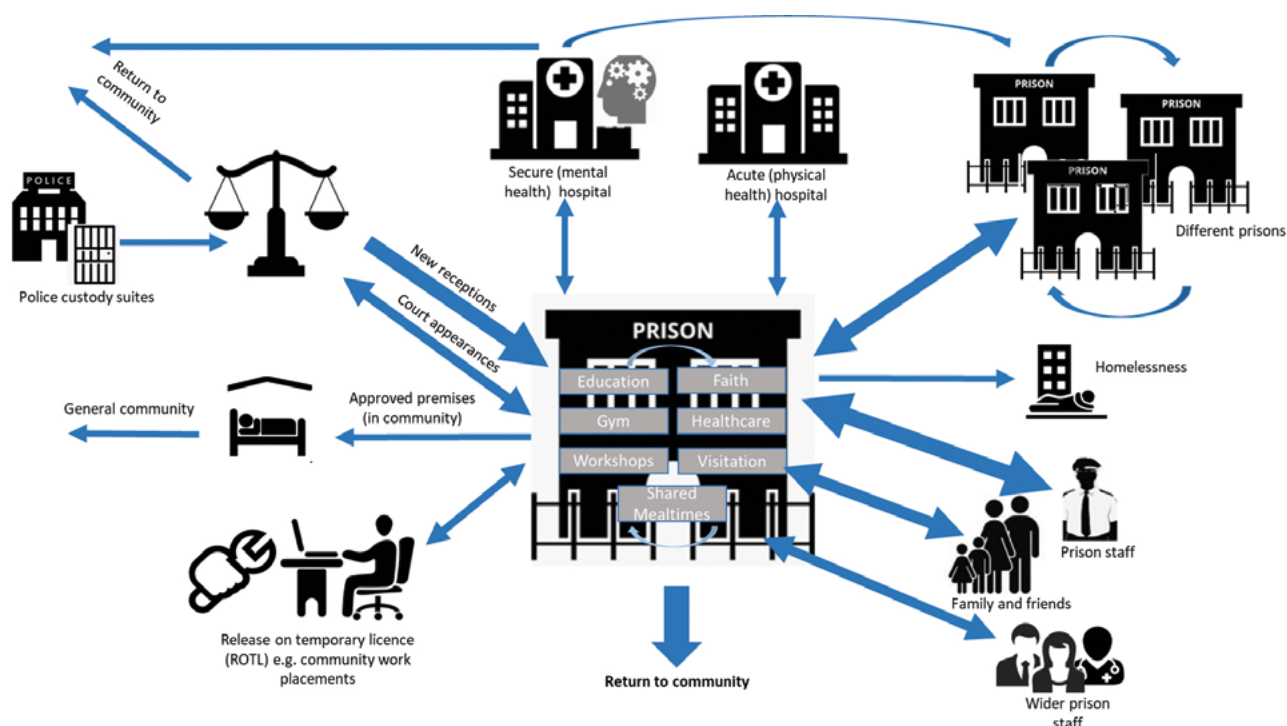
Source: HPZone health protection case management system, UKHSA see the appendix

Prison settings and those living or working in them are likely to have a higher risk of infectious disease and its impacts for the following reasons.

Prisons vary in design and have high levels of movement and shared spaces which increases the risk of disease spread. Prisons in England range from old Victorian buildings to modern, newly built prisons and from urban centres to rural areas. The condition and layout of these facilities can affect the risk of infection spreading. There is a lot of movement within prisons, as staff, visitors and prisoners frequently enter, exit and transfer between different areas (figure 3). These movements create opportunities for infections to be brought in, spread and even exported back to the community¹⁷. High levels of movement between prisons can also interrupt how people receive treatment, for example TB treatment.

Many prisons in England are overcrowded and the prison population is expected to grow in the coming years¹⁸. Overcrowding increases the risk of infections spreading and makes it harder to isolate individuals with infectious diseases.

Figure 3: movements within and between prisons and the community, adapted from the Scientific Advisory Group for Emergencies (SAGE) Environmental Modelling Group (EMG) report on COVID-19 in prisons



Source: Scientific Advisory Group for Emergencies (SAGE) Environmental Modelling Group (EMG) report on transmission of COVID-19 in prisons

Many areas in prisons, such as education rooms, dining areas and faith centres, are shared by multiple people. Most people share cells or occasionally dormitories. Mixing can also occur for other reasons such as queuing up for medication or sitting in a healthcare waiting room. Outbreaks can quickly spread between wings especially if infectious staff or prisoners who have access to multiple wings through work (such as cleaners or gym orderlies) move between areas. During the pandemic, a policy called ‘compartmentalisation’ was used to limit contact between different groups: the general prison population, those known to be infected and those who were vulnerable¹⁹. This policy worked because the prison population was smaller due to fewer people coming in and out. However, it would be harder to implement now, given the current pressures on prison populations²⁰. Modelling showed that during the pandemic, prison staff posed the highest risk of bringing COVID-19 into the prison, with visitors being 10 to 15 times less likely to introduce the virus²¹.

Prisons may have suboptimal sanitation. Older prisons, particularly Victorian ones, may have poor sanitary facilities such as lack of in-cell toilets or issues like sewage leaks. This can make infection control difficult, especially during outbreaks of gastrointestinal disease which can increase the risk of infections spreading among people in prison²².

Infection prevention and control measures in prison and probation settings can be difficult to implement and require improvement (see the appendix). Standard infection prevention and control (IPC) measures which are important for stopping disease spread are harder to apply in prisons. For example, providing liquid soap or alcohol hand rubs is difficult because they might

be misused. Personal protective equipment (PPE) use is also inconsistent, as staff and people in prison have different levels of training and perceptions of risk. Implementation of basic IPC principles such as cleaning, laundry and waste management is also challenging. A study in 2023 gathered feedback from people living and working in prisons about managing infectious diseases. Cleanliness was a major concern, with participants pointing out barriers to effectively using basic IPC measures²³.

Staff are at risk from health protection threats in prison. They can also bring infections into the prison and potentially spread them back to the community. Health protection guidance and responses should always consider the needs of staff. Challenges to protecting staff health include:

- high levels of close contact: prison staff may be required to restrain people with infectious diseases
- limited access to PPE: for example, FFP3 face masks, which are important for protection from respiratory diseases, may not always be available to staff or staff may not have been fit tested
- inadequate contact tracing and challenges to staff screening: there are limited procedures for tracking staff exposure to disease, which makes it harder to prevent further spread; staff are often not included in disease screening as part of outbreak response
- limited occupational health services: staff may not have sufficient access to occupational health resources to support their health and safety within the prison setting, including limited access to vaccinations
- limited knowledge: staff report a lack of knowledge on the risks of different diseases

Lived experience: perceptions of staff risk

“It’s probably also at that stage we’d asked about what are the dangers of tuberculosis to us and that’s, again, probably a lack of knowledge on our part as to how dangerous it is to us, potentially our families. And it’s probably a lack of knowledge as to why the reluctance [for screening] is” (Prison officer)

Current approaches to tackle infectious disease in prisons and probation

In English prisons, there are several initiatives aimed at preventing, detecting and treating infectious diseases. Testing for infections helps reduce the spread of diseases, contributing to national goals for elimination²⁴. All new receptions into prison should be offered²⁵:

- opt-out testing for hepatitis B, hepatitis C and HIV, (repeat testing every 12 months)
- verbal screening for symptoms of active TB within 48 hours of arrival

- vaccine catch-up in accordance with the national schedule including a universal offer of hepatitis B vaccination
- consideration of sexual health screening needs including syphilis, chlamydia and gonorrhoea

While prison policy states that condoms should be available, it's unclear how consistently this is implemented across the estate. Even when condoms are available, prisoners may hesitate to request them due to stigma²⁶. Unlike in the community, needle exchange programs, shown to reduce the transmission of bloodborne viruses, are not available in English prisons, even though they have been shown to be effective when combined with opioid substitution therapy^{27 28}. Programmes which employ people with experience of prison, often called 'peer programmes' are widely thought of as good practice. There is good evidence that peer interventions in prison improve the health of recipients and are cost-effective for prevention of HIV²⁹.

Lived experience: perception of infections in prisons

Recent engagement³⁰ with people with lived experience of prison reported that few people saw themselves at risk of infectious disease during their time in prison, mostly because they were not 'doing anything that may put them at risk'. Stigma around behaviours like sex work or injecting drug use often prevents individuals from disclosing their disease status or accepting offers for disease screening. This stigma can create barriers to accessing necessary healthcare and prevention services.

"There's a difference between drug users and junkies, and this wing is 99% junkies..., they use needles and stuff like that... People are dirty and they've let themselves go to a certain stage where it wouldn't be surprising if they had infections and diseases, you know?"

The role of probation settings in supporting health protection initiatives is currently less well defined, although there are some examples of good practice such as bloodborne virus testing in some probation services. Recent engagement with probation³¹ found that there are limited routine procedures for managing infectious diseases when prisoners transition to probation and that staff engaged did not see infectious disease guidance as part of their role. The Sentencing Review³² means more people will be under supervision by probation and the importance of its role in health protection will increase. Improvements in primary care registration and recommendations around data sharing should improve continuity of care between prison and probation. Further work is required to support treatment continuity for TB on release from prison and to identify contacts requiring TB screening on release. Health protection risks to those on probation can also be reduced if people are supported to access preventative or harm reduction interventions, such as substance misuse treatment or needle exchange. As people under the supervision of the probation service are disproportionately from inclusion health groups, they are likely to have lower vaccination rates than the general population, may be eligible for additional vaccinations due to being in certain risk groups and may not have a well-documented immunisation history. To address this, healthcare providers should follow the

[recommendations](#) for the vaccination of people with an incomplete or unknown immunisation status³³.

Lived experience: responsibility for health protection

Communication between prisons and probation staff about prisoners' health varies and depends on individual staff members. While someone is in contact with probation services much of the guidance and signposting given is focused on substance misuse or mental health rather than on infectious disease. Prison officers often had limited knowledge of infectious disease and probation staff reported a lack of training in this area.

"We can signpost, but it's not our responsibility to treat – we're not funded to do that. Infectious disease is very low on the list of priorities that we have, it's not something we're regularly able to explore." Probation officer

The burden of key infectious diseases in prisons

Respiratory infections

This section focuses on respiratory infections such as influenza, COVID-19 and TB which can easily spread in closed, crowded environments. Other factors that contribute to the burden of respiratory disease in prisons include lower vaccination rates^{34 35 36 37} and higher rates of pre-existing chronic health conditions or risk factors such as smoking in prison populations than in the general population^{38 39}.

Influenza

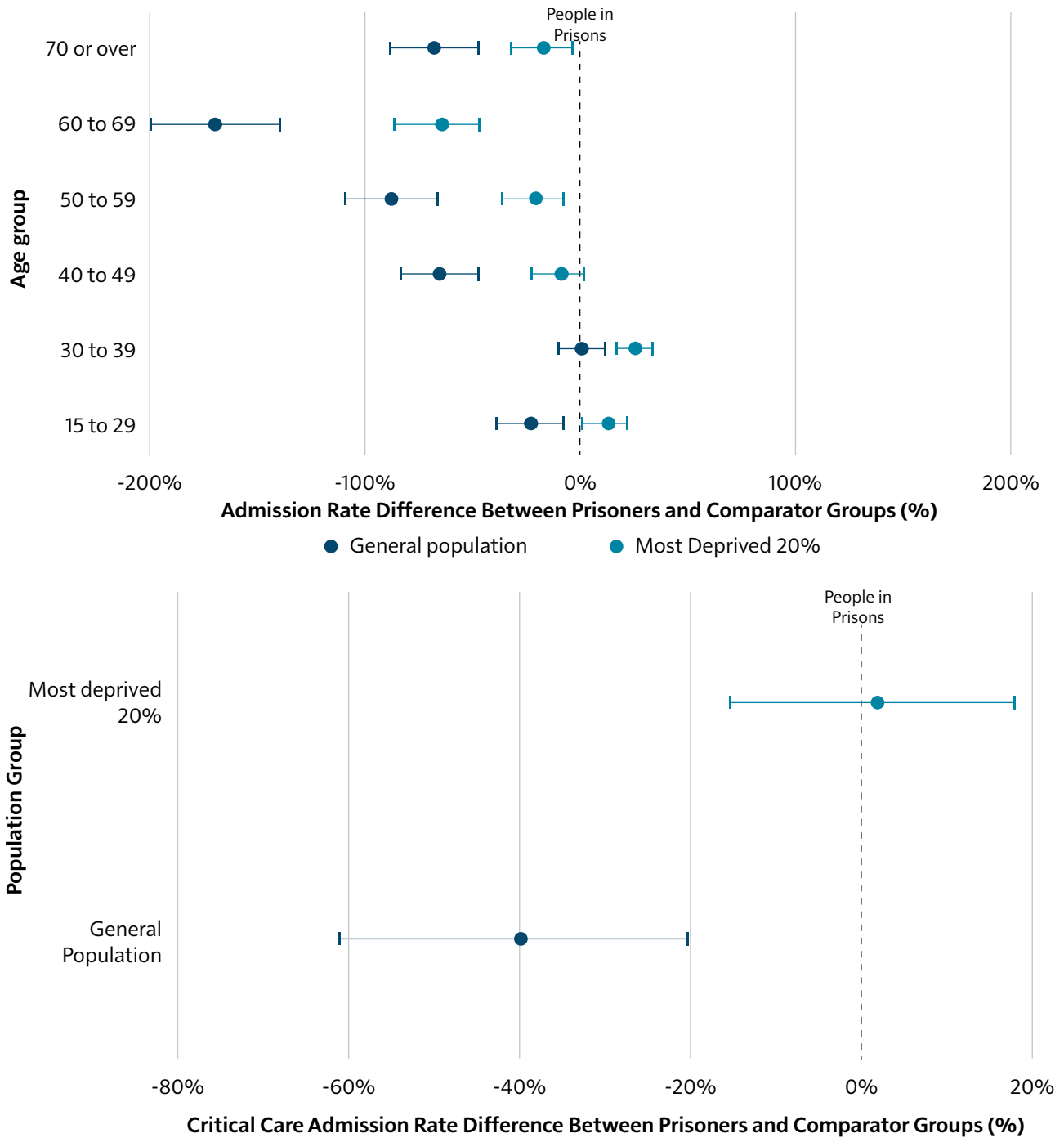
Influenza outbreaks vary in size but can cause significant operational impacts. Between 2011 and 2024, there were 83 outbreaks of influenza in English prisons⁴⁰ (see appendix). When outbreaks occur, they can have serious consequences and cause significant disruption to the prison operational regime including isolation and stopping of visits and prison transfers. Research on the attack rate of influenza in prison settings is sparse, but historic outbreak report data suggests attack rates can vary from 2.1% to 34.0% across the entirety of prisons, with attack rates of up to 73.0% on affected prison wings⁴¹ (for more information see appendix).

COVID-19

People in prison were severely impacted during the COVID-19 pandemic, experiencing higher rates of disease, hospitalisations and deaths compared to the general population and with major operational impacts affecting the prison regime (see appendix). During the peak of the pandemic, infection rates in prisons were 2.5 times higher than in the general population⁴², with 768 outbreaks of COVID-19 in English prisons between 2020 and 2024. During the first waves of the COVID-19 pandemic (March 2020 to February 2021) people in prison were 3.3 times more likely to die from COVID-19 than someone of the same age and sex in the community^{43 44}.

People in prison had significantly higher hospital admissions for COVID-19 compared to the general population living in the most deprived areas but similar critical care admission rates (figure 4).

Figure 4: people in prison had significantly higher rates of hospital admission than the general population in those aged 40 and over (top) and significantly higher rates of critical care admissions than the general population (bottom)



Source: UKHSA

Methods for identifying hospital admissions for people in prisons are limited and are highly likely to be underestimating total admissions. Further caveats around the interpretation of this data are given in the appendix.

Ventilation can help clear air that contains virus particles, prevent the spread of respiratory infections and be used to reduce environmental hazards such as radon (explored later in this chapter)⁴⁵. Ventilation quality varies across prisons, with many older 19th-century prisons having poor ventilation, especially since windows in these buildings often cannot be opened⁴⁶. Access to natural ventilation in communal spaces also depends on the age and layout of the building.

Tuberculosis

Prison populations experience a much higher rate of TB than the community overall. Prison populations have a higher prevalence of risk factors for TB, such as history of homelessness or drug use, than the general community. In 2023, 111 people notified with TB in England and Wales (2.2% of all TB notifications) reported current or recent imprisonment. People with a history of imprisonment had a TB rate 4 times higher than the general population (32.8 per 100,000 people for those with a prison history compared to 8.2 in the general population)⁴⁷ (see appendix).

Notably these individuals are also more likely to:

- have a bloodborne virus infection (risk ratio HIV and/or hepatitis 2.7, risk ratio Hepatitis B and/or Hepatitis C 4.0)
- be part of a cluster (2 or more confirmed active TB cases which are linked by time and place and are genetically related suggesting recent transmission occurred between them) (risk ratio 4.5)
- have pulmonary disease (risk ratio 2.7)
- have died from TB (risk ratio 1.7)

The rates of multi drug resistant TB among people with a prison history is lower than the general community and is currently not a concern but is being monitored closely (see appendix).

Infectious outbreaks in prisons can be disruptive and resource intensive. While measures are in place to identify, test and treat TB in prisons these are not sufficient to identify all cases, leading to delayed diagnosis and potentially large, resource intensive outbreaks with widespread transmission. The costs associated with TB outbreaks can be high. It is estimated that diagnosing and treating each person with TB in prison costs the NHS over £50,000⁴⁸. Additionally, mass screening of staff and resident contacts during an outbreak can cost, on average, £170,000 per outbreak (see appendix). Tests for TB such as chest x-ray help identify if TB has spread to (or is already present in) people who were in close contact with the original case. There are logistical challenges with organising testing, identifying staff and released prisoner contacts and achieving high testing uptake. There are also evidence gaps relating to TB contact tracing in prisons. Given the high population turnover and the crowded high-risk nature

of the setting, the traditional ‘stone in the pond’ approach to screening TB contacts⁴⁹ may be less effective and lead to delayed case detection, loss to follow up of contacts and further transmission.

Staff are also at risk from infectious TB; in the past 7 years prison staff made up 10% of the TB cases in prison outbreaks in England and Wales highlighting a transmission risk and reinforcing the need for adequate staff PPE and inclusion in outbreak screening (see appendix for example of prison to staff transmission).

Lived experience: reflections of prison staff on management of TB in prisons

Discussions with prison staff on TB management highlighted issues with isolating people in prison alongside concerns about adequate PPE, close contact with cases and a general ask for better information on the risks associated with TB. Prison officers escorting people to hospital and performing ‘bed watch’ overnight at the hospital will be handcuffed and/or in very close proximity to the patient for long periods of time, often over the 8-hour threshold which is considered a risk for TB exposure and transmission:

“It’s pretty much a case of, if we’re going out on an external escort, they’re always cuffed unless it’s life threatening where they need to be resuscitated or something, we’re going to be cuffed to them.” (Prison officer)

Latent tuberculosis (LTBI) means someone has been infected with TB, but the individual has no symptoms or disease and is not infectious as their immune system is controlling the infection. It is increasingly appreciated that other TB states occur between infection and active TB disease, for example subclinical TB disease. Here, an individual may have no symptoms but may still be infectious to others. The prevalence of LTBI among prisoner’s ranges from 2% to 14% varying by prison, sex and age (see appendix). This is similar to the proportion of people testing positive in the national LTBI testing programme for migrants from high incidence countries (15.1% in 2023). Treatment for LTBI may prevent future development of active or subclinical TB disease. Blood tests called interferon gamma release assays (IGRA) can show if a person has been infected with TB including people who have been previously treated for TB and people who have active disease. National Institute for Health and Care Excellence (NICE) guidance recommends prisons in high incidence areas of the UK test for LTBI in prisoners under 65 years in contact with substance misuse services. World Health Organization guidance recommends screening and treatment for active TB disease in prisons. Currently there are no routine LTBI screening programmes in English prisons however current evidence suggests targeted screening could be cost saving (see appendix).

TB management in prisons could be optimised, including improvement of TB screening on entry into prison (see appendix). Upon arrival in prison, individuals are asked at the first stage reception screen whether they have any symptoms of infectious TB. However, this screening test for active TB cases has poor sensitivity and fails to detect many cases of infectious TB leading to late identification. This may be due to several factors at reception screening:

- patients may be focused on other concerns when entering prison and may not disclose symptoms
- staff may lack sufficient training
- there may be insufficient resources to isolate and test suspected TB cases
- some individuals may have pre-symptomatic disease, which a verbal screen would not pick-up

There remain gaps in the evidence as to the best way to screen people for active TB on entry into prison. A review on the effectiveness of strategies for case finding for TB in prisons concluded there was limited evidence⁵⁰. Screening is only effective if subsequent public health actions can be taken on results (in the case of TB, isolating people until they receive confirmatory diagnostic test results). Given capacity pressures, isolation in prisons is difficult and may affect decisions to test people. By the time TB is suspected or diagnosed, people may have had close contact with lots of other individuals in the setting. There is a current multi-agency working group including members from UKHSA, NHS England, HMPPS, Home Office and academia that has made recommendations to a national TB tripartite group and NHS England to improve TB screening and control (see appendix).

Lived experience: reflections of prison officers on management of TB in prisons

“it’s not always possible to find a single cell for them straight away. And obviously it’s sort of the way it seems is that if they’ve already been in a double cell with another prisoner, they’re just sort of kept in the cell because both of them are expected to have TB, so they’ll just be kept in a double cell...” (Prison officer)

“They could be in a cell with 15 people then they’d have to get searched in a room by 2 male officers interviewed on a one-to-one basis before going to healthcare, where they could be in another holding cell with, again, like 10 to 15 people, see healthcare and then one of the healthcare nurses would come and tell us, by the way, is suspecting TB” (Prison officer)

Bloodborne viruses

BBVs like Hepatitis B (HBV), Hepatitis C (HCV), and HIV are prevalent among people in prison, often linked to a history of injecting drug use (IDU)⁵¹. The extent of BBV transmission within English prisons remains unknown, however international data suggests that transmission within prisons occurs through sharing of non-sterile injecting equipment, tattooing, sexual activity and physical violence. The Unlinked Anonymous Monitoring (UAM) Survey of People who Inject Drugs (PWID) reports that since 2017 around 12% of people who have ever been in prison injected drugs while inside. While there is opt-out BBV testing when people enter prison, there is no exit testing to determine if people acquire infections while in prison.

In the community, areas can commission needle exchange programmes and there is evidence of community effectiveness for reducing infection related harms. In prisons, needle exchange programmes are not currently provided. There is limited evidence on the impact of opioid agonist therapy (OAT) on infection-related harms in prison, educational interventions and needle exchange in prisons⁵². There are also concerns about safety and the potential for drug use to increase if needles are provided. Prisons are advised by HMPPS to provide bleach tablets for disinfecting needles as an alternative option, but evidence suggests this is ineffective⁵³.

The HBV vaccine is available to everyone entering or working in prisons to prevent HBV infection, however good data on uptake is not available. There are also gaps in the evidence on other transmission routes for BBVs such as through self-harm. Learning can be drawn from other countries on ways to prevent and reduce harms related to BBVs such as safer tattooing programmes^{54 55 56 57}.

NHS England commission a national programme of opt-out BBV screening for every new prison entrant for HCV, HBV and HIV. While uptake of a test on first and second reception in prisons has risen from 11% in 2016 to 2017 to 72% overall in 2022 to 2023, this is below the 75% target and there is variation by region and prison⁵⁸.

Engagement⁵⁹ with residents and staff in several prisons reported consistent offers of BBV screening and reasonable uptake on entry in to prison. Participants reported that uptake improved if linked to medical clearance to use the gym or work and also through proactive follow up with those who initially refuse testing. Prisoners' recollections of the BBV screen were often hazy with some mistaking it for a mandatory process.

Hepatitis C

Diagnoses of HCV are higher among PWID and people in prison than the general community⁶⁰. Several data sources provide insight into HCV positivity and prevalence among prisoners, shown in Table 1. In almost all, HCV positivity and/or prevalence is markedly higher among people in prison. See appendix for more information on HCV.

Table 1: Hepatitis C (HCV) positivity and prevalence among people in prison in England and community comparator data

HCV Data source	HCV RNA positivity rate
National sentinel surveillance of bloodborne virus testing (2022) ⁶¹	2.7%
HCV Data source	HCV prevalence
UKHSA biobehavioural surveys core antigen – <i>indicating current infection, either acute or chronic</i> (2022 to 2024) ⁶²	0.8% (Men 0.3%, Women 1.2%)
High Intensity Test and Treat antibody positive – <i>indicating current or previous infection</i> (2019 to 2024) ⁶³	7.4%
High Intensity Test and Treat RNA positive – <i>indicating current infection</i> (2019 to 2024) ⁶⁴	1.1% (Men 0.7%, Women 2.4%)
Community comparator data source	HCV prevalence
Modelled estimate of general community prevalence in England ^{65 66}	0.1%
Prevalence of chronic HCV infection (antibody positive) among participants in the Unlinked Anonymous Monitoring (UAM) Survey of people who inject drugs using dried blood spot testing (2023) ^{67 68} – <i>indicating current or previous infection</i>	7.8%
Opt-out emergency department testing in England (2023) ⁶⁹ HCV antibody positive – <i>indicating current or previous infection</i>	1.0%
Opt-out emergency department testing in England (2023) ⁷⁰ HCV RNA positive – <i>indicating current infection</i>	0.2%

Note: UKHSA biobehavioural surveys and High Intensity Test and Treat (HITT) events offer testing to all prisoners in a setting. Biobehavioural surveys included only 8 prisons therefore sentinel surveillance data is more likely to be broadly representative of the prison population in England as sentinel surveillance of blood borne virus (SSBV) covers approximately 80 prisons.

Women in prison have a higher prevalence of HCV infection than men. Data showed that women who had ever been tested in a prison setting have a higher HCV incidence rate than those testing in other services⁷¹. The risk of infection is amplified among women who are also tested in drug services⁷² suggesting that the higher risk of infection is related to injecting drug use.

The proportion of people that test positive for Hepatitis C (HCV RNA) has decreased from 5.2% in 2018 to 2.7% in 2022, likely due to testing and treatment initiatives implemented in prison and community settings⁷³. As part of the commitment to achieving HCV elimination nationally, goals to achieve ‘micro-elimination’ within prison settings have been agreed⁷⁴ (see appendix).

Since 2019, NHS England has commissioned ‘High Intensity Test and Treat’ peer led initiatives in prisons which aim to test everyone for HCV and fast track them onto treatment. Since 2019, 54,080 prisoners have been tested through this initiative, resulting in 478 people commencing treatment (see appendix).

People in prison are less likely to start treatment and be cured of HCV (achieve a sustained virological response (SVR) compared to the general community (Table 2).

Table 2: treatment pathway for individuals with a positive HCV RNA in prison between 2015 and 2023 (see appendix for further details)

Group	England	Prisons
Percentage who started treatment out of all HCV RNA positive tests with identifiers	78%	76%
Percentage achieving SVR after starting treatment	83%	79%
Percentage achieving SVR out of all HCV RNA positive tests with identifiers	65%	60%

The rate of people reinfected after treatment for HCV in prison is high, especially in women (20.4 reinfections per 100 person years⁷⁵ overall and 32.1 reinfections per 100 person years in women⁷⁶) (see appendix). As HCV prevalence in England decreases, testing strategies will need to focus on cost-effective ways to diagnose and connect people in prisons to care, while also reducing reinfections and identifying transmission networks^{77 78}. Achieving continuity of care for treatment of HCV on release from prison is challenging.

Hepatitis B

In most instances people in prison have a higher burden of HBV (including current acute or chronic HBV) than the general community and people who inject drugs (table 3). Men in prison had a higher burden of disease than women in prison. Data on linkage to care and treatment for HBV is not currently available and remains a gap in our understanding. Changes to data recording templates would permit national data extraction and assurance on HBV care. See appendix for more information on HBV data.

Table 3: HBV prevalence data for prisons and community comparators

Prison HBV data source	HBsAg positivity rate
National sentinel surveillance of bloodborne virus testing (2015 – 2022) <i>indicating current acute or chronic HBV infection</i> ⁷⁹	1.0 – 1.7%
UKHSA biobehavioural surveys (2022 to 2024) – <i>indicating current acute or chronic HBV infection</i> ⁸⁰	0.7% (men 0.8%, women 0.6%)
Prison HBV data source	HBV core antibody prevalence
UKHSA biobehavioural surveys (2022 to 2024) – <i>indicating current or previous HBV infection</i> ⁸¹	5.7% (men 6.1%, women 5.3%)
Community comparator data source	HBV prevalence
Modelled estimate of general community HBV prevalence in England ^{82 83 84}	0.6%
Prevalence of HBsAg among participants in the Unlinked Anonymous Monitoring (UAM) Survey of people who inject drugs using dried blood spot testing (2023) <i>indicating current acute or chronic HBV infection</i> ⁸⁵	0.4%
Opt-out emergency department testing in England HBsAg – <i>indicating current acute or chronic HBV infection. (2023)</i> ⁸⁶	1.1%
HBV antenatal screening programme in England HBsAg – <i>indicating current acute or chronic HBV infection</i> ⁸⁷	0.4%

Note: UKHSA biobehavioural surveys offer testing to all prisoners in a setting. This included only 8 prisons therefore sentinel surveillance data is more likely to be broadly representative of the prison population in England as SSBBV covers approximately 80 prisons.

An effective vaccine for HBV exists and has been recommended for everyone in prison since 2003⁸⁸. Current NHS England data suggests in 2022 to 2023, 48% of people in prisons were identified as having had at least one dose of HBV vaccine although this could have been received in either the prison or community. There is no target for HBV vaccine uptake for people in prison, however the target agreed between UKHSA, DHSC and NHS England for infant HBV immunisation in the public health functions agreement is 95%⁸⁹, suggesting prison uptake is far lower than required; ensuring people can complete vaccination schedules started in prison is important.

HIV

NHS England opt-out testing data and biobehavioural survey data reported positivity among people in prison of 0.7% and 1.1% respectively. In comparison, outside of prisons, community opt-out emergency department testing data showed that 0.9% of tests were positive for HIV⁹⁰. In a survey of people who inject drugs outside of prison 1.0% tested positive⁹¹. The estimated modelled prevalence of HIV in England overall is 0.2%^{92 93} (see appendix for more information on HIV data). HIV prevalence varies considerably between prisons, with the highest prevalence in busy high churn prisons. The highest prevalence was found in those aged 55 and older, compared to other age groups (see appendix).

People with HIV should be seen for HIV care at least once a year⁹⁴. However, no data is available on HIV treatment attendance for people in prison or probation meaning we cannot be assured optimal treatment pathways are being provided. Changes to data recording templates would permit national data extraction and assurance on HIV care. Engagement work has reported gaps in care, including treatment interruptions and breaks.

Lived experience: reflections from people living with HIV in prison

Engagement with people living in prison on HIV⁹⁵ revealed multiple knowledge gaps around HIV and its prevention. Participants were unsure about the impact of HIV on life expectancy or development of AIDS, as well as a lack of understanding about transmission routes. Half of the respondents were unaware that condoms were available, and those who did know expressed hesitancy in requesting them. Concerns included the potential for condom reuse in prison and the opportunistic nature of sex in prison, which often prevented condom use. Stigma and bullying were common, with people expressing reluctance to share cells with those known to be living with HIV. People living with HIV reported feeling ashamed and were hesitant to hold their own medication, fearing it would reveal their status. Others avoided HIV testing due to the fear of stigma.

“It was out there on the wing that he had it [HIV], people were cautious about sharing cups or forks with him. It caused bullying and victimisation, getting called names and being outcast or isolated from the wing as no one wants to talk to them. I wouldn’t talk to them” individual in prison

HIV pre-exposure prophylaxis (PrEP) is a medicine that has been proven to be highly effective at preventing HIV transmission. Pre-exposure prophylaxis for HIV is available in prison but access and awareness may require improvement. People in prison should be able to access HIV PrEP if required. No national data is available on PrEP access for people in prisons, however, 2 regional audits on prison sexual health services showed variation in provision and access to PrEP (see appendix) and engagement with people in prison suggested limited awareness of PrEP.

Lived experience: reflections from people in prison on PrEP

"It's surprises me if you can get it in prison, no one has spoken to me about PrEP or PEP [post exposure prophylaxis]."

"There's a lot of sex that goes on in prison and there's no information about PrEP on the wing, so I don't believe a lot of these people know about it."

"I think there needs to be posters up on the wings just explaining what it is and how it's used and what it does. Then let people make their own minds up whether they want to use it or not. Also, if the Governor was aware of it and included it in the Newsletter, everybody reads that. I believe that if they done a little bit of information on the leaflet just to say about PrEP and what it's used for, I think there would be a few questions to be answered."

Sexually transmitted infections (STIs)

There is a risk of STI transmission in prison through sexual activity. The extent of sexual activity in UK prisons is poorly understood but it is generally acknowledged that consensual sex does occur^{96 97}. Coercive or non-consensual sexual behaviour is likely underreported⁹⁸, as is a history of sex work. People may be reluctant to disclose sexual activity due to the presumed illegality and associated stigma. Standards for the management of sexual health in UK prisons⁹⁹ are available and include a range of measures including prevention, health promotion and education. All prisons have access to STI testing; however, tests are not routinely offered to every new reception.

Lived experience: reflections from people in prison on sexual health

Engagement¹⁰⁰ found prisons tried to opportunistically engage people in the sexual health agenda through interventions such as informal conversations on medication rounds, provision of in-cell sexual health testing kits and hand-outs at broader meetings:

"Yeah, so they go to meetings every so often in the chapel, like LGBT meetings or whatever, and they always come with like bags full of condoms and leaflets and things."
Current prisoner

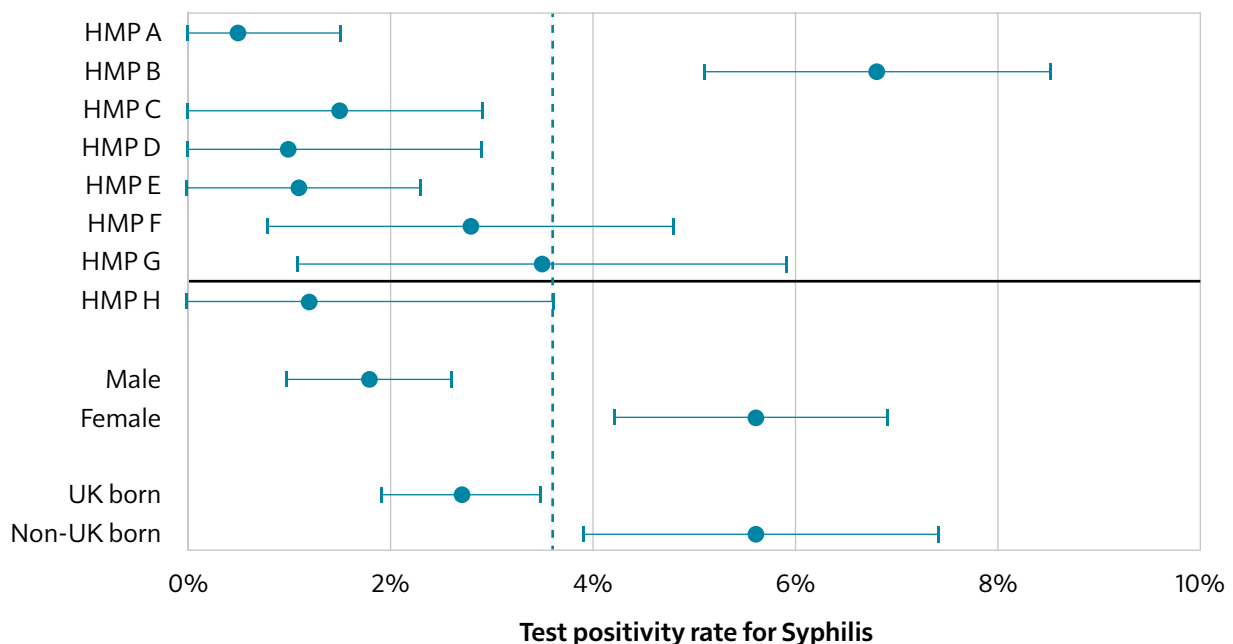
The number of STIs in prisons is likely to be underestimated due to issues with different data systems for reporting positive tests. In this section we have used several different data sources to understand levels of STIs in prison including national laboratory testing data, prison reported data and biobehavioural survey data. Standardising the recording and reporting routes for STI tests and diagnoses would provide more complete data and understanding on the burden among prison populations.

Practice example: opt-out STI screening for all new arrivals in a female prison

HMP Foston Hall is a prison which accommodates women aged 18 years and over. All new arrivals are offered opt-out STI testing, and test results are routinely reported to national laboratory surveillance. This opportunity to get tested has been welcomed by the women, particularly older women who have not engaged with community services. In 2024, 8.2% of people tested positive for syphilis, 4.0% for chlamydia, 4.2% for gonorrhoea and 5.4% for trichomonas. To better support the residents at HMP Foston Hall, it has been vital to build strong working relationships with community sexual health services to improve pathways.

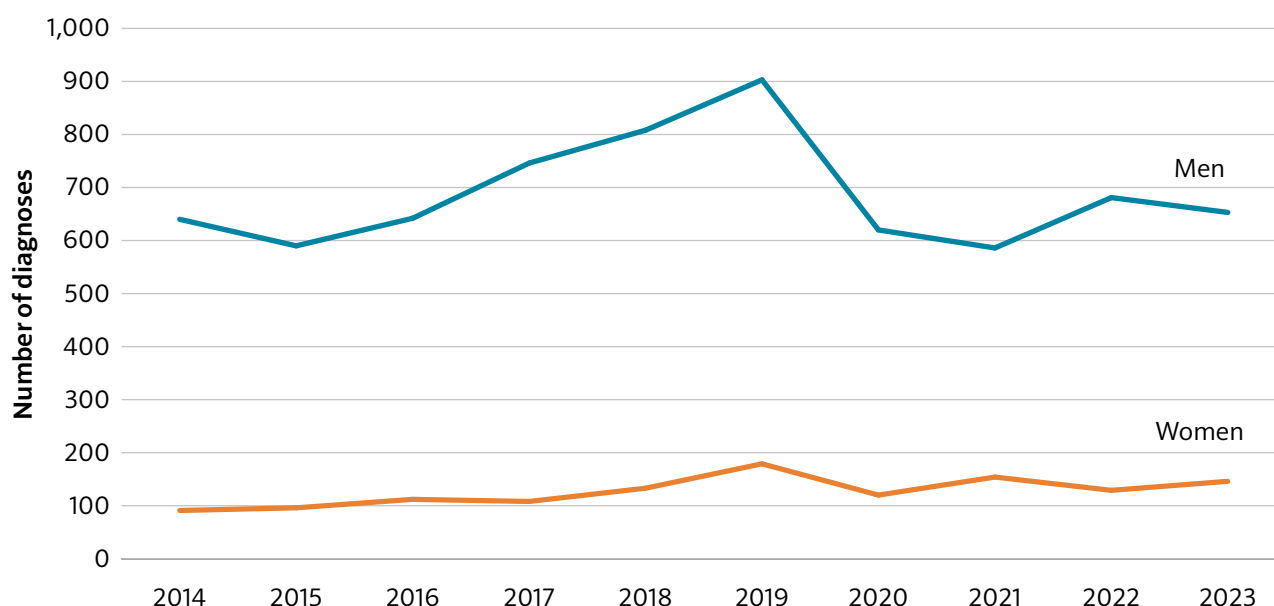
Data from 2023 shows syphilis diagnoses in England are at their highest level since 1948¹⁰¹; levels of syphilis are higher among women in prison than in the community. Biobehavioural surveys found that of the 2,252 people tested for syphilis in prisons (including past or current infection), 82 (3.6%) were positive. The prevalence was higher in females than males (5.6% compared to 1.8%) (figure 5). In comparison, the reported population prevalence of syphilis from antenatal screening is 1.64 per 1000 people (0.16%)¹⁰² (see appendix).

Figure 5: test positivity rate for syphilis among different prisons in the biobehavioural surveys



Source: UKHSA

Chlamydia diagnoses in prisons have not yet returned to pre-pandemic (2019) levels (figure 6). 2022 data indicates a test positivity of 4.8% in prisons. While chlamydia is more common in younger age groups, there is some indication that people aged 25 to 44 in prison are also at risk¹⁰³ (see appendix).

Figure 6: number of chlamydia diagnoses in England among people in prison by gender identity, 2014 to 2023

Source: data from routine surveillance returns by primary diagnostic laboratories to the CTAD Chlamydia Surveillance System (UKHSA)¹⁰⁴. The numbers of diagnoses reported in 2020 and 2021 are notably lower than previous years due to the disruption to healthcare provision during the first year of the COVID-19 pandemic.

Gonorrhoea in UK prisons is comparatively less common but still greater than the community. UK studies have reported gonorrhoea prevalence to be 0.8% for men¹⁰⁵ and 0.2% for women in prison¹⁰⁶. Biobehavioural surveys identified a prevalence of 0.3%. In the community, gonorrhoea rates have increased significantly from a diagnosis rate of 87 per 100,000 in 2021 to 149 per 100,000 in 2023¹⁰⁷. In 2025, the government accepted the Joint Committee on Vaccination and Immunisation's (JCVI) advice for an NHS roll out of the 4CMenB vaccination to protect against gonorrhoea in those at greatest risk of infection¹⁰⁸. Prisons should ensure there are adequate routes to access vaccination for anyone identified as eligible, preferably through in-reach vaccination models, considering factors such as the known association between female prison residents and a history of sex work¹⁰⁹. Full details on the eligibility criteria are in the gonorrhoea chapter of the Green Book¹¹⁰.

Research into the experience of sexual health services among LGBTQ+ groups in prison highlighted areas for action¹¹¹. Participants reported barriers to accessing sexual health support and complying with advice including fear that there would be consequences of seeking help, issues around privacy during intimate examinations and a lack of LGBTQ+ awareness, with participants afraid that disclosing a same sex relationship would lead them to be treated differently. Peers were viewed as a valuable way to access non-judgemental sexual health advice. Those interviewed described that they felt that more sexual health promotion within prisons would normalise the fact that sex happens in prisons. More information would help enable people to assess whether they needed a health appointment and ultimately improve sexual health.

Most STIs will only be detected if someone chooses to get tested, often because they have symptoms. Given the higher prevalence of STIs among people in prison compared to the

general community, more could be done to encourage people who are symptomatic or have been a partner of someone diagnosed with an STI to come forward for testing and treatment. This will require carefully designed approaches to health promotion and easily accessible services people know are confidential. Early treatment both prevents longer term complications and reduces spread.

Vaccinations and vaccine preventable diseases

Outbreaks of vaccine preventable disease happen in prisons and immunity to diseases such as measles and rubella is below required thresholds. Between 2011 and 2024, there were 100 outbreaks in prisons of diseases that can be prevented with vaccines, the majority of which were due to influenza. There were 9 outbreaks of measles, 4 outbreaks of HBV, 2 outbreaks of mumps and 2 outbreaks of whooping cough. Outbreaks can have significant impacts on settings; even if there are only a few cases, as this can result in lots of people having to isolate, depending on the disease, and potential for stopping of visits and transfers.

Influenza vaccine uptake is generally poorer than in the community. 43.0% of people aged 65 or older in prisons were vaccinated for autumn and winter 2023, compared with an average of 78.0% in the community¹¹². In Wales and Scotland, everyone in prison is offered the flu vaccine. In England, people in prisons are offered an influenza vaccination if they fall into the same risk categories as the general population since there is limited evidence on the benefits of offering flu vaccination to everyone living and working in prison. Research is being undertaken to build this evidence (see appendix).

COVID-19 vaccine uptake in people in prison is poorer among younger eligible age-groups. In England, prison residents are offered a COVID-19 vaccination if they fall into the same risk categories as those not in prison. As of 31 January 2024, NHS England data on COVID-19 vaccine doses in prison showed that 52% of all under 65 year olds in prison had received at least one primary dose of COVID-19 vaccination, while 89% of those aged 65 and over had received it. For the COVID-19 vaccine booster, at 31 January 2024 there was an overall uptake of 41% in people in prison, with 35% of eligible under 65s receiving the booster and 69% of people aged 65 and over. This is compared to 70.4% of people aged 65 and over in the general community¹¹³.

Biobehavioural surveys tested people in prison for immunity to measles and rubella. 85.9% were positive for measles antibodies and 81.1% for rubella antibodies (see appendix), lower than the 95% needed to have immunity, either from previous infection or vaccination. Given the high-risk nature of the prison environment for disease transmission, this lower immunity level increases the risk of outbreaks.

Practice example: co-produced MMR campaign

In 2023, National Prison Radio was commissioned to produce and broadcast a 6-month radio campaign to raise awareness of the risks of measles and the benefits of the MMR vaccination. An evaluation found that 59% of those interviewed had heard of the MMR vaccine on the radio and 80% expressed that their knowledge and awareness of MMR and measles had increased. 46% were more likely to seek support for measles or get the MMR vaccine, and 27% had either been vaccinated or spoken to their healthcare team about vaccination.

People in prison should have the same access to all vaccinations as the general community, with the added eligibility for HBV vaccination upon entry to prison. However, vaccine coverage data for people in prison is limited. Overall, vaccine coverage is considered sub-optimal, often due to poor engagement with health services prior to imprisonment and high levels of vaccine hesitancy. A recent audit (2023) of vaccine provision in the English prison estate found that most healthcare teams in prisons (88%) aim to routinely check the vaccine history of people at reception. Most settings offered relevant vaccinations to eligible individuals, with the highest offer rates for seasonal vaccines (flu 99%, COVID-19 96%) and the lowest for tetanus and/or polio (78%) and HPV (72%). There was variation in the number and proportion of settings that routinely stocked relevant vaccines, from 66% for flu vaccine to 23% for HPV vaccine. Some healthcare teams in prisons reported that they could not access relevant vaccines if not routinely stocked. A large proportion of settings that did not offer certain routine vaccines cited this was because they were 'not appropriate' despite eligible individuals residing there. This highlights the need for improved prison healthcare staff knowledge and training in vaccination to ensure that they understand the importance of offering routine and specific vaccinations to be able to appropriately support this population group¹¹⁴.

Vaccine confidence among prison populations is generally low, often linked to poor health literacy and broader feelings of mistrust and fear of negative consequences¹¹⁵.

Lived experience: prison staff reflection on vaccination in prison

Engagement in prisons¹¹⁶ showed that prison staff understood that vaccine rates were low overall but also recognised that certain groups of people were either likely to have lower or higher uptake, so may need different strategies to drive up overall uptake.

"So, I know from the healthcare partnership meetings that our vaccination rates are terrible."

"They tend to be happy to have it. Depends on the age. I find with the very young lads, they don't comprehend the risks and despite you telling them, advising them, they tend to say they don't want it."

“No, I would say the vaccination uptake’s really good. The only one I would say wasn’t was by the end of the COVID. But your general Hepatitis vaccinations...it’s very rare that anybody will turn that down.”

Co-produced educational materials may increase trust¹¹⁷; and given the success of the Hepatitis C trust peer model for improving HCV testing and treatment a similar peer vaccine model approach may be worth trialling. Rapid or accelerated vaccination schedules such as for HBV vaccine can increase acceptability and uptake¹¹⁸.

As well as proactive delivery of preventative vaccinations there are occasions when reactive vaccination is required in response to an outbreak. Local agreements need to be in place to outline how vaccinations will be deployed. Currently HMPPS occupational health services lack the capacity to provide staff vaccination in response to an outbreak of vaccine preventable disease or to offer catch up immunisations identified in pre-employment checks. As a result, staff must seek support from their GPs for these services which may mean uptake is lower and delayed than it might be if offered in the work setting.

Practice example: managing a measles outbreak in a male prison

In 2024, there was a measles outbreak in a Category C prison housing nearly 2,000 men. Seven cases were confirmed between April and May, including 4 prisoners and 3 staff members. These cases were linked to the same wing, where 65% (39 out of 60) of prisoners were unvaccinated. In response, contacts were isolated in their cells, transfers to and from the wing were paused and additional control measures were implemented, including cohorting for exercise, reduced movement, social visiting restrictions and cohorting of vaccinated staff to the affected wing. The Incidence Management team (IMT) recommended that vaccination (MMR) be prioritised for unvaccinated prisoners and staff on the affected wing. This was in addition to a general recommendation for all staff and prisoners at the prison to receive immunisation for those with incomplete or unknown vaccination status. Additional MMR clinics were set up and MMR vaccination was included in COVID-19 vaccine clinics. HMPPS occupational health could not provide MMR vaccination for staff, so staff were initially expected to seek vaccination from primary care. A mobile vaccination unit was then jointly commissioned for staff by the local authority and integrated care board (ICB). MMR vaccination was offered to 282 prisoners. 41% received their first dose, 38% declined and 21% did not attend. Out of 110 staff who expressed interest in MMR vaccination, 53 staff took up the offer. Challenges in addressing this outbreak included a lack of access to vaccination records, lack of face mask fit testing for prison staff and lack of occupational health delivery of staff MMR vaccination.

Antimicrobial resistance and antimicrobial use

People in prisons are at increased risk of antimicrobial-resistant (AMR) infections¹¹⁹ due to a combination of environmental and behavioural factors. These include overcrowding¹²⁰,

challenges accessing healthcare¹²¹ and a high prevalence of risk behaviours such as self-tattooing¹²², self-harm¹²³ and substance misuse¹²⁴.

Staphylococcus aureus (*S. aureus*) and Group A Streptococci (GAS) are the primary pathogens responsible for most skin and soft tissue infections (SSTIs) which can range from mild to severe or life threatening infections. Between April 2019 and March 2024, women in prison experienced SSTIs at over 3 times the rate of men (women: 13,466 per 100,000 person years; men: 4,627 per person 100,000 years). The reasons for this disparity remain unknown. Over the same period, the proportion of *S. aureus* isolates resistant to antibiotics, particularly methicillin-resistant *S. aureus* (MRSA), rose from 7.4% to 10.4% (see appendix for more information on SSTIs).

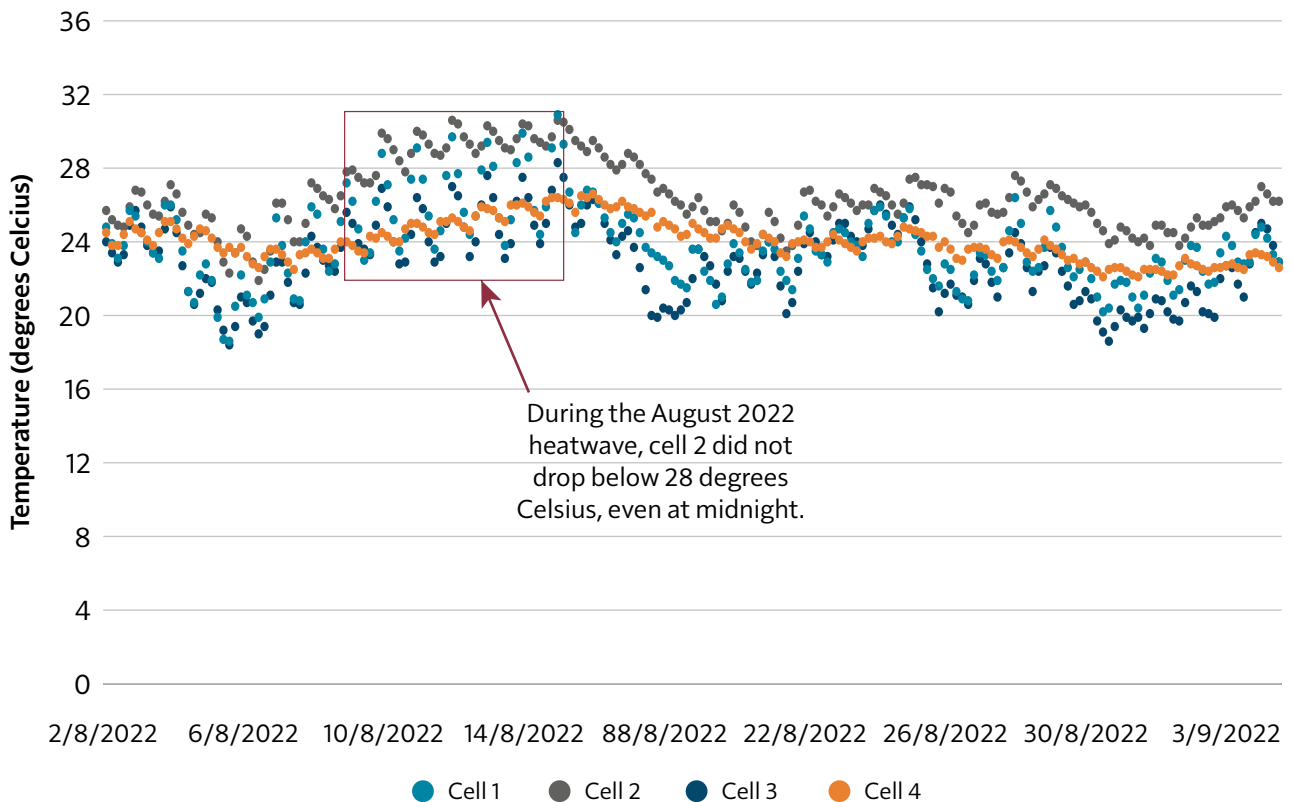
Bacteraemia refers to the presence of bacteria in the blood, which can lead to serious illness and potentially sepsis, and can be caused by a range of infections such as those originating from the skin or urinary tract. Between 2019 to 2020 and 2023 to 2024, 459 episodes of bacteraemia were reported in 365 individuals in prisons. Women experienced twice the rate of bacteraemia compared to men (women 247.8 per 100,000 person years; men 114.9 per 100,000 person years). A recorded 29% of episodes were MRSA, significantly higher than the 4.7% MRSA resistance seen in community-acquired cases; this is likely linked to more high-risk behaviours by those in prison (See appendix for more information on bacteraemia).

Environmental threats

Temperature is linked to levels of violence¹²⁵, rule breaking¹²⁶ and safety and wellbeing^{127 128}. Heat is also a risk factor for poor health outcomes in vulnerable groups, such as the elderly. Given the aging prison population, the ill-health impact of heat is therefore likely to increase. A thematic report from the Independent Monitoring Board in 2024 cited "Heating, ventilation issues and flooding led to uncomfortable, at times intolerable, living environments for prisoners"¹²⁹.

Temperature fluctuations are more extreme in some prison environments. Many prisons are built with materials which collect heat during the day and release it at night¹³⁰. A pilot study using Earth Observation data from 2014 to 2023 revealed that prison compounds in London experienced higher land surface temperatures than the city average, particularly during the summer heatwaves. In 2022, most prisons were several degrees hotter than the rest of London, with one compound reaching 48.2°C. During the winter, all prison compounds, except for one, had land surface temperatures lower than the average for London, which was 8.4°C. The coldest prison compound recorded a mean temperature of 3.3°C (for more details see appendix). Indoor temperature monitoring in newly built prisons also showed extreme temperatures during the August 2022 heatwave, where cells consistently exceeded 23°C, and in some cases, surpassed 30°C¹³¹. Relative humidity often exceeded 70%, which is considered the maximum recommended level. These extreme conditions can have serious health consequences, especially for vulnerable residents.

Figure 7: temperature readings for 4 cells in a new-build prison, 21 August 2022 to 4th September 2022, Midlands



Source: heat-health alert issued by UKHSA 2022

[Note]:UKHSA issued a heat health alert covering midday on Tuesday 9 August until 9am on Tuesday 16 August

Prisons are often located on contaminated sites or near polluting industries¹³² and many, especially in London, remain situated in busy urban areas with high levels of air pollution. Recent reports from HM Inspectorate of Prisons have highlighted issues with damp and mould in prison cells¹³³, which can increase the risk of asthma and lower respiratory infections. For further information see the appendix.

Radon levels exceed recommended limits set by the Health and Safety Executive in 20% of prisons. Radon exposure increases the risk of lung cancer¹³⁴ and when combined with tobacco smoke, the risk is even higher¹³⁵. The Ministry of Justice (MoJ) is working with radon mitigation contractors to design and install systems that are compliant with prison security. In summer 2024, HMP Dartmoor was closed due to high radon levels^{136 137} and it remains closed while awaiting remediation work. For further information see the appendix.

There is limited evidence on the effects of noise and lead pollution. Prisons can be noisy environments due to sources like clanging gates, slamming doors, alarms, shouting, footsteps and the hum of ventilation and air conditioning systems. The level of noise can vary based on factors such as occupancy density and the design of the building, with older prisons especially having acoustically hard materials and high ceilings that intensify the noise. While the adverse psychological and physiological effects of noise exposure are well documented in residential settings^{138 139 140 141} there is limited evidence on how this applies to prison residents^{142 143 144}.

Another concern is the presence of lead pipes in older buildings, especially those constructed before 1970. Lead pipe use was banned¹⁴⁵, but many older buildings still have lead pipework underground or within the building. Over half of operational UK prisons were built before 1970, though the exact number of prisons with lead pipes is not known. The water industry is currently removing lead pipes from schools, and a similar approach may be necessary for prisons. For further information see the appendix.

Partnership approaches to health protection

Protecting the health of individuals in prison and probation settings requires strong collaboration and partnerships at local, regional, and national levels. The National Partnership Agreement (NPA) involves organisations such as NHS England, UKHSA, DHSC, MoJ and HMPPS focusing on actions related to communicable diseases, including prevention and testing¹⁴⁶.

Additionally, the national Public Health Functions Agreement (S7a)¹⁴⁷, a tripartite agreement between DHSC, NHS England and UKHSA, includes health protection indicators relevant to prison settings, such as vaccination programs, opt-out testing for BBVs and screening for chlamydia and TB. Performance oversight is provided through regional and national multi-agency forums, ensuring support from public health agencies in the effective delivery of these functions.

When outbreaks or incidents occur in prisons, a multi-agency incident management team is formed to offer support. This team includes representatives from UKHSA, NHS England, HMPPS and local authorities¹⁴⁸. They collaborate to assess the situation, evaluate risks and provide public health recommendations, which are then implemented by local HMPPS and NHS England teams.

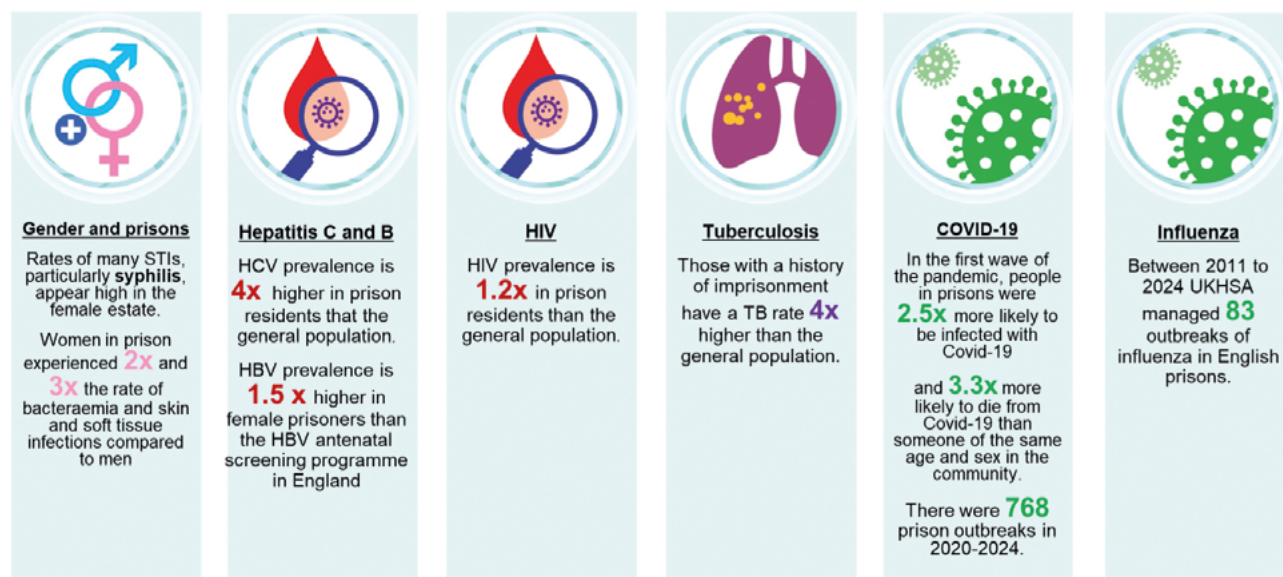
There is an important community health organisation role in supporting health protection and resilience of their local prisons. Apart from very rare circumstances, people cannot be detained past the end of their prison sentence even if they are currently receiving treatment for infectious disease, therefore it is important that local healthcare systems work in partnership with their prison establishments to achieve continuity of care. The Independent Sentencing Review¹⁴⁹ has, among other areas, provided recommendations in relation to increasing use of non-custodial sentences. Consideration will need to be paid to ensure any benefits of increased healthcare access offered by in-prison healthcare teams is not lost to a cohort of people serving time solely in the community.

Conclusions

This chapter has highlighted several critical themes regarding health protection within prison populations and emphasises the need for a multi-partnership approach to address both the immediate health impacts and the root causes of these challenges. Below is a summary of the key findings:

Prisons populations experience a higher burden of infectious disease compared to the community (figure 8). Diseases such as syphilis, HBV, HCV, and TB are notably more prevalent in prisons. Active TB, despite having a lower overall number of cases, poses significant operational and resource challenges, making it a high priority. There are potential community dividends to the effective detection, treatment and management of infectious disease in prisons including a reduction in the wider disease reservoir, and an increased ability for people to rehabilitate back into the community and become productive members of society¹⁵⁰.

Figure 8: snapshot of the burden of disease in English prisons



(Note: numbers are approximate. See appendix for details of data sources)

There are differences in disease prevalence between men and women in prison, though the reasons for these disparities are not fully understood. These include that:

- men tend to experience higher rates of TB and HBV
- women in prison are more likely to contract or experience HCV, HIV, syphilis, skin and soft tissue infections, and bacteraemia

Addressing these disparities requires more targeted research to understand transmission routes (including the potential role of sexual transmission, injecting drug use, tattooing and self-harm^{151 152 153 154}) and to develop effective, tailored interventions for women drawing on learning from other countries.

Prisons present a unique opportunity to engage with a population that often has poorer health and limited access to mainstream healthcare services. While testing and treatment programs for infectious diseases are in place, there is a need for a stronger focus on health promotion, prevention and harm reduction, taking a 'people and place' approach – using interventions that will be effective across multiple pathogens and promote health-seeking behaviours.

HIV PrEP is an important part of the HIV elimination programme and commissioners and providers of healthcare in prisons must ensure it is widely understood and easily accessible to

residents. Additionally, enhancing harm reduction efforts, such as supporting safer injecting practices and re-engagement with drug treatment services upon release, is critical.

Expanding peer-led programs to issues such as BBVs, immunisations and TB and collaborating with voluntary sector organisations to provide accessible, co-produced health messages could further strengthen these interventions.

Challenges remain in implementing IPC measures in prison settings due to structural and security reasons; greater access to relevant PPE such as FFP3 fit-tested masks must be provided for staff alongside improved access to vaccination as part of preventative and reactive outbreak response.

Environmental hazards, including extreme heat and air quality issues, pose increasing threats to health in prison settings. The impacts of climate change and extreme weather events will likely intensify these risks, necessitating further research to understand the level of vulnerability among the prison population¹⁵⁵ and to drive forward innovations to address these. Factors such as building quality, design, and variation between prisons must be considered in mitigating these threats. Further research is required to fully understand the risk of environmental threats in prisons. NHS England are working with HMPPS to ensure new build prisons facilitate health, this should include planning for extreme temperatures to ensure they are weather-proofed and be designed to support adequate ventilation.

There are substantial gaps in clinical data capture and surveillance systems within health systems in prisons. Standardising data recording across prisons and improving data sharing and linkage across organisations would enable a more comprehensive understanding of health risks, care pathways, and outcomes. Gaps in data on vaccine coverage, STI diagnoses, HIV and HBV care pathways should be addressed using standardised template recording in electronic health records in prisons to better inform surveillance, policy and interventions. Where possible data comparisons should be made to the community to allow understanding of the scale of inequalities, for example for rates of antibiotic resistance.

To reduce health protection inequalities among people in prison it is crucial that all partners involved in the criminal justice system recognise their roles and commit to improving health outcomes. As the shift towards community-based sentencing continues, there will be an increased focus on the probation service, integrated care boards and the integration of health protection interventions for individuals on community sentences. Collaboration between probation and community health organisations will be essential in ensuring continuity of care for individuals transitioning from prison back into the community.

In conclusion, this chapter underscores the need for a concerted, multi-agency approach to health protection in prisons, with particular emphasis on addressing disparities by sex, improving health interventions with a holistic approach focused on preventative measures, enhancing environmental protection and closing critical data gaps. Achieving equity in health outcomes for people in prison and on probation requires a partnership between justice and health sectors, community organisations, and those with lived experience of imprisonment.

Additional recommendations

1. Infection prevention and control measures in prison and probation settings can be difficult to implement and require improvement. UKHSA should develop training, education and practical IPC guidance for non-healthcare prison and probation staff and residents, and HMPPS should champion better local leadership for IPC.

To be led by: HMPPS and UKHSA

2. People in prison are less likely to achieve a sustained virological response to HCV treatment than the general community and referral or receipt of care is currently unknown for HBV and HIV.

NHS England should make data improvements to standardise recording and reporting to understand treatment attendance for HBV and HIV.

To be led by: UKHSA, Voluntary Community and Social Enterprise (VCSE), academics, health protection research units, NHS England and ICBs and NHS England including regional commissioners and providers

3. There are gaps in access to preventative measures and educational materials in prison for sexually transmitted infections. Prisons and healthcare teams should ensure there is adequate and confidential access to preventative measures and health promotion materials and education which resonate with people of different sexual orientations.

To be led by: NHS England including regional commissioners and providers, UKHSA and VCSE, prison governors

4. The evidence available suggests women in prison are disproportionately affected by sexually transmitted infections, most notably for syphilis. UKHSA and NHS England should consider the feasibility of universal opt-out STI testing for chlamydia, syphilis, trichomoniasis and gonorrhoea to all women entering prison.

To be led by: NHS England and UKHSA

5. There are knowledge gaps among prison healthcare staff on vaccinations. UKHSA should develop training and materials to address knowledge gaps around which vaccinations to offer, particularly to those with an incomplete or uncertain immunisation history.

To be led by: NHS England and UKHSA

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13 National screening programmes in prisons

Authors: Elliot Graves, Elizabeth Taylor-Diparno

Contributors: Kim Sheridan, Paul Eastwood, Harrison Carter, Nikki Luffingham, Dr Chantal Edge, Dr Nicola Dennis, Dr Emma Plugge, Natalie Austin

Introduction

Screening is a way to identify people who may be at higher risk of certain conditions. In England, the NHS offers various screening tests, known as the national screening programmes, to specific groups of people. National screening programmes help with disease prevention, early detection, timely treatment and better health outcomes. Ensuring everyone has equal access to these programmes is important for reducing health inequalities. This is especially important for individuals in the criminal justice system, who often have higher rates of disease and challenges with accessing healthcare. Indeed, people in prison are less likely to receive curative treatments and have lower overall survival for cancer than the general population¹. Improving access to national screening programmes is a key part of the government's 10 Year Health Plan for the NHS which aims to shift focus from treatment to prevention, including for those in prisons.

Under the NHS Public Health Functions agreement, the Secretary of State for Health and Social Care delegates responsibility for delivering certain public health functions, including national cancer screening programmes to NHS England. NHS England Health and Justice (H&J) are responsible for delivery and access to public health functions for people in secure and detained settings, as outlined in Specification 29². Prison healthcare providers are responsible for ensuring that adult cancer and non-cancer screening pathways are offered and accessible. This includes the following programmes:

- diabetic eye screening (DES)³: everyone with diabetes aged 12 years old and over
- abdominal aortic aneurysm (AAA) screening⁴: men aged 65 and over
- bowel cancer screening⁵: people aged 50 to 74 years
- cervical cancer screening⁶: women aged 25 to 64
- breast cancer screening⁷: women aged 50 up to 71

While additional screening programmes exist in prisons, for example reception screening for bloodborne viruses (discussed in chapter 12) the focus of this section is on the above 5 population screening programmes for detained adult populations in England, referred to throughout as the 'national screening programmes'. Most screening programmes in prisons are provided by community screening providers, often through in-reach services. Prison healthcare teams mainly support access to screenings, for example breast screening, by identifying

potential eligible individuals, inviting them to screening and helping screening services access the prison.

National screening programme performance data

Screening activity in prisons is monitored nationally by NHS England H&J on a quarterly basis, which includes reporting on the total number of people eligible (that is due for screening as per national screening programme guidance), uptake (that is the proportion of eligible individuals invited for screening who then had a screening test result recorded) and reasons for non-uptake.

Screening coverage is the percentage of the total eligible people who were adequately screened within a certain time period. Population coverage (that is total number eligible and up to date with the screening regardless of where screening was undertaken) is not currently reported for prison populations due to data quality issues. Prison screening data is also subject to significant caveats given data quality issues due to challenges in the recording and reporting pathway. This means we are limited in our ability to understand screening performance in prisons and to directly compare national screening programme coverage in the prison population against coverage in the community.

Table 1 below compares the uptake of national screening programmes in the community to that in English prisons in quarter 3 of the 2024 to 2025 financial year. Uptake of cervical and diabetic eye screening are comparable to the community. Breast screening relies on specialist mobile screening units in-reaching to the prison setting or requiring escort of the patient out to secondary care for screening. Without prison-specific guidance, or ring-fenced funding, in-reach of these specialist mobile screening units is routinely only available once or twice per year in the female estate. Since women are often serving shorter sentences, they may be more likely to leave the estate before accessing screening but will still be included in reported figures. For these reasons it is not unexpected that uptake is lower for this programme, but this still represents a matter of inequity.

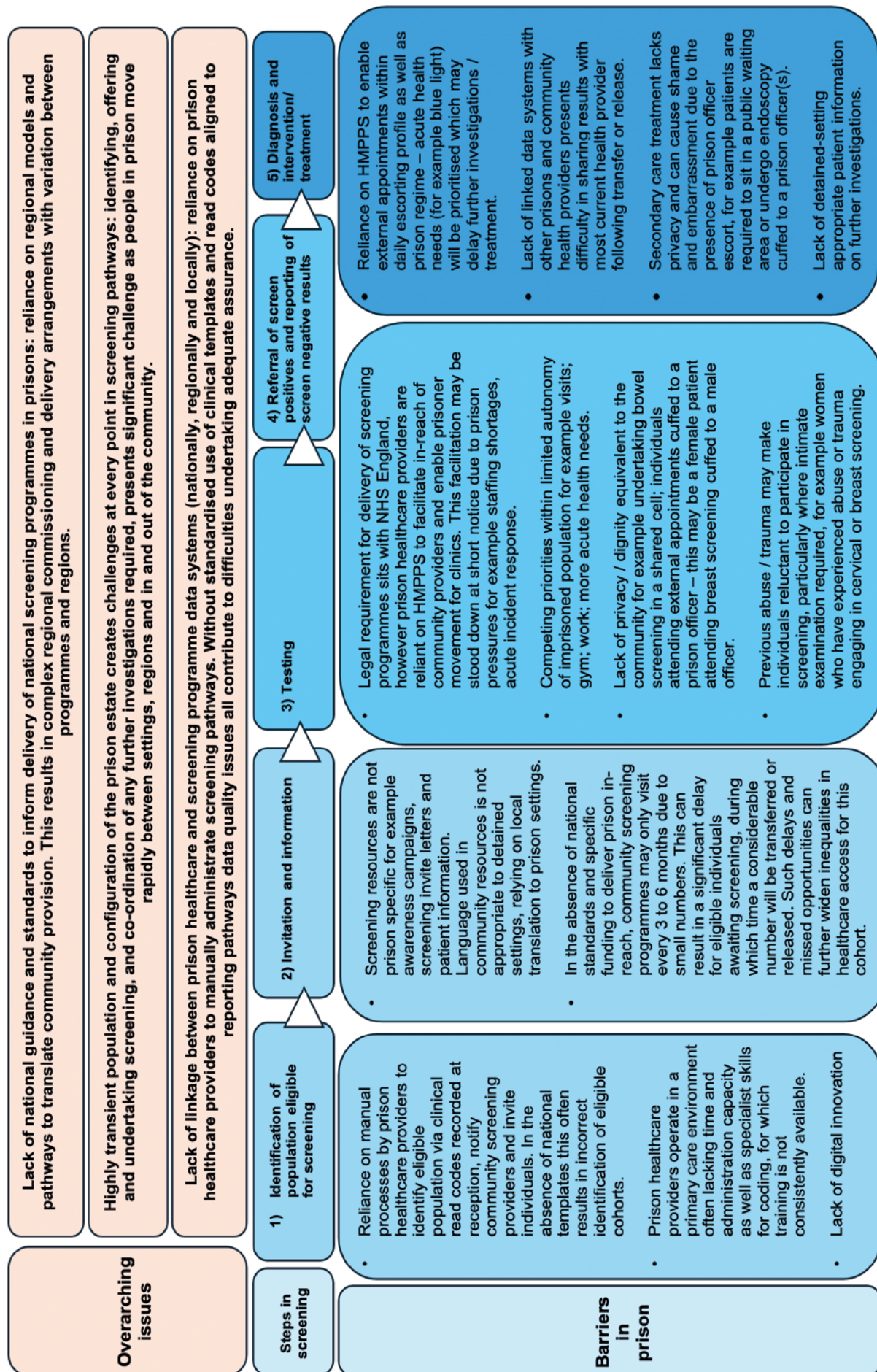
Table 1: uptake of national screening programmes in prison and immigration removal centres compared to the community*

National screening programme	Community uptake (percentage of those eligible who were invited to screening and who were screened) 2023 to 2024	Prison uptake (percentage of those eligible who were invited to screening and who were screened) Q3 2024 to 2025
Bowel cancer screening	68% ⁸	65%
Breast cancer screening	70% ⁹	18%
Cervical cancer screening	62% in 2024 ¹⁰	66%
Abdominal aortic aneurysm screening	82% ¹¹	74%
Diabetic eye screening	81% ¹²	77% ^{**}

*Immigration removal centres are out of scope for this report, but it is not possible to disaggregate the data **includes a small number of children in the children and young people secure estate

Engagement with national and regional stakeholders involved in the commissioning, delivery and oversight of national screening programmes in prisons has identified both over-arching and programme specific challenges to delivery in the detained estate. These are predominantly system challenges that prevail despite the efforts of local, regional and national teams to mitigate. These issues are shown in figure 1 and described in detail throughout this chapter.

Figure 1: pictorial summary of the themes that are described in this chapter



Delivery of national screening programmes in the prison environment

Prisons are unique environments, presenting significant challenges to delivering some of the national screening programmes in a manner which is equitable to that of community populations. This is despite significant efforts of local, regional and national teams. While custodial sentences present an opportunity to support individuals to access healthcare services it is an oversimplification to view the population as a 'captive audience' for engagement in screening programmes.

Overarching issues

Prison-specific national guidance and standards

The National Screening Programmes Specifications have not been translated nationally to consider the unique environment of prisons, enable standardised delivery across sites and ensure equity in access compared with community populations. There is a lack of prison-specific documentation (including guidance, standards or protocols), patient resources (including awareness materials, patient information) and nationally standardised recording and reporting processes.

The Prison Health Checks Programme provides a positive example where a population programme has been translated nationally into the context of the prison estate. There is prison specific national programme guidance¹³ and standards¹⁴ which outline the expectations for the delivery and oversight in prisons. The absence of such guidance for the national screening programmes underpins a series of challenges to delivery in prisons and inequities in access.

Significant variation in the 'offer' between estates, regions and programmes.

In the absence of nationally translated guidance and standards for prisons, delivery of national screening programmes in prisons is reliant on the development of regional pathways and local models. In practice this often means retrofitting community pathways with local arrangements for community screening providers to provide 'in-reach' services to prisons. The result is a complex set of pathways for prison healthcare providers to navigate and an over-reliance on manual processes. While there are excellent examples of regional partnership working to increase access and uptake to screening for people in prison, the resources and capacity of community screening providers can be limited. Without national standards or ring-fenced funding, specialist providers are routinely limited to providing prison in-reach services on a quarterly, biannual or annual basis. This leads to inequities in access, with some prisons or screening programmes receiving fewer regular visits than others.

Practice example: regional development of prison-specific screening pathways

In the North West and South East, regional models have been developed whereby a mobile breast screening van visits the female prison, one or twice per year. This has significantly increased uptake in the programme by patients on site by avoiding the need to escort women to hospital for screening.

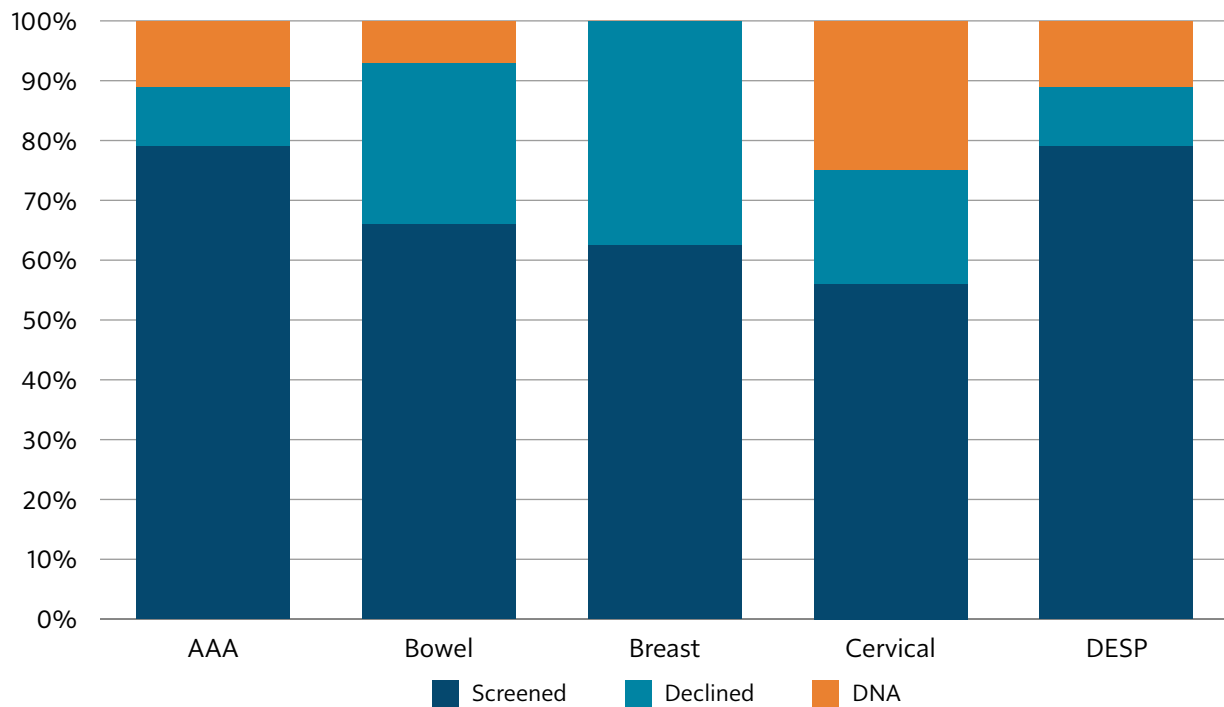
The West Midlands region has undertaken significant improvement work for the prison bowel screening programme, resulting in an increase in bowel screening activity. A regional working group focused on screening in West Midlands prisons was established and stakeholder workshops undertaken, bringing together prison healthcare providers and regional health teams, including the bowel hub, NHS England H&J commissioners, Public Health and Screening and Immunisation teams. This engagement underpinned a number of regional workstreams focused on developing a regional prison bowel screening pathway to streamline administrative processes between healthcare providers and the bowel hub and reduce variation across prison sites, improving data collection and increasing prison health promotion activities.

The prison population is highly transient and dynamic

Individuals move through the prison estate during their sentence, as well as between the prison estate and the community. Given the time taken to identify eligible patients, co-ordinate in-reach with specialist community providers and complete screening, a significant proportion of the population will be transferred or released before they have an opportunity to be offered and engage in screening.

Figure 2 below shows the number of people (NHS England H&J data, quarter 3 2004 to 2025) in English prisons who were offered an appointment for a national screening programme and of those that remained in that prison site, the numbers that were successfully screened, declined or did not attend (DNA). Most people who are offered screening went on to complete it, with only a few declining or missing appointments.

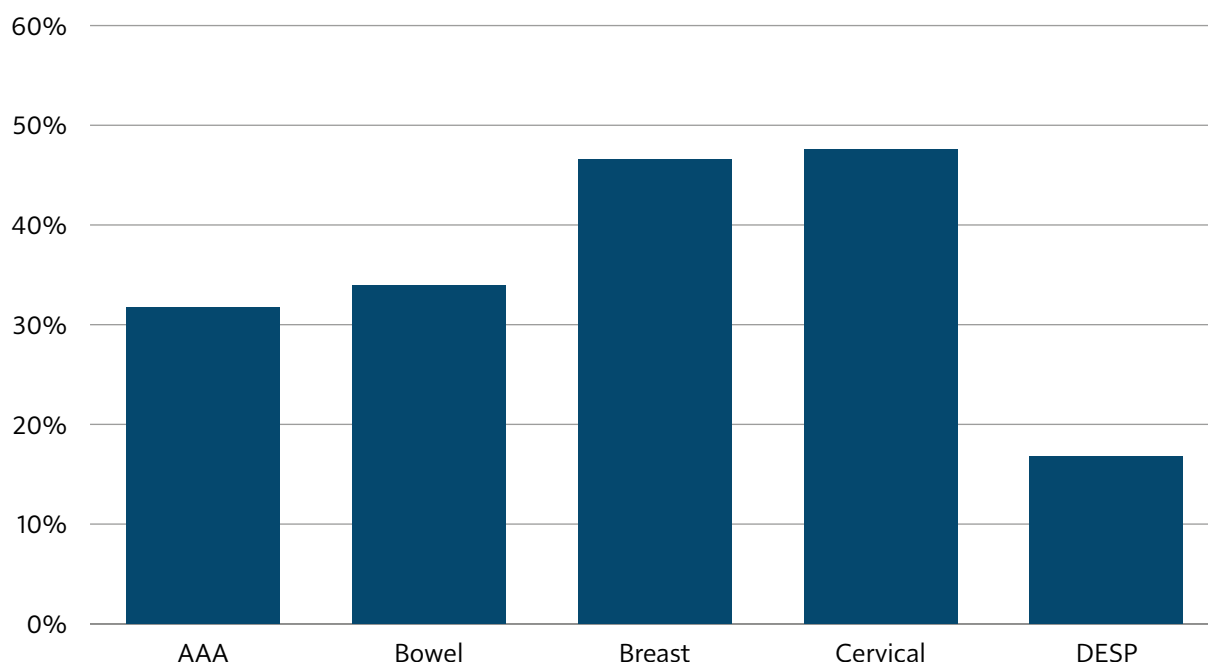
Figure 2: proportion of individuals that were offered screening and remained in that prison site, that were screened, declined or did not attend screening (quarter 3 2024 to 2025)



Source: NHS England Health and Justice

Figure 3 in contrast shows the number of people who left the setting before they could be screened. The high turnover of people in prison means many potential opportunities for screening are missed. This issue is especially evident in reception prisons, which tend to be large, often housing over 1,000 people. Many people are only held for short periods meaning the population can change quickly, with potential for almost the whole population to ‘turn-over’ in 6 months. Healthcare providers are expected to meet the same targets as those in prisons with more stable populations and as community populations, even though the constant turnover of people makes it much harder to identify eligible cohorts, offer and co-ordinate screening. National screening programmes are currently applied to the population in prison directly as per the community programmes, without national prison-specific guidance or protocols. This creates specific challenges in pathways, for example, with bowel screening: once requested, bowel testing kits may take several weeks to be distributed from the bowel hub to the prison site, during which time individuals may move sites. As each test has a unique code assigned to the individual, healthcare providers are not currently able to hold a stock of tests for more rapid and opportunistic use.

Figure 3: proportion of individuals identified as potentially eligible for screening by prison healthcare that left that prison before screening could be undertaken (quarter 3 2024 to 2025)^a



Source: NHS England Health and Justice

Movement between settings and healthcare providers can result in patients being ‘lost’ in screening pathways and lost to follow up. This may occur for many reasons including failures in continuity of care, patients not registering with a prison GP on entry to prison, or a community GP on release, or barriers preventing individuals leaving prison from engaging with healthcare services in the community.

The level of movement within the prison population also presents specific issues for data reporting. When individuals move between prison sites within the same quarter, they can appear in multiple screening activity reports as eligible and not offered, or offered but not screened, distorting figures. Current reporting and monitoring systems are not able to track population movements accurately, making it difficult to effectively oversee and assess screening activities at a local, regional and national level.

^a Individuals are identified as eligible by prison healthcare teams before screening teams confirm eligibility therefore proportions include a small number later not identified as eligible. The individual may have left prison to return to the community or were transferred to a different prison during the reporting quarter prior to being screened.

Prisons environments can present physical challenges to delivery of screening

Prisons may be located in rural countryside or city centre locations and take many forms including Victorian buildings, re-purposed military barracks and brand-new purpose-built sites. While the different prison categories deliver a range of prison regimes, a primary function for all prisons is safety and reform¹⁵. The physical restrictions and strict security measures create challenges for the delivery of national screening programmes. Successful delivery requires significant planning and co-ordination by the prison healthcare provider together with community screening providers and HM Prison and Probation Service (HMPPS). For example, gaining the necessary security clearance for specialist community staff to access the sites and for access to large specialist equipment.

Practice example: translating community programmes to prison environments

The newly established Targeted Lung Cancer Screening programme is being rolled out across community populations with a range of delivery models, which may not directly apply to prisons. For example, access into prisons for the large vehicles (mobile CT scanners) used in some areas may be prohibited due to the vehicle requirements and the prison location or layout, for example, those in city centres, with narrow entry gates, lacking physical space or appropriately re-enforced grounds. Where mobile CT scanners are not used, a significant number of eligible patients in prison would require escorting to community locations. As yet, there has not been any national modelling to consider the 'size' of the population in prison eligible for this programme: with 80% of the prison population having a history of smoking this is expected to be significant. National NHS England H&J are working collaboratively with the national lung check team to develop an information guide to support awareness of the detained estate. As a new national screening programme, there is a window of opportunity to also develop prison-specific national guidance, minimum standards and identify the required resource to facilitate roll-out of the programme in prison settings alongside the community. This would prevent a delay in access for the prison population.

Reporting and assurance

Prison healthcare systems are currently unable to link with the national screening programme data systems. As such, each component to prison screening pathways requires manual administration, including recording and reporting of screening. Prison screening data is currently manually reported by prison healthcare providers for each site to NHS England H&J national on a quarterly basis.

Practice example: challenges with data and assurance

In a 2023 review of screening programmes in North West prisons, community screening providers highlighted a significant number of individuals reported by prison healthcare providers as eligible for screening were either not due screening (for example aged 65 but had already completed AAA screening) or not eligible (for example reported as eligible for diabetic eye screening but not diabetic). On investigation these issues were found to be underpinned by incorrect use of clinical read codes, either applied at reception or used within search criteria of locally built reports.

When then comparing prison screening activity as recorded by prison healthcare providers against those recorded by community screening providers in the same period, the number reported by prison healthcare teams as eligible was significantly higher than community screening providers. The number of patients reported as screened was consistently lower in data reported by prison healthcare providers.

There is variation in the processes used by prison healthcare providers to identify eligible cohorts and record screening. Quality issues are therefore common in reported eligibility, offer and uptake data, with significant implications for assurance and subsequent service improvement.

Trend data is not possible due to movement within the estate and population coverage is not routinely reported. A more robust and sustainable method for national oversight and assurance is essential, however there is notably limited national resources within NHS England H&J for both Section 7A (framework for delegation of public health functions from the Secretary of State to NHS England) and data analysis to manage the current process, much less to develop a new model.

While the performance of national screening programmes in prisons is monitored through NHS England H&J commissioning structures, the involvement of community screening providers and enablement by HMPPS are beyond the control of prison healthcare providers or NHS England commissioners. Without formal joint governance structures and data-sharing processes, reporting and oversight at local, regional, and national levels are fragmented. Regional models that bring together partners across NHS England H&J commissioning and NHS England public health commissioning teams have been established in some areas to support joint commissioning oversight, escalation of issues and partnership working.

Challenges to specific steps in the screening pathway

Identification of the population eligible for screening

Currently, people in prison are not routinely identifiable in national screening programmes data systems. There is a reliance on manual processes by prison healthcare teams to identify those eligible for screening. The nationally procured prison primary care clinical record system is not able to link directly to national screening programme systems, or community screening provider

systems and does not generate invites as per community programmes. This is with the exception of the bowel screening programme, where those that agree to have their full electronic health record registered with the prison GP will be automatically invited in the same way as in the community.

Prison healthcare providers are required to manually identify eligible patients, by searching electronic clinical records, inviting them for screening and recording screening outcomes. This places additional pressures on healthcare providers and introduces the risk of human error. The resulting list is then shared via email with community screening providers who, where possible, will manually cross-reference with screening programme databases to confirm individuals' eligibility. Any changes to national screening programmes must be individually locally translated. For example, with the recent bowel screening programme age expansion, individual healthcare providers across the country were required to revise their templates for identifying eligible cohorts. This presents unnecessary duplication of administration. Nationally standardised templates to identify those eligible for screening would improve recording, reporting and reduce administrative burden.

Practice example: challenges identifying the eligible population

There have been attempts to improve this process for the bowel screening programme. This has however highlighted the complexities of system linkage, particularly in relation to patients who either remain registered with their community GP or who were not registered with a GP pre-custody. In August 2024, detained settings registrations were enabled on the NHS Spine, allowing prison populations to be invited as per the community and reducing reliance on manual processes between bowel screening hubs and prison healthcare providers. Unfortunately, this was unsuccessful: test kit requests for those not fully registered with the prison GP were refused, due to differences in patient details held on the bowel cancer screening system. The process was therefore reverted so as not to disadvantage any individuals.

Invitation and information

Resources to encourage engagement and support informed decision making are often unsuitable for the prison estate. In 2024 a national bowel screening leaflet, bespoke to the prison population, was produced. This, however, is the only nationally developed resource of its kind. Community resources associated with the national screening programmes, including campaign materials and patient information often, use language and imagery that is unsuitable for the prison estate. For example, images do not reflect prison surroundings or the patient cohort in prison, and direct people to weblinks, QR codes and telephone numbers which are inappropriate because mobile phones and internet access are not accessible for those in prison.

Lived experience: reflections on the importance of screening

Feedback from bowel screening engagement in North West prisons, undertaken by ABL Health, 2024, highlighted the need to tailor resources to the prison population, including recognition of the lower literacy levels, a sense of helplessness and fears of fatality among people in prison.

“If I’m going to get it, I’ll get it, so why worry about something that I have no control over, I’ll worry about it if I get it.” Individual in prison

“I just feel helpless as nothing is in my control. I have young children.” Individual in prison

“But the difficulty is if you can’t read. You come back to the same question” Individual in prison

Practice example: challenges identifying the eligible population

In the South West, prison-specific bowel screening resources were co-designed with people in prison and produced in a format that could be printed and given to individuals. Positive messages around prevention, early identification of symptoms and engagement with the bowel screening programme were included with a range of prison-appropriate infographics. Feedback from people in prison involved in the design suggested resources should be produced as ‘easy read’ by default to reduce stigma.

Screening

People in prison often have little choice or autonomy, living within a strict prison regime. At the simplest level, screening can be viewed as one of the few opportunities for an individual in prison to exercise their choice and say ‘no’.

People in prison have competing priorities which may reduce engagement in screening opportunities. People often have limited time out of their cell in which they can participate in activities that are fundamental for rehabilitation and maintaining wider health and wellbeing. For example, attending work, participating in family or legal visits, taking part in education, going to the gym, or seeking healthcare for more acute needs. Unlike community populations, people in prison do not have choice to schedule their healthcare appointment around other commitments.

Lived experience: the priority of screening

Feedback from bowel screening engagement in North West prisons, undertaken by ABL Health, 2024, identified that screening can be lower in priority than other things in prison.

“I’ve got too many other things to worry about in here. I just block it out of my mind” individual in prison

“Men’s concerns and priorities in here are court dates, forthcoming trials or how long their sentence will be. Cancer is right at the back of our minds.” individual in prison

“Well, in the community you’re at home, you’re doing it privately aren’t you. Not like in here.” individual in prison

Prison healthcare providers are reliant on HMPPS to facilitate delivery of screening. Usually people in prisons are required to be escorted by prison staff to the healthcare department for screening appointments (with the exception of open prisons – Category D). In the context of screening programmes this can include facilitating community providers to come into the estate, internal movement of patients for on-site clinics or escorting patients to external clinic appointments. HMPPS facilitation may be stood down at short notice due to prison pressures, for example staff shortages¹⁶ or acute incident response, meaning that healthcare appointments are cancelled or delayed. This happens often. In this scenario, even if the individual is willing to engage they will be recorded as a ‘did not attend’ (DNA) and may need to wait several months for the next screening opportunity. There is potential for repeated DNAs to result in removal from future invitation to screening, further contributing to the health inequalities experienced by this population. Healthcare staff need to also be sufficient to avoid cancellation.

Individuals within the prison estate have often experienced significant trauma which can also reduce their engagement with healthcare services. Sexual trauma for example, particularly among women in prison, is a significant barrier to engaging in intimate healthcare examinations such as those required for cervical and breast screening. There are also numerous examples where the national screening programmes cannot be delivered with the same level of privacy and dignity as available to community populations. For example, individuals may be required to undertake bowel screening in a shared-cell or attend breast or cervical screening escorted by prison staff for their examination, potentially while cuffed to a prison officer. This also applies to investigations that result from screening, such as endoscopy. These challenges to dignity and privacy do not provide equitable access or experience for people in prison, but are still viewed and recorded as ‘patient choice’.

Practice example: trauma informed approaches to screening

The healthcare provider at HMP Styal, a female prison in the North West, have adopted a trauma informed approach to cervical screening. The targeted approach provides dedicated support tailored to women with a history of trauma who are offered one-to-one sessions to see the screening equipment and discuss their concerns. Women are encouraged to write about their experience of screening in a peer-support model and have longer appointments and further opportunities to ask questions.

Since implementing the scheme, uptake increased to 91% in the 25 to 49 age cohort and 97% in the 50 to 64 age cohort, with positive patient feedback:

“I felt frightened and apprehensive when I received a letter inviting me for a smear test at HMP Styal. I ignored it and the letters that followed but after the nurse came to see me for a chat and showed me all the equipment, I felt more in control of the situation. I am very proud to say I had it done now and I even encourage other women to attend when they say they are scared.” individual in prison

As described in chapter 3, women’s health and wellbeing hubs are being implemented across all 12 women’s prisons. These will be trauma informed and trauma-responsive and provide information and awareness about screening services, as well as attending to a range of other women’s specific health needs.

Referral of screen positive and reporting of screen negative

Given the high churn in the prison population people may have left the prison by the time their screening result returns. A lack of linked data systems with the community can present difficulties in locating the individual to share their result and ensure they receive any further ongoing care or investigations that are required.

Diagnosis and intervention and/or treatment

The requirement for prison officer escorts to external appointments can impact both access to and experience of treatment. The experience of attending screening appointments handcuffed to prison officers can also be stigmatising and humiliating, for example, attending breast screening or cervical colposcopy escorted by prison staff for examination. Given HMPPS staffing pressures escort availability is limited, meaning appointments associated with screening may also be delayed or deprioritised.

Recommendations

There is considerable effort nationally, regionally and locally to improve access, experience and outcomes for people in prison eligible for the national screening programmes. The structural and systemic challenges described are substantial and mean that despite these efforts people in prison do not consistently receive equivalent access, experience, or outcomes from national

screening programmes in comparison to the community. Many of these recommendations requires dedicated resource that is not currently available within organisations. There is a need for a national resourced joint task force between the national screening programme leads, DHSC, NHS England H&J and HMPPS, to deliver these recommendations.

Functions of this group should include:

1. Prison-specific National Screening Programme guidance and standards should be developed to inform translation of National screening programmes to the prison estate with a focus on parity, consistency and equity in access. There is an immediate opportunity to undertake this work for the Targeted Lung Cancer Screening programme.

This should include:

- a clear description of organisational roles and responsibilities for the commissioning, delivery and assurance of national screening programmes in prisons at a local, national and regional level
- a review of eligibility cohorts and targets for national screening programmes in prisons (in the context of population movement, establishment categories and sentence length) and development of prison-specific quality indicators

This requires resource that is not currently available within organisations.

2. Development of nationally standardised prison-specific screening resources, including campaign resources, screening invite letters and patient information is required. These should reflect detained setting-appropriate language, be aimed at lower literacy levels and translated to ensure accessibility for foreign national populations. This requires dedicated resource that is not currently available within organisations.
3. A sustainable and nationally standardised model is required for the identification of people in prison eligible for the national screening programmes.

Where possible, automated linkage between NHS England national screening programme and prison healthcare systems should be established to reduce reliance on manual processes. Where this is not possible, nationally standardised templates should be developed to identify eligible cohorts within the prison healthcare system with associated guidance to support prison healthcare providers in using these templates.

4. A sustainable model, with a focus on improved data quality, is required for the recording and reporting of screening activity in prisons. As far as possible, prison reporting pathways should align to reporting processes for the national screening programmes in the community.

Clinical coding should be standardised through the use of national templates to record screening activity in prisons, supported by national guidance documents. Additional reporting fields should be considered to include population coverage and 'DNA' reasons.

5. There is an opportunity to improve governance, assurance and oversight.

National dashboards for prison screening delivery should be developed with the ability to isolate regional and site-level data to support monitoring of performance at a local, regional and national level. Population demographic data should be incorporated to support oversight of access and identification of health inequalities within the prison population.

Opportunities to align governance structures across NHS England H&J national and the national screening programmes should be explored, including reporting and monitoring of prison screening activity and ensuring that prisons are considered early in planning for future programme changes and innovations.

6. A significant proportion of the prison population will be transferred or released before an opportunity to be offered screening and engage in national screening programmes.

The joint task force should review and identify opportunities to strengthen continuity of the entire screening pathway on transfer between estates and release, for example, through NHS England RECONNECT and data sharing agreements.

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14 Health promotion and improvement

Authors: Professor Michelle Baybutt, Dr Alan Farrier, Rachel Campbell

Contributors: Amanda Hizzett, Shab Shivji, Dr Caroline Watson, Dr Linda Harris, Sarah Skett, Samantha Hughes, Dawn Stevens, Claire Hallam, Linda Stent

Introduction

People in prison and on probation are at risk of premature death compared to people in the general population¹. Cardiovascular disease, stroke and chronic conditions such as heart failure and chronic obstructive pulmonary disease are among the leading causes of death for people in prison in England and Wales². The average prevalence of chronic illnesses such as cardiovascular disease (CVD), diabetes mellitus, hypertension and cancer is greater than the general population^{3,4,5}. The majority of ill health from these causes is driven by risk factors such as obesity and smoking, which are more common in the prison population than the general population^{6,7,8}. This premature poor health is therefore preventable. The prison population is getting older and this burden will therefore increase over time.

People in prison should have access to the same health as the general population. However, prisons are generally considered unhealthy places, rather than being able to support and create health⁹. Accessing people in the places where they live their lives and make choices is a key public health approach¹⁰. Prisons are, therefore, a prime opportunity to address the disproportionate health and social circumstances of people in prison and offer a way of tackling inequalities in health and justice, through promoting health, facilitating community integration and reducing reoffending¹¹. While this is not the primary business of prisons, they do provide access to marginalised and disenfranchised groups who would otherwise be classified as 'difficult to reach' in the wider community particularly in terms of primary healthcare and substance use¹². Improving the health of people in prison not only improves the health of individuals and therefore reduces their need for healthcare, but most people in prison return to the community, with many oscillating repeatedly between prison and community¹³. Prison health is a concern for broader society and public health.

It is also a unique opportunity for all aspects of health promotion, health education and disease prevention, for example:

- developing specific, targeted interventions to address health inequalities
- opportunities to access and address health needs
- reducing the burden of disease and chronic illness (CVD, diabetes) through the prevention of ill-health while people are in prison, especially for long-term people in prison
- an opportunity to promote the health of staff

This chapter sets out the imperative to promote health in prisons to address the priority health needs, and prevention of ill health, of people in prison. The 'settings approach' is used as a framework to illustrate the benefit of working across and engaging with the 'whole prison'. This includes the importance of the environment in determining health outcomes, alongside access to good quality healthcare. The chapter concludes priority areas for health promotion, noting challenges and opportunities of implementation in the prison setting, supported with case study examples of good practice.

A framework for whole prison health promotion

Prisons have potential to make a major contribution to improving the health, wellbeing and life chances of some of the most marginalised and excluded individuals in society^{14 15}. However, there are some important challenges to achieving improvements in health in prisons.

Commissioned healthcare provides prison-based primary care services equivalent to those in the community and within this would be usual opportunities for health promotion, for example brief interventions and health education and awareness raising. This is not without challenges, for example, the volume of people in prison and movement within the prison system and competing priorities for individuals such as housing and employment.

Health promotion in prisons tends to follow a medical model, viewing health primarily as the absence of disease and focusing on individual lifestyle choices rather than wider determinants that influence and underpin health¹⁶. While there are examples of community initiatives such as health coaches being developed in some prisons, there is no outcome data relating to the benefits of such new health promotion approaches. The settings-based health promotion prioritises a 'whole prison' perspective underpinned by key health promotion values of equity and empowerment. It has been widely argued that the settings approach offers opportunities to realise the potential of prisons to embrace health promotion and meaningfully tackle health inequalities¹⁷.

A 'health promoting prison' is one where the whole regime is geared towards promoting the physical, mental and social health and wellbeing of people in prison and staff and should, as far as possible, replicate the environment and services of the community while in a secure setting.

Figure 1: key elements of promoting health in prisons

Source: adapted from Dooris, M. and Doherty, S.¹⁸ and Baric, L.¹⁹

A core principle of a 'whole prison' approach is the notion of decency in prisons and a recognition that health promotion is 'everybody's business', not just the responsibility of healthcare staff²⁰. Developing a whole prison approach to health and wellbeing supports equitable access to care for all²¹. Putting this framework into action could therefore comprise the following elements²²:

- implementation of prison policies that support the health of people in prison and staff (for example, healthier canteen options and menus)
- creating an environment in each prison that is supportive of health and the concept of decency – that is, ensuring that the prison regime supports prisoners' wellbeing
- delivery of disease prevention, health education and other health promotion initiatives that address the health needs in each prison (specifically and more broadly) using engagement methods appropriate for the environment (for example, brief interventions, peer mentoring and/or health coaches) to help them adopt healthier behaviours

Current evidence: the need for health improvement

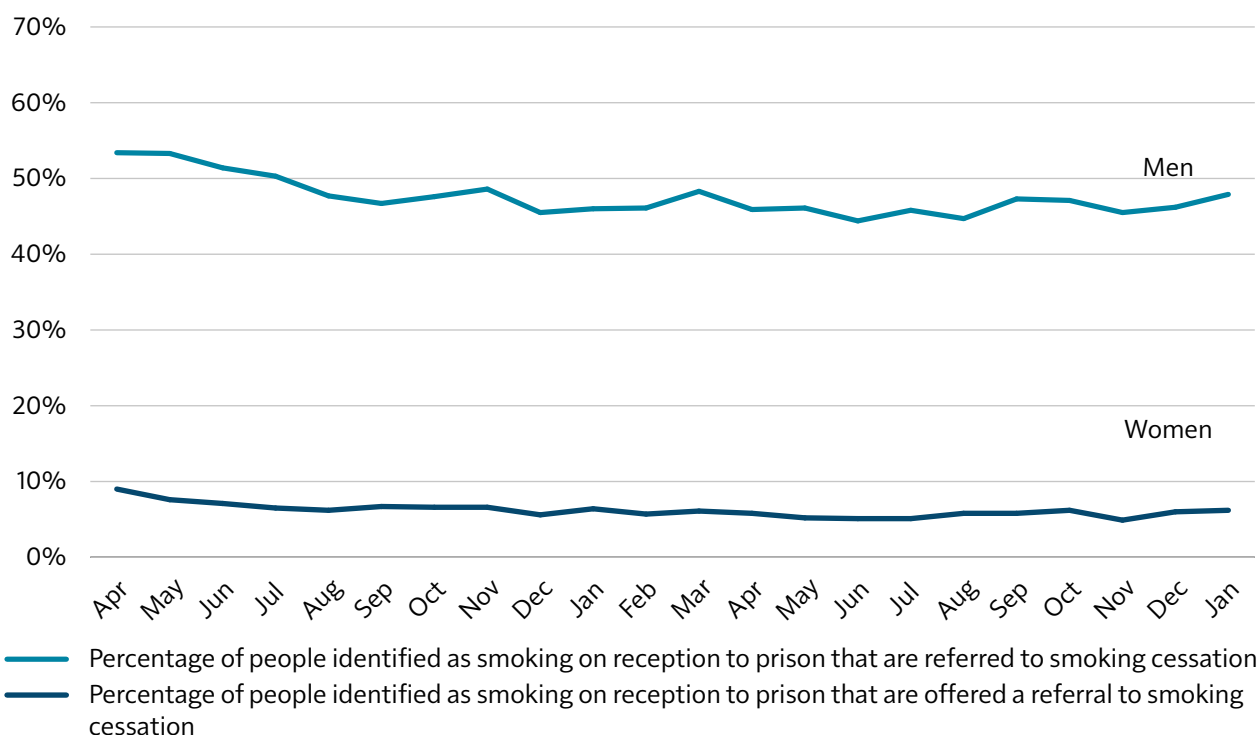
Smoking and vaping

People arriving into prison are 4 times more likely to be smokers in comparison to their peers in the community²³, at around 80% to 83%^{24 25 26}, compared to 15% in the general population. Since 2007, HM Prison and Probation Service (HMPPS) were working toward smoke-free prisons. Smoke-free prisons was phased across the adult 'open' estate for England and Wales

between November 2015 and September 2018 with all settings being smoke-free since September 2018²⁷. In 2015, a partial smoking ban inside all open prisons was introduced. This meant that all staff, people in prison, contractors and visitors were no longer able to smoke inside any open prison buildings, only designated outside areas. During 2016, HMPPS started to implement a smoke-free policy in Wales and commenced implementation at 4 early adopter sites in England. By May 2018, all closed prisons were smoke-free. Research from Scotland identified that the smoking ban in prisons resulted in a 9% reduction in prescribed medications for smoking related illnesses²⁸.

Healthcare teams continue to be commissioned to provide smoking cessation within prisons and all prison residents who smoke should be offered smoking cessation clinical support. A complete smoking cessation offer, equivalent with the community, should include primary care, pharmacy for nicotine replacement options (NRT) provision and psychosocial support. Data from NHS England shows that the proportion of smokers that are identified on arrival to prison that accept referral to smoking cessation services is low.

Figure 2: proportion of smokers at reception to prison who are offered referral to smoking cessation and accept referral in 2023 to 2024



Source: NHS England Health and Justice

Our engagement for this report identified that smoking cessation support is not available in all prisons. The programme is 8 weeks (compared to 12 weeks in the community) and is more readily available in remand prisons than training prisons. In open prisons (category D) smoking is permitted in designated areas, tobacco products may be available to purchase and people may choose to start smoking again. Some regions have chosen to stop offering smokers packs for sale. Patches can be purchased from the Prison Retail Service (canteen), but these are expensive compared to vapes and still require clinical support to reduce the dose.

The proportion of people in prison who use vapes is not reported, however, vaping has, for many, become the preferred option in prisons. Individuals can purchase e-cigarettes and/or vapes and vape liquid through the Prison Retail Service (canteen). Nicotine vapes are National Institute for Health and Care Excellence (NICE) recommended and can support cessation and enforced abstinence as a harm reduction tool. However, vaping is not risk-free.^{29 30} Although anecdotal, an unintended consequence has been the use of vapes as a currency in prison and therefore associated with debt and violence. There is currently no stop vaping support in prisons. Therefore, there is a need to support both those who vape and those who use both tobacco and e-cigarettes and/or vapes, tailoring support accordingly.

Practice example: smoking cessation services within West Midlands prisons

At the beginning of 2024, West Midlands NHS England Health and Justice and HMPPS undertook a joint review into the current provision of smoking cessation services within prisons and to gain views from residents. As well as questionnaires to the 12 heads of healthcare, a questionnaire for residents received 1,749 responses. This identified that:

- many people started vaping in prison with some not having vaped or smoked prior to prison
- there is a high demand for support to stop vaping
- there is a general lack of awareness of smoking cessation services available in prisons
- there are requests that vaping bans are adhered to and that people don't have to share cells with those who vape
- people felt vaping helps with boredom and to combat stress

A recent review of studies published from 2017 to March 2024 found that most prior smokers return to smoking after leaving a smoke-free prison, despite many people hoping or intending to remain smoke-free³¹. There are some regions with joint working between probation, RECONNECT and liaison and diversion and the prison estate to support those who are likely to start smoking on release, for example, through an advisory team in the departure lounge to book appointments and signpost to the service. This is not widely available and the support that is available to people on leaving prison varies between regions. There is a missed opportunity to improve the health of a priority group and to reduce health inequalities.

Substance use treatment and recovery

Substance use within prison populations presents significant and evolving challenges. In recent years, the range of substances and levels of sophistication in the availability and access to illicit drugs has rapidly increased. This creates additional risks to population health, impacting on drug related deaths and instances of intoxication and under the influence presentations³². Drug dependence often co-exists with other health disparities such as poor mental health and

homelessness. Some people experience multiple and complex needs, with drug addiction co-occurring with a range of health inequalities such as mental ill-health, homelessness and rough sleeping and contact with the criminal justice system. In England, over a quarter of a million people each year experience at least 2 out of 3 needs across homelessness, substance use disorder and involvement in the criminal justice system and at least 58,000 people have contact with all 3³³. Drugs and crime are closely linked and drug use does not spontaneously cease upon arrival to prison³⁴.

In prisons in England and Wales^{35 36}:

- 1 in 6 men (17%), and 1 in 7 women (15%) serving a sentence in prison are there for drug offences³⁷
- two-thirds of women (66%) and nearly 2 in 5 men in prison (38%) report committing offences to get money to buy drugs³⁸
- more than two-thirds of women (68%) and over half of men (55%) said they were under the influence of drugs when they offended³⁹. Seven in 10 people in prison with a self-identified alcohol problem (70%) said they had been drinking when they offended⁴⁰
- almost one-third of women entering prison report having a drug issue (30%) compared with just under a quarter of men (23%)⁴¹
- 1 in 7 women and men (14%) entering prison said they had a problem with alcohol⁴²
- in 2023, 3 in 5 people in prison serving less than 12 months (60%) had an identified substance misuse need, and 2 in 5 (39%) had an identified alcohol misuse need⁴³

The challenges of substance use in prisons have been extensively explored in the independent review by Dame Carol Black published in 2024⁴⁴. This described a wide range of harm reduction and treatment programmes with notable variations in the programme offer and limited access to data and information evaluating the impact of such recovery-oriented models⁴⁵. The purpose of this section is therefore to describe recent developments in whole prison health promoting approaches.

There are multiple opportunities to engage men and women in prisons with substance use specific health promotion interventions, from diversion from custody through release and resettlement. The building block of a preventative and health promoting approach for people who use substances is being trauma informed, recognising that individuals who experience dependency have often been exposed to trauma which can be a driving factor behind their vulnerability to addiction. In addition, a psychologically safe and supportive environment is proven to help address the root causes of addiction with built in sensitivities to diverse populations.

Therapeutic communities (TCs), Psychologically Informed Planned Environments (PIPES) and Incentivised Substance Free Living Units (ISFLs) are based around a whole prison approach. ISFLs are dedicated wings for people in prison who want to live in a drug-free environment, whether that be free from the consumption of drugs, the violence related to drugs or the culture of drug use⁴⁶. There are 45 ISFLs running in prisons across England and Wales⁴⁷ –

supporting people to come off illicit drugs and reducing their reliance on synthetic opiates that are used as part of a treatment regime, like methadone.

ISFLs offer a structured and supported regime with programmes and activities. Peer-led talking therapies, purposeful activities and building supportive relationships have been described as important in supporting recovery and effective in helping people in prison to understand the drivers of their drug use and how to address their mental health needs on ISFLs⁴⁸. Many health and prison staff believe that an ISFL should primarily be a settled environment where people in prison can access help to support their needs, and that a mix of people in prison, with and without histories of drug use, was beneficial in creating this environment. There is some research suggesting merit in parts of these settings, for example, the peer led components, purposeful activities and settled environment. However, there is significant variation in how prisons implement Drug Recovery Wings (DRWs) and ISFLs, and how they relate to NHS England commissioned drug and alcohol teams prison commissioned abstinence recovery programmes and dual diagnosis pathways⁴⁹. Formal evaluations of DRWs and ISFLs are currently in their final stages and due for completion later in 2025. Health promotion for substance use disorder recovery is by its very nature most effective when its collaborative across sectors and between providers including HMPPS working with health, education, lived experience and voluntary, community and social enterprises (VCSE)⁵⁰.

At the heart of successful and impactful health promotion for substance use disorder in prisons, is staff who are trauma informed⁵¹ and make every contact count (explored under opportunities) and committed to shift the narrative from a deficits-based conversation to one that recognises and builds on an individuals' inherent resilience and capabilities and their personal assets, where individuals are encouraged to take an active role in their recovery, fostering a sense of ownership and empowerment⁵². Evidence suggests that fundamental to this is peer support, providing education and promoting healthy behaviours which can reduce harm, improve engagement and sustain recovery⁵³.

Mental health improvement

Over half of surveyed men (54%) and just under two-thirds of women in prison (62%) say they have mental health problems⁵⁴. In surveyed prisons, more than half of patients had previously self-harmed (54%), 2 in 5 had attempted suicide (40%) and a similar proportion had a history of substance use disorder alongside poor mental health (39%). A recent review of interventions to improve health and wellbeing in Scottish prisons concluded that meditation and mindfulness were effective and horticultural and art and creative interventions were promising⁵⁵. The setting factors that influence mental health and opportunities for health promotion are explored in chapter 7.

Practice example: a whole system health and justice intervention – Greener on the Outside for Prisons (GOOP) illustrated with an example from HMP Preston

Greener on the Outside for Prisons (GOOP) is an asset-based health and justice intervention that focuses on nature-based activities and a broad programme of therapeutic horticulture⁵⁶. GOOP is currently established in 26 prisons in England for men, women and children. Using a 'settings-based' approach to health promotion, GOOP takes account of the complex interactions between personal, organisational and wider environmental factors that influence health. It is underpinned by principles of equity, participation, empowerment, sustainability and working in partnership⁵⁷.

For example, prison security assesses people to work in prison gardens and usually prohibits people with specific profiles (for example, severe and enduring mental health issues). However, from a health promotion perspective, these are the very people who will benefit the most from being connected with the natural environment⁵⁸. In comparison, people can be referred to GOOP by both prison and healthcare staff, meaning it is available to people who may not otherwise have been able to benefit. The referral pathway is monitored by all who are invested in achieving change at the individual and organisational levels (whole prison engagement).

GOOP has been evaluated since 2008. Data demonstrates a positive impact on mental health and wellbeing. For example, 88.2% of participants feeling more confident to manage their everyday lives, 94.8% experienced increased opportunities for social interaction and 86.1% of participants reported new skills or knowledge gained⁵⁹. In HMP Preston participants have noted the supportive and inclusive space developed by staff:

"[the staff] got respect for us on here, they talk to me and have time for my mental health issues and everything" Male in prison

Participants and staff have made clear links between participation and positive behaviour change relating to self-harm:

"I'd be lost without this to be honest. I don't know where I'd be or what I'd be doing. I wouldn't be in a good place I don't think, probably trying to escape or kill myself. I'd have gone off the rails [...] Having this [...] has just saved me, it's just changed my whole prison experience." Male in prison

Behavioural change of participants with a history of violent and/or disorderly behaviour participating in GOOP is observed:

"It can help a person that's aggressive [...] to come over here, because it's a relaxing job and I've seen people that's come over here and that's been a bit aggressive on the wings that end up loving the job. So it does help. It helps people that can be violent." Male in prison

Physical activity

An independent review of sport in justice in 2018 identified that 8% of boys in young offender institutes went to the gym more than 5 times a week, with a third of children and young people spending up to 22 hours a day in their cell due to the need to restrict movements to prevent conflict with others⁶⁰. In 2018, monthly gym participation averages 56% for men and 29% for women⁶¹ compared to 67% of adults meeting the recommended moderate intensity for at least 150 minutes per week in the general community⁶². This is important because increasing exercise is associated with improved physical and mental health.

Research evidence has identified mostly positive impacts of increased structured physical activity interventions, including yoga on factors such as physical fitness, blood pressure and cholesterol^{63 64} and mental health outcomes⁶⁵. When combined with education this can also have positive impacts⁶⁶. Park runs in prisons are now popular, mirroring community engagement for physical health and social wellbeing and with positive impacts on mental and physical health, connection and stability described.^{67 68} Royal College of General Practice provide resources for cell-based workouts⁶⁹.

Healthier eating and weight management

People in prison are at greater risk of being overweight and obese⁷⁰, a risk factor for CVD and many cancers. The exact prevalence of obesity in English prisons is not reported. A study in 1 male prison in Wales found that 81% were overweight or obese⁷¹. People may arrive in prison overweight and also gain weight in prison as a result consuming excess calories and highly processed foods⁷². This is combined with generally having low levels of physical activity, explored below. Reducing obesity can reduce rates of CVD, which are high in the prison population. The World Health Organization (WHO) cites⁷³ unhealthy diet as a modifiable factor. As well as helping individuals, preventing non communicable diseases will reduce the burden on healthcare and prison operations in due course.

Research has explored nutritional interventions aimed at improving the availability of a balanced diet and nutritional education through a variety of formats with some positive impacts on dietary choices, body mass index and clinical measures such high blood pressure^{74 75 76}. Education programmes and nurse or pharmacy led services for people with diabetes can improve weight and diabetic control⁷⁷. Examples of innovation in prisons that focus on supporting prisons to deliver practical food-based education and promote healthy eating are emerging including the work of Food Behind Bars⁷⁸ and Food Matters⁷⁹. HMPPS also has policy in place to support national standards for meals, and a newly formed National Food, Physical Activity and Wellbeing team who are working on nutrition and food education, for example, each menu has a symbol identifying healthy eating options that can be chosen. In the minority of prisons where people in prison are able to access laptops in their cells, there is work underway to enable access to nutrition education. High levels of poor literacy and comprehension in the prisoner population may hinder reaching those most in need. There are also limitations on access to dietician support and nutrition guidance within the team for the people in prison. There is also an opportunity to have a more informed discussion around the canteen provision and more active engagement and championing from catering managers.

While there is evidence for individual interventions, a system-wide response to improving healthier food options and aiding better support for weight management is required.

Practice example: healthy eating initiatives in Thames Valley and London

Historically, food choices from servery and canteen were unhealthy and often ultra-processed, high in salt, saturated fat and sugar⁸⁰.

In October 2022, a dietetic service for the Thames Valley Prisons was commissioned. By working with the patient, multidisciplinary team (MDT) and catering, nutritional care plans are created to support patients in meeting specific requirements for their clinical conditions, for example, patients with diabetes at high risk of hypoglycaemia. Supporting these individuals on site facilitates engagement and reduces additional external appointments and prison escorts. By working with prison kitchens, the Regional Dietician supports development of healthier meal options and menu coding to enable these changes. Thames Valley prison menus have been shared by HMPPS as good practice nationally.

One of the healthcare providers in London has employed a regional dietitian who has implemented several initiatives including the following:

- co-chairing a nutritional working group with a prison governor, head chef and head of education to work towards introducing nutrition education into mainstream lessons and the induction booklet, starting cookery classes, commencing a 'cell to 5K' exercise project and improving the menus so that meals are healthier and more balanced
- working with a prison food charity (Food Behind Bars) trained chefs and catering teams to analyse menus and develop nutrition training packages
- expansion of the traffic light system for colour coding the health status of meals on offer and inclusion of one designated 'healthy heart' meal at each mealtime using British Dietetic Association criteria
- running regular dietetic-led group education sessions about conditions related to cardiovascular disease (obesity, type 2 diabetes and high blood pressure) and how a more healthy diet can reduce the risk

Secondary prevention

This chapter has so far described primary prevention opportunities to reduce risk factors and prevent disease. Secondary prevention requires early detection of disease and treatment of risk factors to slow disease progression.

The NHS Health Check is a national programme designed to identify early signs of stroke, heart disease, type 2 diabetes, renal disease or dementia. In the community, it is offered to people aged 45 to 74 years, whereas in prison it can be offered for people aged 35 to 74 years. There is an absence of robust available data to describe the proportion of people that are eligible for an

NHS Health Check in prison that are offered one and therefore evidence for how to improve implementation. In one study of 6 prisons in England, more than 3 out of 4 eligible males took up the opportunity for NHS health checks when offered (compared to 37% in England)⁸¹. Of these, 12.1% had new significant CVD morbidity, including type 2 diabetes and hypertension. The CVD risk was identified to be similar to the general population, but the prison population screened were 10 years younger, suggesting they had more advanced risk for their age⁸². A recent Care Quality Commission (CQC) Inspection (2023) included notable good practice at HMP Huntercombe through using a 'Health Hub' to screen for CVD risk. For example, men are screened for high blood pressure and when identified are referred onto appropriate care pathways. These men would not ordinarily have attended healthcare as many had no symptoms, but their risk of early death from CVD is now more likely to be averted following appropriate onward referrals.

Dental health, oral health promotion and disease prevention

People in prison often have significantly poorer oral health than the general population due to pre-existing neglect, substance use disorder and limited access to preventive care before imprisonment⁸³. Poor oral health can lead to severe pain, infections and systemic health issues, which, if left untreated, may contribute to increased healthcare costs and a higher burden on prison medical services⁸⁴. Additionally, inadequate dental provision can negatively impact people in prison's mental well-being, nutrition and rehabilitation efforts, exacerbating existing health inequalities⁸⁵. While there is limited evidence in prisons, it is plausible that women in prison may have higher levels of untreated dental disease and more complex oral health needs than their male counterparts due to a history of trauma, domestic abuse, and substance misuse, which can contribute to poor dental hygiene and increased dental anxiety. Women are also more likely to suffer from eating disorders, which can have significant oral health implications, including enamel erosion and severe tooth decay⁸⁶. Additionally, pregnant women in prison require specialised dental care, as hormonal changes during pregnancy increase the risk of gum disease.

Current dental services in prison

In the UK, prison dental services are commissioned by NHS England. Unlike NHS general dental services, which operate under the Unit of Dental Activity (UDA) model, prison dental care is commissioned on a sessional basis, reflecting the unique challenges of providing care in a secure environment. All prisoners and individuals in young offender institutions are entitled to NHS dental treatment, including when on day release. They are exempt from NHS dental charges.

Delivering dental services within prisons—essentially “somebody else’s house”—presents major difficulties, as clinical priorities must navigate the constraints of security policies, staff shortages, and operational prison regimes. One major issue is “no access” visits, where patients are simply not brought to their dental appointments due to staffing issues or security concerns, leading to missed treatments and longer waiting lists.

Despite clear evidence linking oral health to wider systemic health issues, including CVD, diabetes and oral cancer, dental care is often deprioritised compared to general healthcare within prisons⁸⁷. Dentists play a crucial role in identifying signs of poor nutrition, eating disorders, self-harm, substance abuse and early indicators of oral cancer, yet these insights are rarely integrated into wider prison healthcare planning due to the lack of collaboration between dental and health teams⁸⁸. As with health in prison, frequent transfers, often mid-treatment, means that only urgent care can be provided due to the potential short period of time before transfer or release. This disrupts continuity of care and makes it difficult to complete even routine procedures like fillings, extractions, and regular oral cancer screenings.

The prison dental service operates largely in isolation from the wider primary care dental system, meaning that released individuals face barriers when trying to access community dental care, often having to start treatment plans from scratch. Addressing these issues requires a more integrated and collaborative approach between national dental teams and detained settings commissioners of dental services, including ensuring contracting methodology meets the demands of a secure environment rather than adapting current contracting methods to fit. The ability to transfer dental records electronically, similar to electronic patient health records, would assist with the monitoring of contracts to develop better outcomes for patients through improved oral health prevention programme monitoring and ensuring the clinical setting is fit for purpose.

The current access issues in the community setting to NHS dental care often prove a barrier for continuation of care from release from the secure setting. By ensuring dental services are better embedded within overall prison healthcare strategies and improving continuity of care both inside and outside the secure estate, better patient outcomes can be achieved and better value for the taxpayer attained. This will also foster an integrated care approach.

As with health, the current clinical medical system does not support the collection of detailed dental records, often relying on dental providers making manual data returns which presents a significant challenge in prison dental care, leaving no national overview of the current oral health of the detained population. Unlike general medical records, which are increasingly integrated through shared digital systems, prison dental records are often maintained separately and are not universally linked to NHS dental practices outside the secure estate⁸⁹. This lack of integration results in poor continuity of care, as released individuals frequently struggle to provide their dental history when seeking treatment, leading to duplicated assessments, treatment delays and deteriorating oral health outcomes. Additionally, the absence of comprehensive data collection on prison dental services hinders efforts to assess service effectiveness, identify gaps in provision, and develop improvements. Addressing these challenges requires improved integration between prison healthcare systems and NHS dental services in the community to ensure released individuals can access timely and appropriate dental care without unnecessary barriers.

Perceptions of the service

The perception of dental services among prisoners in the UK is often negative, with many detainees viewing access to treatment as inadequate, slow, and inconsistent, sometimes

leading to patients conducting their own dental work⁹⁰. Long waiting times, sometimes extending for months, lead to frustration, with some prisoners believing they must exaggerate symptoms to receive urgent care. Additionally, there is a culture of mistrust toward prison healthcare services, as many prisoners feel their pain and dental needs are dismissed or deprioritised in comparison to general medical concerns. We should acknowledge that NHS dental services across England are under strain, not just in prisons.

Anxiety about seeing a dentist is also common and is exacerbated by the prison environment, where security constraints, unfamiliarity and a lack of compassionate communication can heighten fear⁹¹. Confidence in the system is further damaged by frequent appointment cancellations due to staff shortages or operational issues. Furthermore, the lack of integration between dental and general prison healthcare services makes it difficult for prisoners to understand the wider health benefits of oral care, reinforcing the perception that dental treatment is a low priority within the system.

Challenges and opportunities for health improvement in prison settings

Although healthcare in prison should be equitable with the wider community, the acute setting of a prison may not provide adequate opportunity for health promotion. People often enter prison with multiple and complex health needs and if they are in prison for a short time there are often challenges in meeting these complex needs that can sometimes reduce opportunities for wider health promotion work such as promoting healthy weight and smoking cessation. Prisons are generally considered unhealthy places, rather than being able to support and create health⁹². Yet working to prevent premature ill health, by tackling its drivers, benefits the individual as well as reduces operational and healthcare challenges.

At an organisation-level, promoting good health in prisons requires investment in the systems and structures (policies and procedures) of the setting to embed joined up working. Intervening at an individual level in prison settings offers opportunities to address a number of key and often interlinked health issues and topics and reduce health inequalities, improve outcomes and decrease the burden of disease and disability. However, these opportunities are not without challenges.

Challenges to promoting health in prison

The prison environment presents specific challenges when it comes to promoting health⁹³. Some of these factors are explored further below.

Environment

The prison environment and regime are determined by governors and HMPPS, not healthcare. The typical prison environment makes it difficult for people in prison to carry out health-promoting behaviours, like smoking cessation, healthy eating or physical activity in fresh air. Being confined to their cells for large periods of time exacerbates boredom and limits

opportunities for people in prison to engage with activities such as using the gym. The fabric of many prisons is poor – prisons were not designed to deliver modern healthcare – are often overcrowded, can reinforce trauma and are challenging for those with neurodiverse needs. Healthcare services are often delivered in physical environments that would not be considered acceptable in the community with little to no ability to drive improvements⁹⁴.

Health services, including health promotion activities, compete with other elements of the regime and patients often must choose what they are going to attend (health appointments, work, education or visits). People in prison are paid for each work and education session they complete⁹⁵, but are not routinely paid for engaging in health activities. Some of the non-health elements promote healthy living and habits, for example, gym courses or learning new life skills or cooking; often, these activities are not promoted or seen as health promoting activities, rather education or work.

The limits on time in the core prison day reduces when clinics and health promotion engagement can be held. This drives services (health and non-health) to compete for engagement and results in clinical session time being underused.

Prison cultures of violence and bullying affect the personal safety and mental health of both people in prison and staff. The importance of a stable, safe environment and providing activities tailored to the needs of the population was highlighted by interviewees in recent research on ISFLs⁹⁶.

Health literacy of people in prison

Health literacy refers to the ability of individuals to gain access to, understand and use information in ways which promote and maintain good health⁹⁷. Health literacy is established as a modifiable determinant of health⁹⁸, thus arguably a way to impact on and reduce health inequalities. People in prison often have difficulty accessing health information as they cannot access phones and the internet. When they do, they may have challenges in understanding or applying it. Data from Ministry of Justice states that over 70% of adult people in prison are assessed on entry to prison as having Maths and English at or below GCSE level. Where known, over half (55%) of people in prison who took an initial assessment and then enrolled on a course had a learning difficulty or disability (LDD)⁹⁹. Health information is generally in written form for people who are not in prison with examples for health improvement (activities) that may not be relevant, sufficient, helpful or accessible for people in prison (such as go for a walk, cycle or have a swim). Improving health literacy of people in prisons can help them to make informed decisions including about behaviour and lifestyle changes. Initial contact with education can for some develop self-esteem and self-worth in order to be able to prioritise health promotion.

Lived experience panel: barriers to promoting health in prisons, NHS England Health and Justice Lived Experience Network

For this report, we undertook a workshop with people with lived experience of prison to explore health promotion. The following barriers to promoting health in prison were identified:

- lack of choice to improve health. The benefit of programmes that educate or provide skills is limited when the environment doesn't allow choice to practice this. Food provided is based on volume and is carbohydrate heavy
- lack of knowledge and education to identify health needs. There is sporadic offer of workshops– you might learn a skill but if you can't exercise those skills and information within the regime then you won't retain it. These options may only be open to only some groups
- variable levels of service, for example, a GP might refer to smoking support, but this might not be available consistently in every prison. Governors may not be aware of opportunities and good practice that can be achieved in other estates
- lack of a joined-up approach; prisons as large organisations with complex systems. Siloed working mean beliefs and practice persist

Recruitment, retention and training of staff

Frequently staff (both health and operational staff) may not feel equipped to promote good health in prisons, which requires an understanding of when and how to engage people in prison with their health needs, and where and how to refer. This is compounded by high turnover of staff and multiple competing pressures making training of staff a challenge. This is explored further in chapter 16.

Prison population

There are also factors relating to the population in prison that make it more challenging to promote health through brief interventions that are often used in the community. For example, earlier life experiences, including high levels of adverse childhood experiences, may influence trust and willingness to engage with services. Some people move rapidly through the prison estate or oscillate between the estate and the community reducing opportunity for engagement with good health promotion. This means it is imperative to embed joint working agencies into the structures and processes of the setting to ensure that promoting good prison health is business as usual.

Opportunities for health promotion and improvement in prison

Prisons offer a public health and health promotion opportunity to intervene with a population who are known to have high levels of complex health and social care needs. For some people,

prison can be the first time they have had the opportunity to access healthcare and focus on improving their health and wellbeing. Preventing ill health not only benefits the individual, but reduces operational and healthcare burden in prison, and on release, in the community. Several opportunities to support healthy eating, physical activity, smoking cessation, substance use disorder and mental health have been explored in this chapter. A lived experience group held for this report reflected on the common ways of achieving health promotion.

Lived experience: ways of achieving effective health promotion in prison settings, NHS England Health and Justice Lived Experience Network

The members of the lived experience group identified the following opportunities to promote health of people in prisons:

- increasing trust by enabling lived experience members to be vetted to work within prisons
- reducing the power imbalance between professionals and current and ex-prisoners
- creating a safe space and culture where people feel heard
- offering consistency in a fair approach from all staff – healthcare and operational
- encouraging co-production by consulting with people in prison over health-promoting events
- understanding the effects of post-traumatic stress disorder (PTSD) and how its prevalence can be a barrier to many people in prison
- following through with what is proposed in initial meetings (requires top-down and bottom-up buy-in)

Whole system health improvement

Embedding a whole system approach to care¹⁰⁰ is key to successful resettlement. One way for prisons to work in a more joined up way is to use the non-medical opportunities of socially prescribed activities. Social prescribing is a key component of Universal Personalised Care that connects people to activities, groups and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing¹⁰¹. Social prescribing is a means of enabling health professionals to refer people to a range of local, non-clinical services – for example, arts activities, gardening, cookery, healthy eating advice, sports, volunteering – to support their health and wellbeing¹⁰². HMPPS have responsibility for wellbeing and key workers could be well placed to identify and link people into social prescribing opportunities. There is also interest in training people in prison as health coaches to deliver health knowledge and reduce the people in prison's high risk health behaviours, while also building capacity in the system and having positive impacts on resettlement through nationally recognised

qualifications. There is evidence of benefit for management of chronic conditions¹⁰³, but limited evidence in prisons.

Practice example: social prescribing in Kent prisons with Change, Grow, Live (CGL)

Socially prescribed activities have been robustly implemented across the Kent prisons since April 2024 via Change, Grow, Live (CGL, a recovery services provider). This in part was enabled largely due to adequate resources and immediate buy in from heads of healthcare, security departments and drug strategy governors. The aim was to implement a different intervention bimonthly. These include vision boards, breathwork, yoga, rhymes and reasoning and virtual reality (VR) headsets.

Feedback has been incredibly positive, with the cohort commenting on the combination of new innovations compared with classic group facilitation. Evaluation has identified positive changes including reduction in stress and anxiety and improved sleep. Some of the learning the team have identified, is the need to vary the offer by different categories, for example, people with a long sentence or who were unsure of the immediate future may find it hard to have ongoing engagement with vision boards. Clients now run their own breathwork groups and yoga interventions and are able to apply what they have learnt when spending time in their cell.

Promoting the health and wellbeing of staff

For staff to be able to support a whole system health improvement approach it is vital that their own health and wellbeing is systematically considered and supported. This is explored in chapter 16 on workforce.

Training staff

Being confident and capable in instigating and leading health prevention and promotion conversations making every contact count (MECC) fosters an environment and team mentality whereby health promotion becomes everybody's business. This is vital to underpin the comprehensive programmes targeting individual risks such as substance use harm minimisation, cardiovascular health or nutrition. Therefore, it should be available for all staff working in prisons. NHS England has created e-learning modules to support systems to implement Core20PLUS5 and comprehensive MECC interactive learning resources¹⁰⁴. Dedicated training in trauma informed practices is also key so staff understand the impact of trauma and can encourage people to engage in non-medical models of wellbeing such as the 5 ways to wellbeing which are also fundamental to all models of health prevention and promotion.

Summary

There are a significant amount of health promotion interventions and activities across the prison estate, however they remain poorly prioritised, poorly understood and evaluation is largely absent. There is a need to reduce silo-based working to bring together existing strategies and activities (for example drug recovery with health and wellbeing) to maximise joint outcome opportunities. A holistic, whole prison approach will be integral to the success of interventions and for effective outcomes.

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15 Health needs on release from prison

Authors: Liz Taylor-Diparno, Dr Caroline Watson, Danny Duffield, Dr Nicola Vousden

Contributors: Dr Lucy Wainwright, Donna Gipson, Dr Nicola Lang

Introduction

People in contact with the criminal justice system are a transient community. Movement can be between a wide variety of different settings, including into and between prisons but also hospitals, secure NHS estates, short-term detainment in police custody or court, mother and baby units, approved premises or temporary accommodation. One individual can experience multiple moves, including between different geographical regions. For example, while there are nearly 88,000 individuals at any one time in prison in England and Wales, in 2024 there were:

- 73,717 new receptions (new arrivals) to prison¹
- 91,771 transfers of individuals between prisons (10% increase since 2023)
- 1,741 admissions to secure hospitals of restricted patients ('offender' that is subject to a restriction order due to the risk of serious harm they post to others), 63% of which were transferred from prison to hospital

Each of these moves can interrupt healthcare and may impact health. Part of the reason for this interruption is challenges in sharing of health data between settings as described in chapter 17. This movement also has significant impacts on the workforce as described in chapter 16. The focus of this chapter is the health needs of people on release from prison. However, arrival into prison and between prisons and secure estates are also important.

For all people, arriving in prison can be a time of acute distress, they may be unable to accurately share detail of their health conditions (described in chapter 10 on complex care). Chapter 2 on pregnant and postnatal women and chapter 5 on older people describe how this is particularly important when people have unique health needs.

One particular concern that arose when people are transferred between prisons to different areas was that people in prison may lose their position on hospital waiting lists. This was a common perception by prison healthcare staff. Appointment booking teams at NHS trusts state there is a system of transferring patients around the country, which is based on the initial date of referral, ensuring they receive a locally appropriate position on the list when transferred, yet prison healthcare providers say this is not implemented for people in prison. Challenges can also still arise if there are delays in hospitals finding out that patients have moved to a different prison. When this results in an appointment being missed, this can result in delays in care or the patient being discharged from care².

Health needs on release from prison

In 2024, 57,277 people were released from custody³. This chapter can be read together with the chapter on people on probation (chapter 14), there is overlap in the themes, but some distinct needs and services. Crucially a prison stay, whether short or long, can disrupt relationships, education and employment while exposing individuals to trauma, stigma and institutionalisation. These can all negatively affect short- and long-term health and wellbeing, making it harder to thrive after release.

In 2025, the lived experience consultancy Empowering People: Inspiring Change (EP:IC) consulted 964 people in 17 prisons in England about their key priorities on leaving prison⁴. Their responses, as reported in the survey, are shown below in order of priority:

- finding safe and stable accommodation
- sourcing stable employment
- reconnecting with family and children
- staying away from crime and drugs and not returning to prison

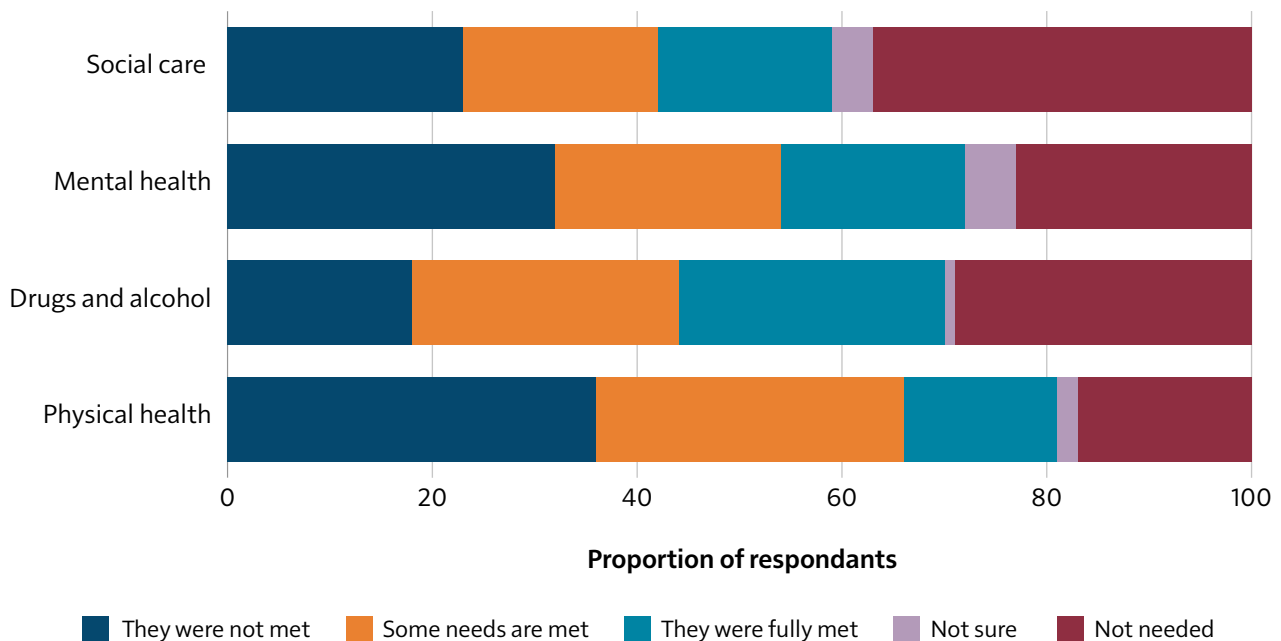
Addressing health care needs after release was also identified as a priority to people in prison but prioritised after the above. People on leaving prison access the same NHS healthcare services as the rest of the general population.

Physical and mental health needs

Research data from high income countries suggests that overall, people released from prison are 7 times more likely to die by suicide than the general population, with women at greater risk than men (standardised mortality ratio 14.9 compared to 4.6)⁵. Risk of suicide among people released from prison is greater in those aged over 25 years, those released from a local prison, with a history of problematic alcohol use or self-harm, a psychiatric diagnosis and/or requiring Community Mental Health Services (CMHS) follow-up after release from prison⁶.

A survey by Core20Plus5 aiming to engage people who had left prison recently on their views around health identified that of 135 people that answered: 79% reported a physical health need, 17% of which was fully met one month after release and 80% reported a mental health need, 18% of which was fully met one month after release as shown in figure 17. No one over the age of 50 years believed their physical health needs were fully met in the first month post-release. In comparison, people that left prison and stayed in approved premises as part of their licence conditions, which provides more intensive support, were more likely to report their healthcare needs were fully or partially met⁸.

Figure 1: survey undertaken by Core20Plus5 on how well their healthcare needs were met in the first month after leaving prison



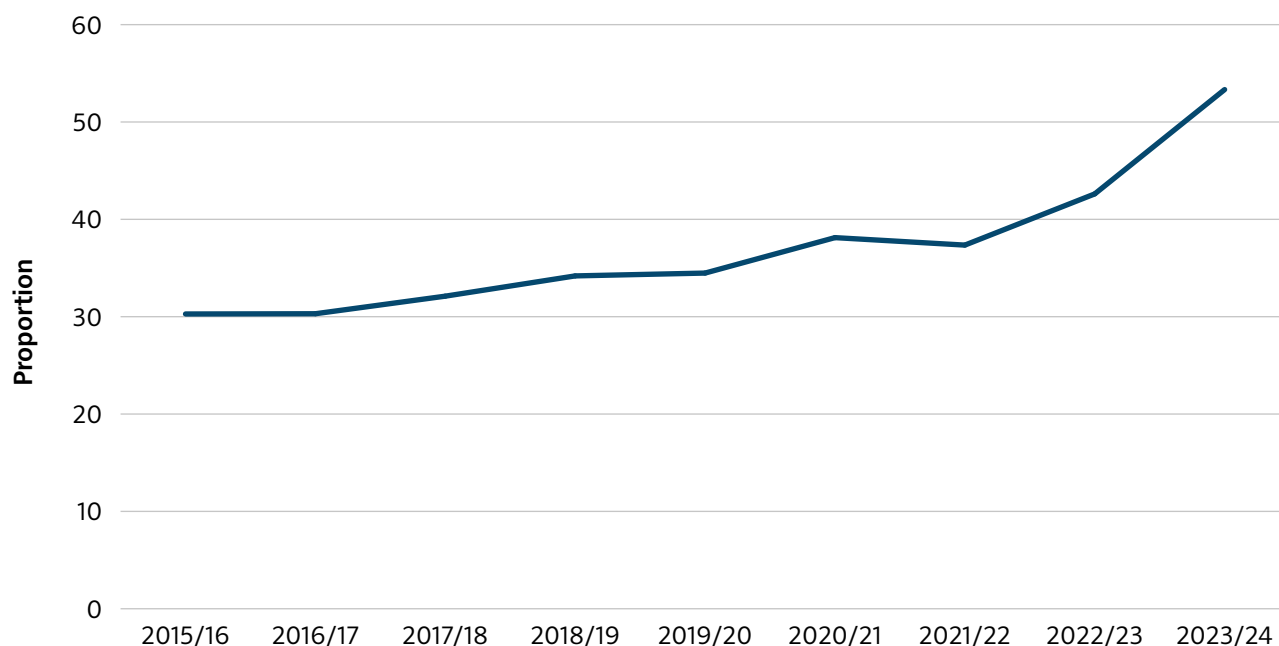
Source: reproduced with permission from a report by Core20Plus5 and Empowering People: Inspiring Chance (EP:IC)⁹

Drug and alcohol treatment

Approximately a third of adults leaving drug and alcohol treatment in secure settings were transferred for further treatment in the community (31%)¹⁰. Just over half of adults (56% in April 2025) with a substance misuse treatment referral were successfully started on community treatment within 3 weeks of release, up from 31% in April 2021, as shown in figure 2¹¹. However, rates vary across England, from the highest (66%) in the North West to the lowest (41%) in London¹². Continuity of care remains vital, especially as starting treatment with a new service during the heightened time of release is challenging.

The time of leaving prison can be an acutely vulnerable time for mental health and substance misuse, which often co-exist. An investigation by the Prisons and Probation Ombudsman identified that of 137 deaths occurring within 14 days of release from prison to the community between September 2021 and December 2023, just over 50% were in the first 4 days after release, and of these, 72% were drug related¹³.

Figure 2: proportion of adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison from 2015 to 2016 to 2023 to 2024

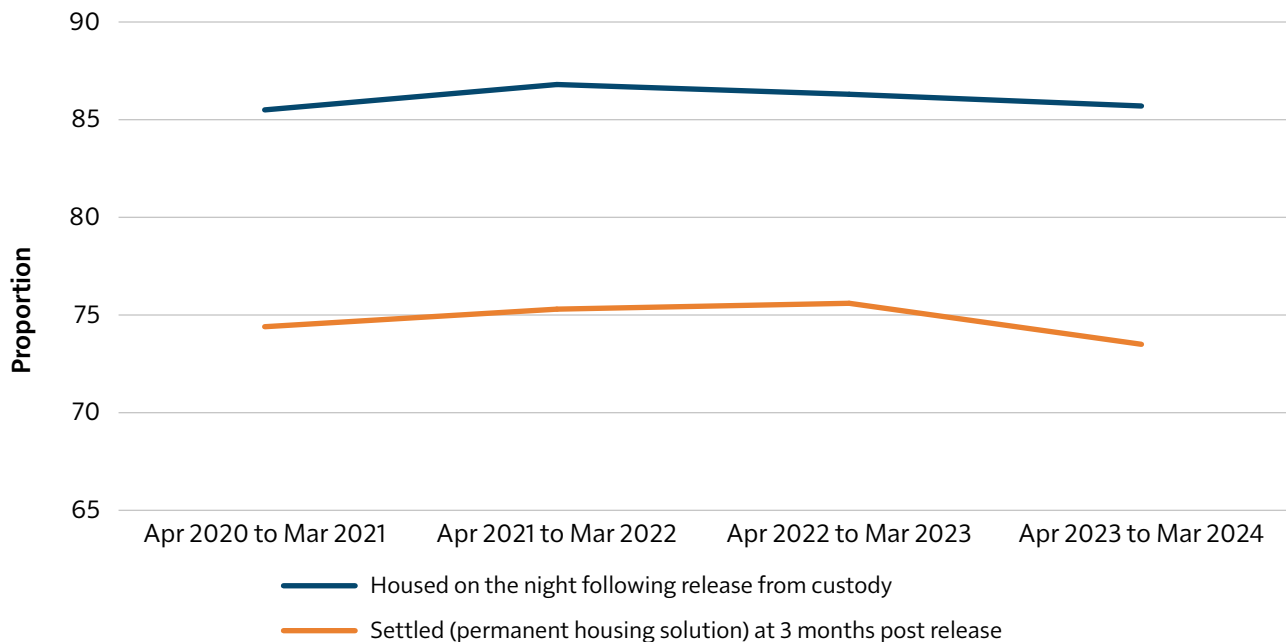


Source: Public Health Outcomes Framework, Fingertips¹⁴

Accommodation

In the year up to March 2024, 85.7% of people released from custody were housed, meaning in any type of settled or temporary accommodation, on the night they were released from custody¹⁵. This means that on average 13.2% were released without any accommodation, a proportion that has been similar for the last 5 years (figure 3). This varies between regions and prisons. Just under 3 in 4 were in settled accommodation that provided a permanent housing solution at 3 months after release from custody, the lowest since the start of the time series in 2020 to 2021 (figure 3)¹⁶. The proportion of people that were housed on the night they were released from custody decreased to 84% in the year to March 2025. This is not included in the figure due to a break in the data series¹⁷.

Figure 3: percentage of people leaving prison that were housed on the night of release and were in permanent housing at 3 months post release, by performance year 2020 to 2024, England and Wales



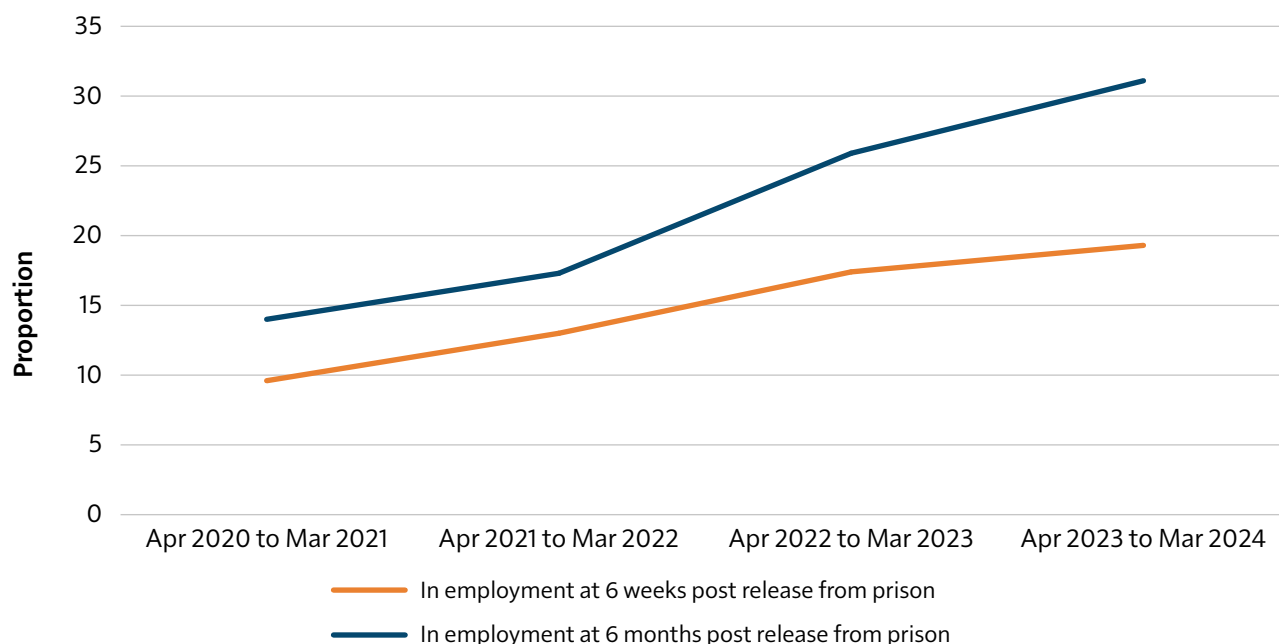
Source: Ministry of Justice, Offender accommodation outcomes

This is important because homelessness is a key driver of mental and physical ill-health¹⁸ as well as reoffending. In England and Wales, 69.1% of people who were homeless or rough sleeping on release from custody reoffended, almost double the proportion for those released with some kind of accommodation (35.1%)¹⁹. During focus groups on a prison visit for this report we spoke with a 29-year-old man who had been released homeless following a short period of remand in a local prison 7 times. Each time he described a choice between rough sleeping or staying with friends involved in criminal activity, which would inevitably lead to his re-arrest and use of substances to block out distress. This is in keeping with previous published reports²⁰. In 2023 to 2024, more than 1 in 4 women were released homeless from HMP Peterborough. This presents additional safeguarding concerns because women will often seek 'safer' accommodation with a man than being street homeless, making them vulnerable to physical and sexual violence²¹.

Employment

In the year to March 2024, less than 1 in 5 of people supervised by the probation service whose employment status was known, were in employment 6 weeks after release from custody, increasing to roughly 1 in 3 at 6 months after release from custody. Both of these have improved significantly since 2020 as shown in figure 4²². In the year to March 2025, this increased to around 1 in 5 people whose employment status were known in employment but this is not included in the figure due to changes in the data series²³.

Figure 4: percentage of people in employment at 6 weeks and 6 months post release from custody, by performance year 2020 to 2024, England and Wales



This is important because people without employment report worse health²⁴ and areas with lower employment rates have lower healthy life expectancy²⁵.

We also know that finding employment after release from prison reduces the chance of reoffending significantly, by up to 9 percentage points²⁶. Furthermore, the proven reoffending of people unemployed at 6 weeks after release is nearly as twice as high as those that were employed (34.6% compared to 17.8%)²⁷.

Current services to support transition of health support to the community

This section primarily aims to describe the key services that support continuity of health and healthcare and any challenges or opportunities to support them.

While accommodation and employment are of critical importance to health, and health impacts on accommodation and employment, they are not managed or supported by health organisations. HM Prison and Probation Service (HMPPS) supports access to employment and accommodation, but it is not their statutory responsibility. The processes and efficacy of prison resettlement services are widely explored²⁸. There have been many recent positive interventions aiming to improve employment, accommodation and other wider drivers of health for prison leavers. For example, reducing the number of releases on a Friday to avoid service closures over the weekend and the initiation of CAS3 (community accommodation service tier 3) which ensures that people leaving prison at risk of homelessness are provided with 'up to 12 weeks' basic accommodation and support to move on to settled accommodation. However, challenges in continuity beyond this period and suitability remain. For example, some people have mental health, substance misuse or social care needs that need a type of housing

that has more support, which CAS3 doesn't provide, as that is provided by local authorities and our engagement reported this can be challenging to arrange. There are broader challenges with identifying suitable housing in this situation, which are outside the scope of this report.

Recent HMPPS initiatives

There have been through-the-gate services available, often provided by the voluntary sector at a local or regional level for many years. There have been a wide range of national changes to support safer release and improved continuity of care in the past 2 years by HMPPS. These include:

- commissioned rehabilitative services (CRS) which allow probation to commission a greater range of resettlement services regionally from specialist organisations that support wellbeing and recovery tailored to meet the needs of individuals and maximise collaboration with local partners with CRS accommodation services to support accommodation and benefits
- the Personal Wellbeing service which addresses needs such as emotional wellbeing and social inclusion through a range of approaches including direct delivery of interventions, support and advocacy and a mentoring 'through the gate' service

There are also programmes to address immediate financial needs that arise from being in custody, wrap-around dependency and recovery services to existing dependency treatment services provided by health services and specific programmes for women and for people who struggle to engage with mainstream resettlement, health and rehabilitative services, delivered in environments that resemble community spaces (Creating Futures Opportunities (CFO))²⁹.

Joint HMPPS and NHS initiatives

The Offender Personality Disorder (OPD) pathway (described in chapter 7 on mental health) is jointly funded between HMPPS and NHS England. It is a set of psychologically informed services operating across criminal justice and health, that uses evidence-based relational and environmental approaches with the aim of reducing risk associated with serious reoffending and improve mental health within a high-risk, high-harm cohort likely to meet the clinical threshold for a diagnosis of 'personality disorder'. Intensive Intervention and Risk Management Services (IIRMS) are a type of intervention service offered by the OPD pathway, all delivered nationally. They are community-based services delivering individually tailored and psychologically informed interventions directly to people who satisfy the criteria for the OPD pathway, to manage risk of serious harm and reoffending and develop psychological wellbeing and social engagement. These pathways have been strengthened recently through further funding to offer pre-release work to ease transitions into the community for those meeting the screen for the OPD Pathway.

Continuity of drug and alcohol treatment services and joint HMPPS and NHS England initiatives such as Probation Notification and Actioning Project (PNAP) are described below.

NHS initiatives

RECONNECT is a care after custody service commissioned by NHS England Health and Justice. Recognising the complexity of need and services at this time, it aims to improve the continuity of care of individuals with identified health needs who would otherwise struggle to engage when leaving prison. The service also supports those leaving immigration removal centres, which are outside the scope of this report.

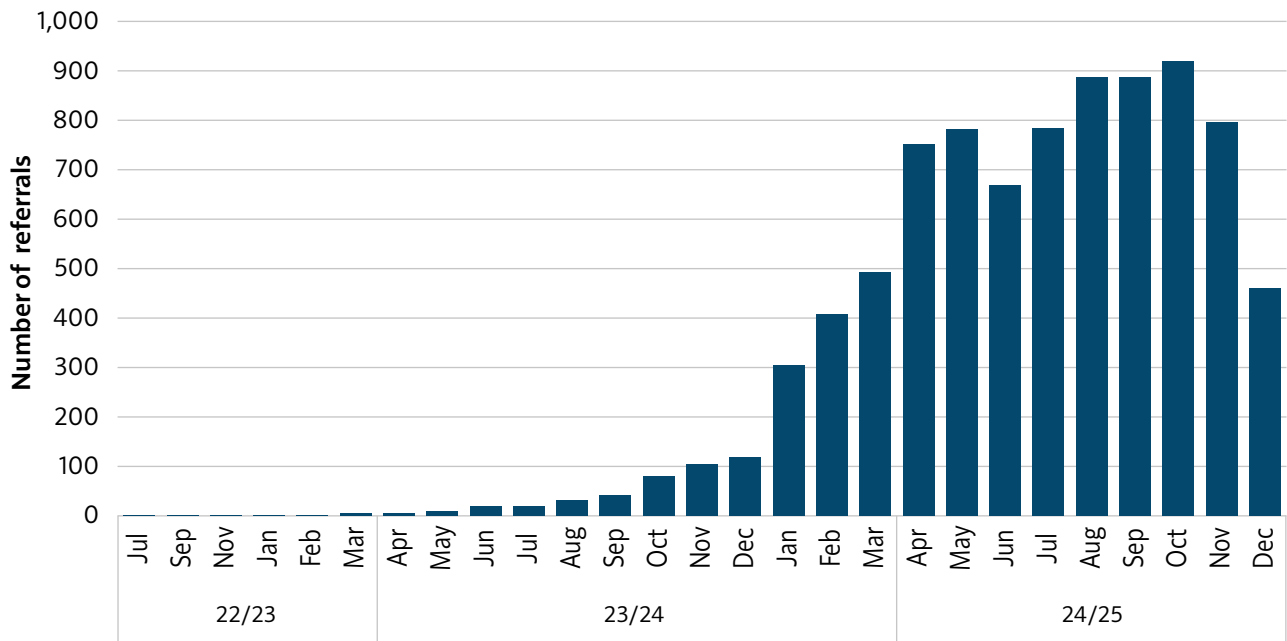
RECONNECT does not provide clinical interventions, but offers liaison, advocacy, care co-ordination and support to those leaving prison to support engagement in community-based health and support services. For example, if an individual is working with substance misuse service in prison, RECONNECT will support the individual to engage when referred in the community. If an unmet substance misuse need has been identified, RECONNECT will complete a referral. The service offers support and release planning to individuals for up to 12 weeks prior to release or as soon as they are referred within this time frame and will work with them up to 6 months post-release date, or when all health care needs are met – whichever comes soonest.

In December 2024, 99.1% of prisons were covered by the RECONNECT service, with full geographical coverage of England anticipated within 2025-2026 financial year. RECONNECT has received 20,038 referrals up until November 2024, with increasing referrals as the service becomes more established (figure 5). The proportion of people leaving prison that would be eligible for referral is not reported. Given that 57,000 people that were released in 2024 and health needs are high, with 27% of people on the prison mental health caseload being due for release in 12 months³⁰, it is likely there were more eligible releases who were not referred. Surveys undertaken with prison leavers in approved premises identified that 43% had seen RECONNECT or other through the gate services, and the majority (76%) found these services helpful or very helpful in connecting them to health services³¹.

The majority of referrals are made by prison, with mental health and substance misuse as the most common identified needs on referral. The most common needs identified on referral to RECONNECT are mental health (65%), substance misuse (62%), physical health need (41%) or support for GP registrations (33%). The majority of people that are referred on to these services and subsequently attend their first appointment is high (71%, 70%, 76% and 79% respectively). An evaluation has been commissioned by the National Institute for Health and Care Research (NIHR) and was commenced by the University of Leicester in April 2023 but is unpublished at the time of writing.

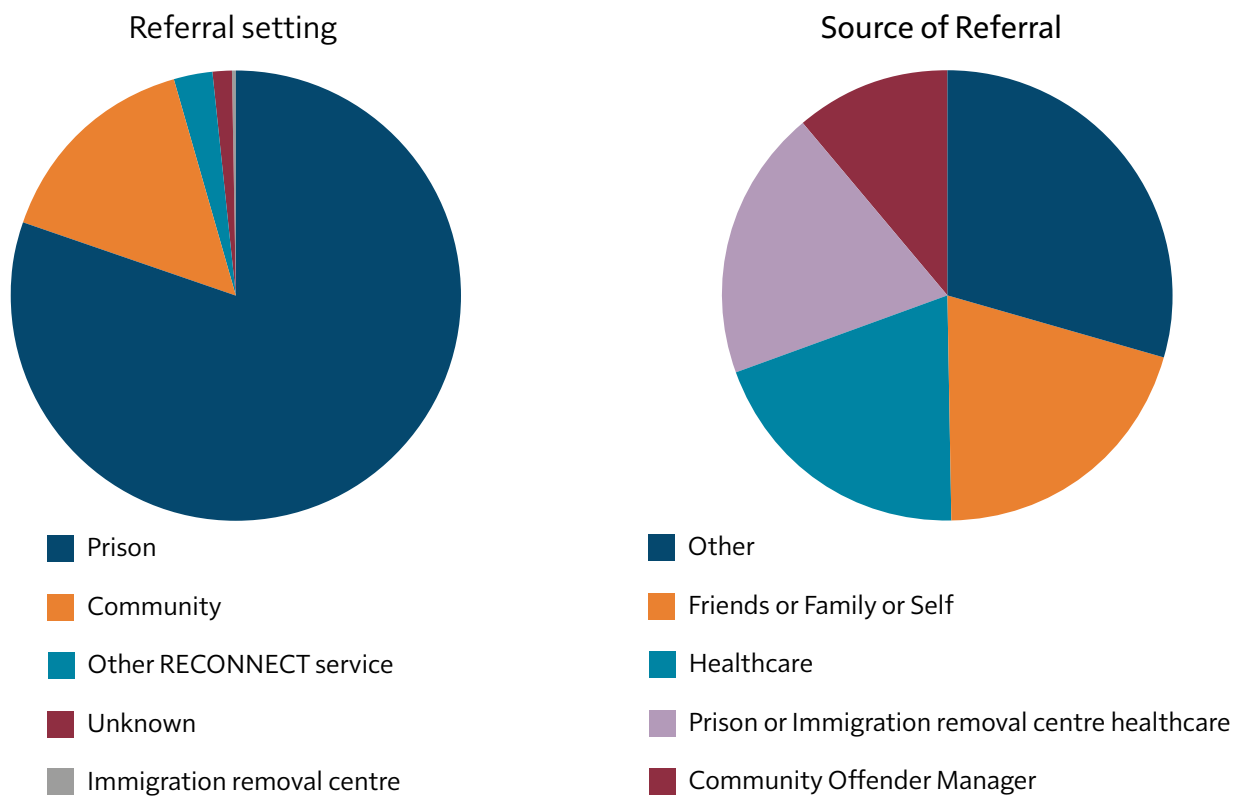
Timely referral to RECONNECT services is reliant on partner services raising awareness and facilitating referral or self-referral. Due to the service rolling out across regions at differing times, communication around this needs to be specific and regular to ensure partners and those requiring the service remain up to date with service availability.

Figure 5: number of people referred to RECONNECT from its start in July 2022 to December 2024



Source: NHS England Health and Justice

Figure 6: referral setting (left) and source of referral (right) to RECONNECT



Source: NHS England Health and Justice

Lived experience: NHS RECONNECT

Feedback collated on behalf of NHS England Health and Justice with people with lived experience was positive.

“I believe your service is essential, especially for people with mental health, anxiety and depression. Your work is absolutely excellent and [RECONNECT staff member] was a great listener.” Individual with lived experience of RECONNECT on leaving prison

“He [RECONNECT worker] is one of the nicest people I have ever met in my life at the age of 54. He is caring, intelligent and understanding in all ways possible. I would not have been able to improve my life without him. His and your service are second to none and they worked for me and I hope for many more in the unpredictable future. I hope that you appreciate him as much as I do.” Individual with lived experience of RECONNECT on leaving prison.

Continuity of primary and secondary health care

A 2025 survey of 964 people in prison identified that the majority (63%) did not know, or were unsure of, the healthcare support that is available to them on leaving prison. One in 4 people within the first year of leaving prison needed help to register with a GP and 43% needed help accessing other community healthcare services including pharmacy and mental health services³². Of those referred to NHS RECONNECT services, 33% required support to register with a GP and of those, 79% accepted this support and subsequently attended a GP appointment.

We observed good joint working between HMPPS and prison healthcare services to plan release when there was adequate time available to do so. Specific for people leaving prison, there is the opportunity to support registration with a GP prior to release. Pre-registering with a GP is not an automatic process but is feasible when the address for release is known and there is time to do so before release, although challenges remain as this disrupts access to the electronic health record for the prison health provider (as described in chapter 7 on data and information). Not every individual is eligible or benefits from pre-registration services, for example in the case of release straight from court. In this case they need to register in the community. Registration with a GP is particularly important if receiving medication that will need to continue once released, or individuals have outstanding hospital appointments. Challenges with registering with a GP and potential solutions to improve access to healthcare, are explored under service barriers in chapter 16 on probation.

Many people have both substance use and mental health needs, but unlike substance use, there is no key performance indicator for continuity of mental health service provision on immediate release from prison. Limited access to timely primary care and community mental health services on release has also been identified by recent engagement by NHS England when reviewing the mental health pathway across the criminal justice system. One potential contributor is that mental health teams will not accept a referral until someone is released. Just

as there are barriers accessing primary care, some people will need support to access mental health services. 65% of people referred to RECONNECT had a mental health need and 71% of those that were referred to a mental health service, subsequently attended demonstrating the value of the intervention.

People are often moved to new areas on release from prison. For people with health conditions that are managed in hospitals, area moves require care to be transferred between NHS hospitals. There is no key performance indicator for continuity of specialist hospital provision on immediate release from prison. Again, we observed good joint working between prison and community healthcare services to plan continuity of secondary care when there was adequate time available to do so. Yet challenges remain and especially with unplanned sudden releases.

The 2024 Health Services Safety Investigations Body (HSSIB) report³³ identified that there are mechanisms that hospital trusts can transfer specialist care between them, if a change of area is identified by a patient. This mechanism is, however is not frequently recognised by Trusts or by prison or community primary healthcare providers. It therefore usually relies on the patient proactively requesting or consenting to a re-referral to the local hospital from the community GP the patient has registered with on release. Care can be disrupted at this point, or if the prison healthcare team cancels all outstanding appointments, once a patient de-registers on discharge. It can also happen if a person moves area after an initial post-release period in an approved premises.

People are not allowed to access their appointment details until they are due to leave due to security requirements. If a person has a short sentence, an unplanned release or is moved by the prison a few days pre-release, they may not be provided with the appointment details. In engagement by Empowering People: Inspiring Change (EP:IC) lived experience consultancy, people leaving prison wanted more clarity and involvement in this process. Discharge templates describing the patient's health issues while in prison should be completed for handover to community NHS health professionals, or to foreign national individuals who face deportation to share with any new healthcare provider.

Some people in prison have very complex physical and mental health needs and multi-agency discharge planning boards are held from 12-weeks pre-release to facilitate care continuity with community health providers, with the support of RECONNECT services, when patients are referred to them. Currently in the primary care service specification health care providers are required to support continuity of care post release and some prisons have recruited specific individuals to undertake clinical liaison roles that work across prison and community boundaries to support clinician-to-clinician communication to ensure care continuity for patients as they leave prison.

There are a wide range of voluntary, community and social enterprise organisations that support people leaving prison with employment, housing, health and care and advocacy. Peer support services are frequently reported to be vital at this time and are an integral part of the RECONNECT service, as well as provided by a range of other organisations. This is described further on chapter 17 on workforce.

Lived experience: barrier to accessing services

Engagement by Empowering People: Inspiring Change (EP:IC) lived experience consultants in 2023 with 135 people that left prison in the year prior explored barriers to accessing community services:

"I have no idea where I will live. I have no ID under my new name, I take medication for epilepsy. I can't live without it. I am scared about how much I will be released with and whether or not I can sign up with GP before I run out."

"Community mental health services have been a nightmare to access – you need a phone – this is the first time I've ever had a phone – and they wanted to make a phone appointment for an assessment – and I struggle to remember passwords. It took me 6-7 weeks before I managed to understand the process and get through to someone. Sometimes I [also get] frustrated. I gave up and I'm trying to get help because I really need it."

There was variation in the feasibility of pre-registering with a GP:

"I think people who leave prison get a good amount of support now. They set it all [up] before I left."

"You need to register prison leavers prior to release so more needs to be done to know which location they are getting [released] to. People shouldn't be homeless after prison. You need to know what address you are going to else you will not know what doctor to register with. Not everyone goes to approved premises and even if they do, you don't know till the day you leave the precise location. So impossible to go to a dr and no wonder people can't get the help they need."

People reflected that probation, drug and alcohol services, mental health services and charities were helpful in supporting access to health care and community services:

"that hub is my therapy. This is pucker. It couldn't be any better. I'm living in a tent now and they help me with so much with everything including health."

"The Muslim Women in Prison Project has been invaluable. I had lots of trauma to deal with and [they] linked me into local services."

Continuity of drug and alcohol treatment services

Continuity of drug and alcohol treatment services was recently reviewed in the independent review by Dame Carol Black, with broader recommendations for change³⁴. Continuity of care for substance misuse treatment is monitored nationally. Drug and alcohol treatment in prison is the joint responsibility of NHS England, their regional commissioners and commissioned health care providers and sub-contracted drug and treatment services, working with HMPPS. In the community drug and alcohol treatment services are the responsibility of local authorities and their commissioned providers. PNAP has been developed to support continuity of drug and

alcohol treatment services through sharing information needed to support prison leavers with substance misuse appointments so that attendance can be supported and encouraged. This is described in chapter 7 on data and information sharing.

The independent review by Dame Carol Black concluded that the process for continuity of substance misuse treatment on release and resettlement is too complex³⁵. The review called for a streamlined process for release and resettlement supported by one HMPPS designed simple, streamlined process for release and resettlement and supported by a single IT system accessible to the right people at the right time with no duplication of effort. This included recommendations that the 'resettlement passport' (now called Prepare Someone for Release (PSfR)), should contain necessary information about all appointments³⁶. Even in the absence of substance misuse referral, preparation for release includes multiple referrals with duplicated information and lack of clarity of responsibility between organisations. 'Resettlement passports', are not expected to provide health information in the foreseeable future, owing to significant data sharing constraints³⁷.

Continuity of medication

Continuity of medication on release from prison is also often cited as a challenge. The National Institute for Health and Care Excellence (NICE) recommends that people should be discharged from prison with a minimum of 7 days' prescribed medicines, or if the release is unplanned (for example, from court) an FP10 prescription should be provided to allow the person to obtain medicines from a community pharmacy until they can get a prescription from the community³⁸. People with lived experience reflected that practice varied and it was challenging to arrange a repeat prescription to ensure continuity of medication within 7 days of release³⁹. More recent advances include guidance from NHS England in 2024 to increase medicines on release to 28 days⁴⁰. This is welcomed, although for people being released homeless this presents the risk of medications being lost or stolen and people need to be aware of this positive change to reduce anxiety. Electronic prescribing has also been rolled out nationally allowing patients to go to any pharmacy with their request. This is a great improvement for many, but when releases are sudden and unplanned healthcare may not be made aware of the release from court until after the event.

The availability and costs of specific medications, such as buprenorphine long-acting injection, means that people may need to be transitioned onto other medications. Electronic prescribing has yet to be rolled out for instalment prescribing of substitute opiate medicines, which means relying on paper prescriptions, which has inherent delays and risks. People leaving prison and in need of supervised consumption of their medicines are also reliant on being accepted onto the roll of a community pharmacy, which can be a particular challenge for people living in rural areas or where public transport is less available or affordable.

Joining up services

There has been improvement in joint working between organisations to support release, for example:

- a national information sharing agreement to enable RECONNECT services to access and record information on the prison recording system, as well as allow HMPPS to proactively support RECONNECT services to identify those who are eligible
- probation officers can now access the national RECONNECT referral form by hosting it on HMPPS 'Equip mapping platform'
- HMPPS health and justice partnership co-ordinators collaborate between prison to probation with substance misuse treatment partners to improve continuity of care

However, there are still multiple processes that require referral as shown in the example below. Continuity of mental health and secondary care services remain a challenge requiring joint working, however since continuity of health care is not a key performance indicator for prisons and courts, it will be challenging to prioritise. Patient experience and involvement in continuity also needs to improve. A universal health, care and resettlement needs-related discharge form would integrate information and avoid duplication of referrals and systems for capturing discharge information (SEAT, Oasys and RECONNECT). Dame Carol Black highlighted the need for an agreed plan of care for individuals when transferring to other prisons or being released to the community. If this is developed it should consider the inclusion of all planned hospital and community health appointments and identify a way for it to be available for people even if release is sudden and unplanned.

Case study: referrals and processes to support a prison leaver

Below is an example of the referrals and processes required to support a prison leaver with complications of type 1 diabetes, opiate addiction and ADHD:

- prison healthcare discharge letter
- hospital appointment for diabetes
- GP2GP post-discharge registration application
- Oasys probation form
- reconnect referral form
- referral to community drug and alcohol service
- prescriptions – possibly electronic patient prescribing for diabetic medication and paper prescription for opiate substitution therapy
- may also have social care or local authority referrals for ADHD

Join up of services is still especially challenged when people have rapid release, for example release from court for people on remand. This can limit time for pre-release services to engage. This impacts the development of therapeutic and trusting relationships prior to exposure to the potential challenges they may experience in the community. Many support services that work in custody, for instance substance use treatment or mental health services, prioritise cases by release date, which significantly disadvantages untried and unsentenced prisoners who do not have a release date. Better communication about court dates could support healthcare teams to plan for possible release, however sometimes prison offender management units only find out the day before the court is scheduled, or cases can be adjourned with little or no notice.

Summary

In conclusion, release from prison is a critical time where support can impact on health and likelihood of reoffending. There have been significant improvements in services to support continuity of care and meet the holistic needs of individuals. Joint working to provide continuity of care for substance misuse services is more established than for mental health or secondary care, although challenges remain as highlighted by the Dame Carol Black report. The complex commissioning and data landscape for health and justice and lack of resource means that there is still work to improve joint partnership working and streamline the parallel pathways for probation, drug and alcohol treatment services, RECONNECT and healthcare continuity.

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16 The health needs and barriers experienced by people on probation

Authors: Chandraa Bhattacharya, Dr Simon Marshall, Andrea Solomou, Darren Redgwell, Lucy Smith, Dr Coral Sirdifield, Dr Jonathan Bartram, Dr Caroline Watson, Professor Bola Owolabi and Mary Hill

Contributors: Jessica Helmer-Pedley, Dr Nicola Lang, Michael Still, Janine Burns, Kelly Dale, Liz Mills, Luke Baumber, Sue Gale, Mark Bamford, Amanda Sherriff, Louise Mann, Sally Reader, Jen Culver, Nicola Caffell, Emma-Louise Archibald, Melanie Jolly, Debbie Edwards-Jones, Donna Gipson, Toby Sherwin, Ed Stradling, Liam Bowles, Zara Hammond

Introduction

Probation means when someone is serving their sentence in the community. With 20,000 full time equivalent staff¹, the probation service supervises almost a quarter of a million people – around 3 times the number currently serving time in the prisons. Every year, they oversee more than 4 million hours of community payback, monitor around 9,000 people on probation on a tag at any given moment and provide sentencing advice to hundreds of courts every single day². People on probation access the same NHS health services as the general public.

The probation population is likely to increase, accelerated by continued growth in police charging, prosecutorial activity, the independent review of sentencing³ and population growth factors impacting the wider community. From the limited available evidence, it is reported that the health of people on probation is worse than that of the general population^{4,5}. The central argument this chapter therefore makes is that the health challenges of people on probation are serious. Whole-system action is needed regionally and locally supported by a national public health strategy. If we do not tackle health problems of this population vigorously and systematically, there will be a long chain of preventable ill-health in the community which will get worse as the current population increases and ages.

There are many reasons for poor health outcomes for people on probation. They face significant barriers to healthcare and experience higher rates of poverty, social exclusion and socio-economic deprivation. Unstable housing, finances and employment compound their health issues, driving dependence on drugs, alcohol and reoffending. Challenges with integration of community health and probation front-line services leads to poor identification of health needs, care co-ordination, symptom management and support. Lack of trust in health services and the experience of re-traumatisation due to repeated sharing of personal information, both negatively impact confidence and engagement.

Currently, the public health needs and associated social issues of people on probation are poorly understood in many regions. A large proportion of this cohort will never have been in

custody, but they are currently underrepresented in local community needs assessments and health and care commissioning plans⁶. Probation health data is poor quality, often self-reported or unverified. Integrated care boards (ICBs) and local authority public health commissioning can face challenges collating data across multiple services (including housing, domestic abuse services, drug and alcohol services) and identifying health needs when some people on probation may not be registered with a GP or identifiable within GP records. Lack of joined up data therefore is the golden thread that creates fragmented service provision, exacerbates siloed working and drives poor outcomes.

This chapter describes the health needs and barriers experienced by those under community orders and suspended sentence orders (and not those under probation supervision post release from custody – ‘prison leavers’ who are covered in chapter 15) informed by available justice data, published health research and insights from frontline probation practitioners.

Role of the Probation Service

As part of HM Prison and Probation Service (HMPPS), the Probation Service is a statutory criminal justice service (CJS) in England and Wales that supervises those serving community orders or released into the community from prison. Court ordered supervision includes community orders and suspended sentence orders and accounts for the highest proportion of the probation community caseload. Community orders are given by a judge or a magistrate to someone who pleads or is found guilty of a crime that does not meet the threshold for a custodial sentence. These orders have the effect of restricting their liberty while providing punishment in the community, rehabilitation and/or ensuring that they engage in reparative activities. A suspended sentence is a custodial sentence given when someone does not go to prison immediately but is given the chance to stay out of trouble and comply with various requirements set by the court. These could include doing unpaid work, being subject to a curfew, undertaking a treatment programme for alcohol or drugs and being subject to a rehabilitation activity requirement⁷.

In England, at the time of writing, there are 122 probation offices⁸ across 11 probation regions in 6 areas as part of HMPPS. Regional probation directors reporting to area executive directors oversee each region to drive greater co-operation with partners at a local level and improve outcomes in areas, such as health and accommodation, which directly contribute to reducing reoffending.

Figure 1: Probation Service structure

Source: HMPPS

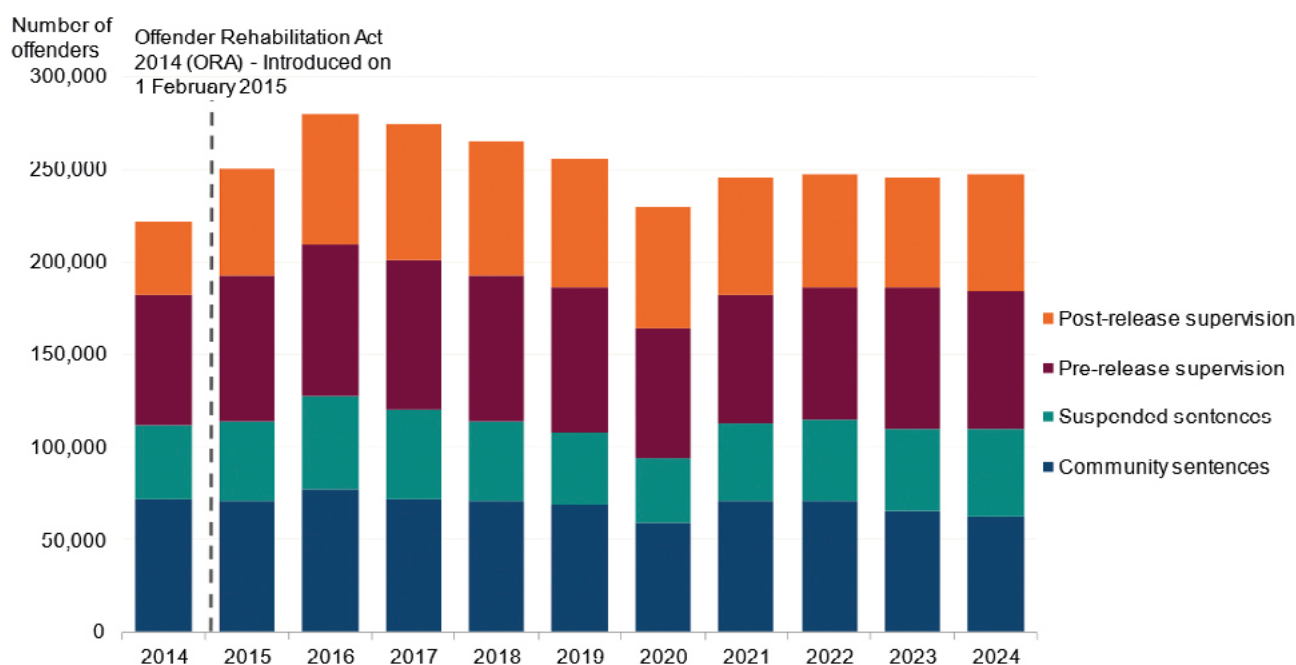
People on probation access the same healthcare services as the rest of the general population. ICBs are responsible for commissioning many NHS services (including primary care, acute care and community mental health services). However, local authorities are responsible for commissioning key public health services that have a high relevance for the probation population, such as sexual health and family planning, specialist drug and alcohol services and behaviour change services such as stop smoking. The local authority commissioned services are important as Directors of Public Health have strategic roles which include membership of community safety partnership boards, chairing of local combatting drugs partnership boards, safeguarding adult boards and local safeguarding children's boards. Like the general public, people on probation can access primary care (GPs, community pharmacy, dentistry, eyecare), secondary care (planned care in hospitals, urgent and emergency care and mental healthcare), tertiary care (such as some mental health services) and community health (district nursing, sexual health services and so on).

Population profile

The total probation caseload in England, as of the 31 March 2025, was 226,826, with 100,737 subject to court orders, 14,412 of which were female and 86,325 were male⁹. Between the end of March 2024 and the end of March 2025, the court order caseload in England increased by 0.1% from 100,665, with the number of offenders on a community order (CO) decreasing by 4% and those on a suspended sentence order with requirements (SSO) increasing by 7%¹⁰.

Across England and Wales the probation caseload has remained broadly stable over the last year, increasing by just 1.1% compared to 31 March 2024 and, more recently, increasing by 0.5% compared to 31 December 2024¹¹.

Figure 2: number of people under Probation Service supervision, 31 March 2015 to 2025, England and Wales



Source: Ministry of Justice and HM Prison and Probation Service, offender management statistics quarterly¹²

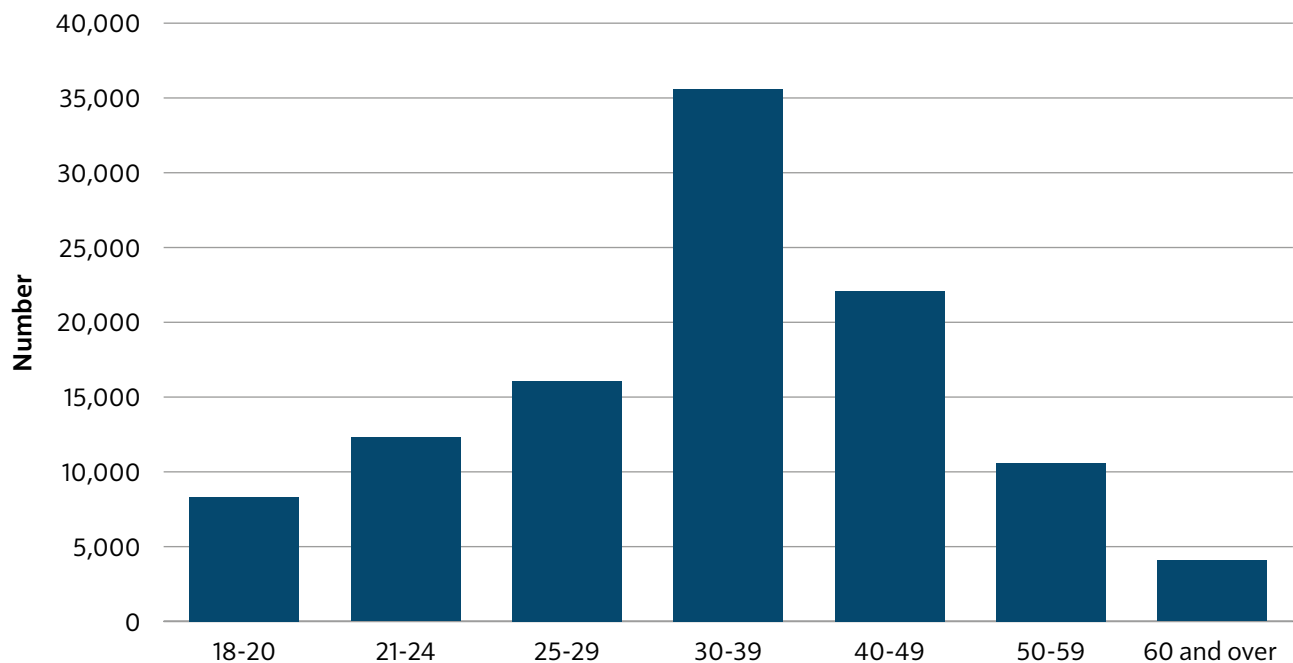
The number of people on the probation caseload in 2020 was substantially reduced as a result of the operational restrictions that were put in place on 23 March 2020 in response to the COVID-19 pandemic. While the impact of these operational restrictions continued into subsequent years, figures in more recent periods have recovered to pre-pandemic levels.

Demographics

The age breakdown of the probation population in England and Wales is shown in figure 3. The largest age group was 30 to 39 (33%) as at 31 December 2024¹³. However, the probation population is aging, with an increasing proportion of older individuals on community orders and suspended sentences. Between 2014 and 2024, the proportion of people aged 50 and over starting community orders increased from 8% to 13%, and from 9% to 13% for suspended sentence orders¹⁴. This trend is partly influenced by an overall aging of the general population

and changes in sentencing and release policies, for example, the Offender Rehabilitation Act 2014¹⁵. By comparison, people aged 50 years and over make up around 40% of the general population¹⁶.

Figure 3: age breakdown of those supervised by the Probation Service on community orders and suspended sentence orders in England and Wales, December 2024¹⁷



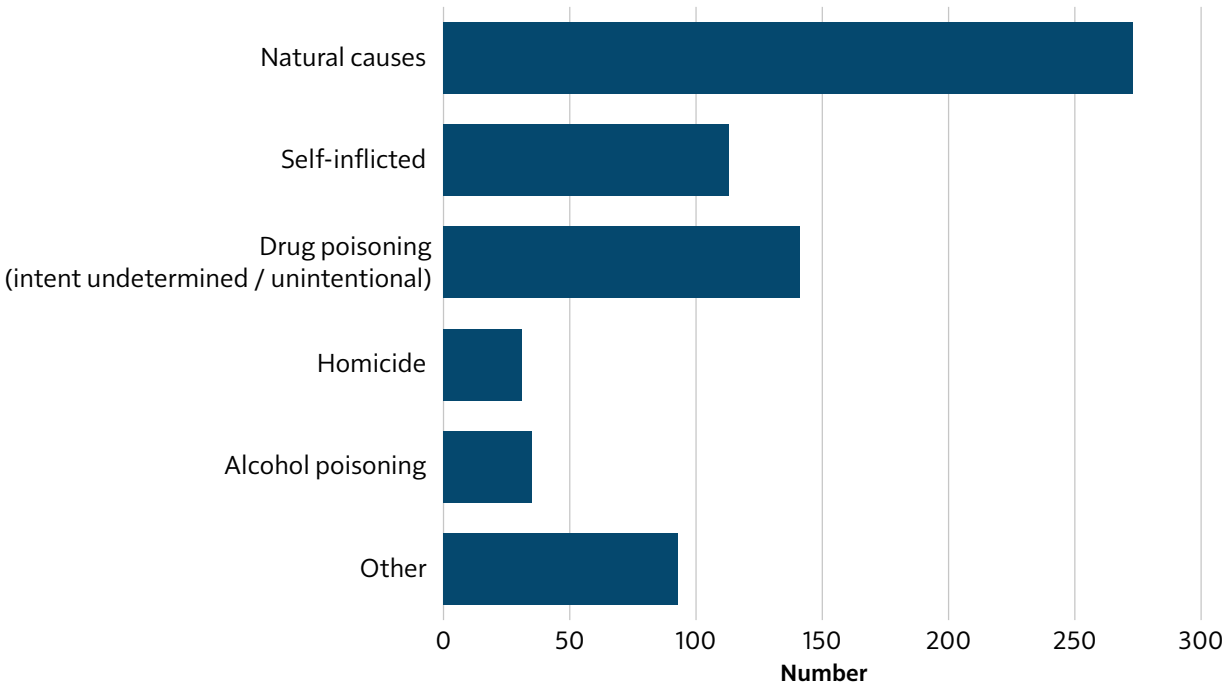
Source: HM Prison and probation service, Probation statistics

In general, ethnic minorities (excluding White minorities) are found to be over-represented at many stages throughout the CJS compared with the White ethnic groups¹⁸. In 2024, of those subject to court order supervision in England and Wales, 78% identified as white, 6% as Black, 6% as Asian, 5% as being from mixed ethnic groups, 2% from other ethnic groups, and 1% did not state their ethnicity. These proportions have remained relatively stable when compared to 2023¹⁹.

Deaths of people under the probation service

There were 1,283 deaths of people under probation supervision in England in the year April 2023 to March 2024 with 686 deaths subject to court order and 597 under post-release supervision²⁰. The most common cause of death for those under court order supervision was health conditions that are naturally occurring (natural causes) (39.8%). Of which 25.6% were heart-related and 12.1% were cancer-related²¹. A self-inflicted death is any death of a person at their own hand, including where intent is undetermined, but excluding drug poisoning where the intent is undetermined. In the year April 2023 to March 2024, self-inflicted deaths made up 16.5% of deaths for those under court order supervision²². Drug poisonings, where death by drug poisoning is unintentional or the intent is undetermined, accounted for 20.6% of deaths.

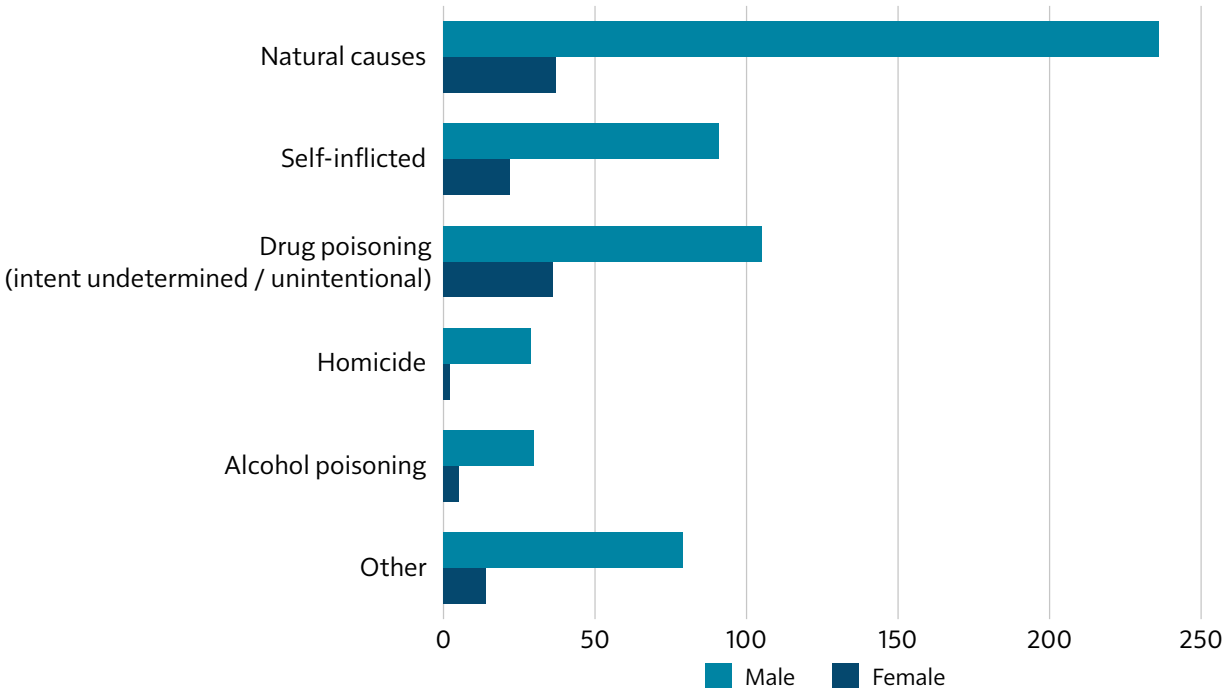
Figure 4: causes of death in those subject to court order supervision, 2023 to 2024, England



Source: Ministry of Justice. Guide to deaths of offenders in the community²³.

In figures 4 and 5, the 'other' category includes deaths awaiting further information required for a classification, and other non-natural causes (excluding alcohol poisoning and unintentional drug poisoning), and the 'self-inflicted' category excludes drug poisonings where intent is undetermined.

Figure 5: causes of death in those subject to court order supervision, by sex, 2023 to 2024, England



Source: Ministry of Justice. Guide to deaths of offenders in the community²⁴

Health inequalities

People on probation have been a key target population for NHS England, under 2 focuses: Core20PLUS²⁵ and inclusion health target population group²⁶ as they are hyper-marginalised²⁷. Core20PLUS involves focusing on the most deprived 20% of the population, PLUS particular groups identified at a local level, in 5 areas of clinical focus (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension case finding with smoking cessation as a cross-cutting theme). People on probation are a key target population, not only because they are in contact with the criminal justice system, but a greater proportion may experience multiple disadvantages or are in inclusion health groups, for example people experiencing homelessness, rough sleeping, misuse drugs or alcohol, that are socially excluded and deprived and that experience trauma and stigma²⁸.

People on probation are not well described, not differentiated and in some cases omitted from local health needs assessment of the general population. From the limited available evidence, it is reported that their health is worse than that of the general population^{29 30 31 32}. One study reported that people on probation were over 3 times more likely to die prematurely compared to 'non-offenders' and compared to individuals without a conviction, they are more likely to die from unnatural causes, as well as 'organic illnesses'³³. Early onset and more rapid progression to multi-morbidity from the major health conditions is likely to be contributing to their dying significantly earlier, contributing to having higher mortality rates than the general population³⁴.

Evidence review suggests neurodivergence is more prevalent in CJS than in the wider community³⁵. Some of the difficulties that neurodivergent people have may result in them being disadvantaged when they come into contact with CJS. One study found that among a sampled probation population, attention-deficit hyperactivity disorder (ADHD) was seen in 21%, autism in 4% and dyslexia 15%, which are higher than the current figures for the general population of 4% ADHD, 1% to 2% autism and 10% dyslexia³⁶. An independent review of neurodiversity in CJS (2021) explored the relationship between neurodivergence and engagement with justice³⁷. Neurodivergence and neurodevelopmental conditions are explored further in chapter 9.

Physical health

In comparison to our understanding of the physical health of people in custody, information on the physical health of people on probation is even more limited³⁸. Currently while people on probation attend NHS services the same as the general population, and therefore their health data would be within routine healthcare data (for example, Clinical Practice Research Datalink), they are usually not systematically identified as being on probation. This limits the analysis of healthcare data for people on probation. Probation systems collect minimal data on health, which is largely self-reported and is often unverified, unless there are other services (drug and alcohol for example) involved and consent has been obtained to share information. At a local level, many voluntary, community and social enterprise and local authority departments may have good insights into this population, which need to be drawn together to give a comprehensive picture of health needs.

Available data sets and study populations often include people who are being supervised following release from prison and do not disaggregate the probation population on community orders that have not been to prison. There are potential distinctions between these groups but not enough evidence to understand where there are unique or overlapping needs and risks^{39 40}.

The available evidence shows a higher prevalence of multiple health problems⁴¹. People on probation are likely to have poorer self-reported health than that of the general population, a higher prevalence of unhealthy behaviours, lower uptake of preventative health services and higher uptake of reactive health services⁴². A cross-sectional study of 257 people on probation in Wales⁴³ found that the odds of having a mental health condition were over 8 times higher than the general population. Prevalence of smoking (52%), and drug use (60%), were all higher than the general population. General practitioner usage and hospital stays were higher, but dentist or optician usage lower than the general population. In 2022 to 2023, emergency departments were accessed by 35%, with 9% frequenting them 3 or more times⁴⁴. A survey undertaken by NHS England of 177 people on probation in England identified that⁴⁵:

- 4% had completed a bowel screening kit test when last provided with one
- 53% of women had attended their last cervical screening
- 83% of women were not aware of when they were eligible for breast screening

Lifestyle risk factors

Key lifestyle risk factors which increase the risk of poor physical health in any population group include smoking and vaping, excessive alcohol use, substance misuse, poor diet, excess weight and physical inactivity. In the probation population, the rates of these risk factors, especially substance misuse, are higher than general population⁴⁶. In terms of health service access, people on probation tended to overuse crisis services, such as accident and emergency departments, but have little input in terms of health promotion and preventative healthcare⁴⁷.

Figure 6 shows the responses of self-reported lifestyle risk factors from a survey of people on probation compared to the general population⁴⁸. It should be taken into account that the age of people on probation is younger than the general population and some factors such as BMI and regular drinking are more likely in older adults.

Figure 6: comparison of risk factors (people on probation vs adult general population)

People on probation	General population of adults in England
Mean BMI 26.9 recorded as for men and 23.1 for women	Mean BMI was 27.6 for both men and women ^a
5% drink alcohol daily	11% drink alcohol on 5 or more days of the week ^a
49% were smokers 14% had never smoked but vaped	12% are smokers ^b Less than 1% had never smoked but vaped ^c
30% take the recommended 150 minutes of exercise a week, while the same percentage had taken no exercise	67% take the recommended 150 minutes of exercise a week, while 23% take less physical activity than 30 minutes a week ^d

Source: ^aNHS Digital, Health Survey for England, 2022; ^bDepartment of Health and Social Care, public health profiles, smoking profile 2023; ^cOffice for Health Improvement and Disparities, 2022, Nicotine vaping in England: 2022 evidence update main findings ^dDepartment of Health and Social Care, public health profiles, physical activity data 2022 to 2023.

People on probation are eligible for the community health services that prioritise prevention and early intervention offered to the general population by local authority public health and ICBs. These include national screening programmes and smoking cessation services. In the probation population, factors such as frequent housing moves, or lack of GP registration can negatively impact their opportunities for engagement, for example through invitations and results being missed.

Mental health

Comorbidity and dual diagnosis are found to disproportionately affect people on probation compared to the general population; with those with current mental illness, around 60% have substance use problems and 48% have personality disorders⁴⁹. Much of the focus of the literature highlights high prevalence of mental health conditions among those currently on probation with prevalence ranging from 14 to 75%⁵⁰. This suggests that the rates of mental

illness are high with many people experiencing more than one mental health illness or a combination of mental illness with a drug and or alcohol problem which are often undiagnosed and untreated⁵¹. One study showed that 39% of people on probation had a current mental illness where the prevalence of mood disorder was 18%, anxiety disorder 27% and psychotic disorder 11%. These rates are much higher than the overall mental illness rates for the general population which was around 16% to 25%^{52,53}. Personality disorder is a common mental health concern among people on community sentences. One study of 173 people under community supervision screened for personality disorder found nearly half of the sample (82, 47%) had probable personality disorder problems with heavy alcohol and/or illicit drug misuse⁵⁴. Similarly, rates of suicide and self-harm are high among people on probation with a recent study reporting that the rates are higher than in the general population by a factor of 8.67⁵⁵. While they are increasing, as a result of an expanding programme to commission primary care Mental Health Treatment Requirements (MHTRs)⁵⁶, the number of MHTRs as part of a community order or suspended sentence order remains low. In October to December 2024, the use of MHTRs increased by 28% to 838 for community orders and by 45% to 547 for suspended sentence orders compared to the same period in the previous year⁵⁷.

Barriers to health and care

People on probation should be able to access the same services in the community as the general population. However, a number of barriers to accessing these services exist. The following themes were identified through research evidence and engagement for this report with operational and strategic leads in all probation regions. They are closely intertwined with one factor impacting others. These barriers have a cost to the health of individuals, and their families, as well as wider services as people are more likely to present to acute services when more unwell⁵⁸.

Invisibility in data

Our engagement identified a greater need for community health partners (for example ICBs, public health teams) in some regions to understand the needs of people on probation saying, “our people on community supervision are hidden in plain sight”. Two key factors contribute:

There is lack of information sharing between probation, health commissioners and providers leading to the lack of understanding of health and criminogenic needs. Despite existence of established information sharing processes, at local levels there are challenges in making this happen. Information sharing principles include the grounds of proportionality and risk, patient confidentiality and consent. Navigating these principles can be complex and staff may be unaware or lack confidence in the principles of information sharing across different departments and organisations. Practitioners report a lack of understanding of the extent and mechanics of how personal information is transferred between various community services.

Community health or clinical pathways do not always systematically identify this population group. While there are pre-existing routine health data codes for probation supervision, these are not always used. Without information sharing, currently there is no systematic way for GP practices knowing that a patient is on probation or that they may need additional support and

flexibility to engage successfully with health and care services. This would only be identified during the consultation or if there is proactive communication from their probation case worker. Data and information sharing is explored further in chapter 7.

Integration of services

Our engagement for this report identified that there are numerous statutory and voluntary agencies delivering services to people on probation (including mental health issues, addiction problems, family support). In many cases these agencies are not integrated. This creates a number of challenges, including:

- people on probation having to disclose and share their health problems repeatedly at each appointment and build relationships with professionals, reducing opportunity for meaningful engagement and risking potential re-traumatisation
- probation practitioners report that fragmented commissioning and approaches create challenges when trying to bring all agencies together to collectively improve processes
- probation staff highlight duplication or poor understanding of boundaries between one agency and another which can lead to gaps presenting in provision of care
- probation staff reported access and experience of community healthcare provision to be complicated and confusing for people on probation, as well as staff
- probation practitioners have limited time during appointments to cover a range of issues and lack of access to information about suitable health services and referral routes means opportunities to signpost are a potentially missed

Lived experience: the importance of integrated care

Probation staff that attended our workshop on workforce reflected on the need for integrated care and challenges achieving this.

‘So you’ve got these integrated care boards, which is where we should be involved to sort of get offender health on the agenda. You know, certainly I can’t get onto the ICB.’

‘The funding streams and adult social care, how challenging that can be to understand for probation practitioners. And we’ve also had the MAPPA 3 cases (multiagency public protection arrangements) where it has felt like particularly adult social care, that they are the referrer, the gatekeeper of the funds. So, you’ve got to persuade them to get access to anything. And it can be really, really difficult.’

Trust in services

People on probation describe⁵⁹:

- a lack of trust of health services
- do not access services until crisis point
- feel that health services do not meet their needs
- previous experiences of trauma may impact their confidence and ability in engaging with professionals to meet their needs

Models of peer support have been found to work in probation that involve individuals with lived experience of the criminal justice system supporting others, offering emotional support, mentoring and practical assistance, often in one-to-one sessions or group settings. Research highlights potential benefits including reducing isolation, positive role-modelling, promoting healthy lifestyles and a decrease in levels of drug use⁶⁰. Examples include peer mentors in East Midlands, Essex and Hull⁶¹, who are supporting those at risk of disengaging and coaching and mentoring those who lack motivation or self-belief.

While experiences of trauma are not exclusive to women, it is widely recognised that women need specific trauma informed service⁶². Our engagement identified positive examples where probation worked closely with health to provide trauma informed healthcare. However, there is a local and regional variability in availability of women's centres and gender-specific services to provide necessary support to women on probation. This is explored further in chapter 4 .

Digital exclusion

Digital inclusion has been found to be key to reducing longstanding healthcare inequalities⁶³. Contact with GPs was reported by probation staff as difficult because of a heavy reliance on letters; this was found to be unsuitable as a communication method for people who are homeless, change address regularly or experience literacy challenges. Use of apps for making appointments or inflexible opening hours were reported as barriers for those with chaotic lifestyles or those without smart phones and who lack the necessary IT skills or ready access to data.

Service barriers

There is a shared strategic agenda between ICBs and probation services: improving and preventing poor health reduces offending. Some regions had excellent join up between services. However, many regions highlighted that community health partners (for example ICBs, public health teams) lacked awareness and understanding of the needs of people on probation. Similarly, specialist services for mental health, neurodiversity, disability and trauma were reported as difficult to access due to long waiting lists.

Variable thresholds mean that people with multiple morbidities can be considered too complex for some services but not complex enough for others, therefore falling between the gaps. For

those with complex needs, having to attend multiple services and constantly repeating the same information was reported to be re-traumatising.

Participants noted inequalities due to geographic differences, such as people living in rural areas having more limited access to health services. For many older people on probation, chronic mental and physical health problems have an impact on their ability to comply with their sentence plan or licence conditions, particularly if managing long-term conditions (such as diabetes, asthma and heart disease which are some of clinical focus areas in Core20PLUS5), frailty, malnutrition and dementia⁶⁴.

Initiation of court ordered supervision offers an opportunity for people to better engage with health and care services and to address chaotic circumstances and lifestyle risk factors that may have led to health being low priority, access to services being poor and resulting in poor health. When people first engage with probation, unlike on entry into prison, there is no comprehensive health screening assessment. There is no standardised joined-up, pro-active personalised approach to accessing formal health and care services and voluntary community, faith and social enterprise provision, available within the community. Registration with a general practice is a key entry point to accessing the wide range of primary, community and secondary care services and social prescribing provision available within a neighbourhood. Registration also offers access to life-long, healthcare provision, with continuity beyond probation engagement. Where a person starting court ordered supervision is already registered with a general practitioner, the general practice and ICB are not notified of the probation supervision arrangement and implications for potential need for enhanced access. Where a person is not already registered with a general practice, there may be barriers to registration including local requirements for proof of address or photo ID (although this is not required in national guidance), difficult-to-navigate service access, digital exclusion, literacy difficulties, mental illness, poor prior experience and low trust of health services. Probation could be used as a time to systematically assess health needs and create personalised care plans for people with high intensity or complex needs, who may require additional support to engage effectively with health and care services available in the community.

Lived experience: access to services

Within the Core20PLUS5 surveys of people on probation, people with lived experience identified challenges in accessing care in the community:

“I’m not sure how to access doctors – not been [to] doctors since a child.”

“It would help if they picked up that actual phone – impossible to get through.”

“I need a medication review as I haven’t had my meds since March. I have PTSD, a personality disorder, paranoia and depression but can’t get to see a GP.”

Probation staff reflected on how these practical barriers can influence people on probation:

“..there’re practical barriers, but there’s the barrier that the person holds themselves because of trauma, adverse childhood experiences. That lots of people I’ve worked with don’t even believe that. Well, it’s not on their agenda. The health isn’t on their agenda. They’ve got so much else to do. They don’t sometimes even believe that they should have access to these services.”

“What we find that is a challenge is that ...some of our most chaotic people in society... are expected to go to lots and lots of different places for lots of different appointments when they’ve got very limited finances, they led chaotic lifestyles. They might have children to look after or pick up and take from school to and from school. And that does create barriers...it creates massive barriers.”

Practice example: Basildon and Bedford community dental service – mobile dentist van

Issue

People on probation either may not have access to a dentist or not attend a dentist. The effect on oral health for people who have years of drug taking, many of whom are on probation, is poor and this can cause issues with poor mental health.

What was done

As part of the service offer to the general population, regional Probation Service sourced an outreach mobile service and agreed costings for the provider to initially attend 2 probation offices where parking spaces are available (Bedford and Basildon). While open to the general population, the additional funding provided enabled 20 to 30 people on probation to attend each setting on the allocated day. This covered the initial review appointment then up to 2 treatments per individual. Funding also covered transport costs for the van.

Outcome

During each session around 20 people attended to access the service. This was supported by the peer mentors attending if required by the individual. The funding is now being extended to cover the third office in Ipswich, which was requested by the local delivery unit as it had heard the good news stories from the other 2 local delivery units where the services had been provided.

Service gaps

Community sentence treatment requirement (CSTR) is an umbrella term for the 3 different requirements that can be used by courts where drug misuse, alcohol misuse or mental ill-health are thought to play a significant role in criminogenic behaviour⁶⁵. It aims to reduce reoffending by improving access to mental health and substance misuse treatment in the community through greater use of treatment requirements in community or suspended sentence orders.

The elements of a CSTR are: MHTR, drug rehabilitation requirements (DRR) and alcohol treatment requirements (ATR). CSTRs are delivered with locally commissioned providers with DRR/ATR being commissioned by local authorities and MHTRs commissioned by regional NHS England commissioners.

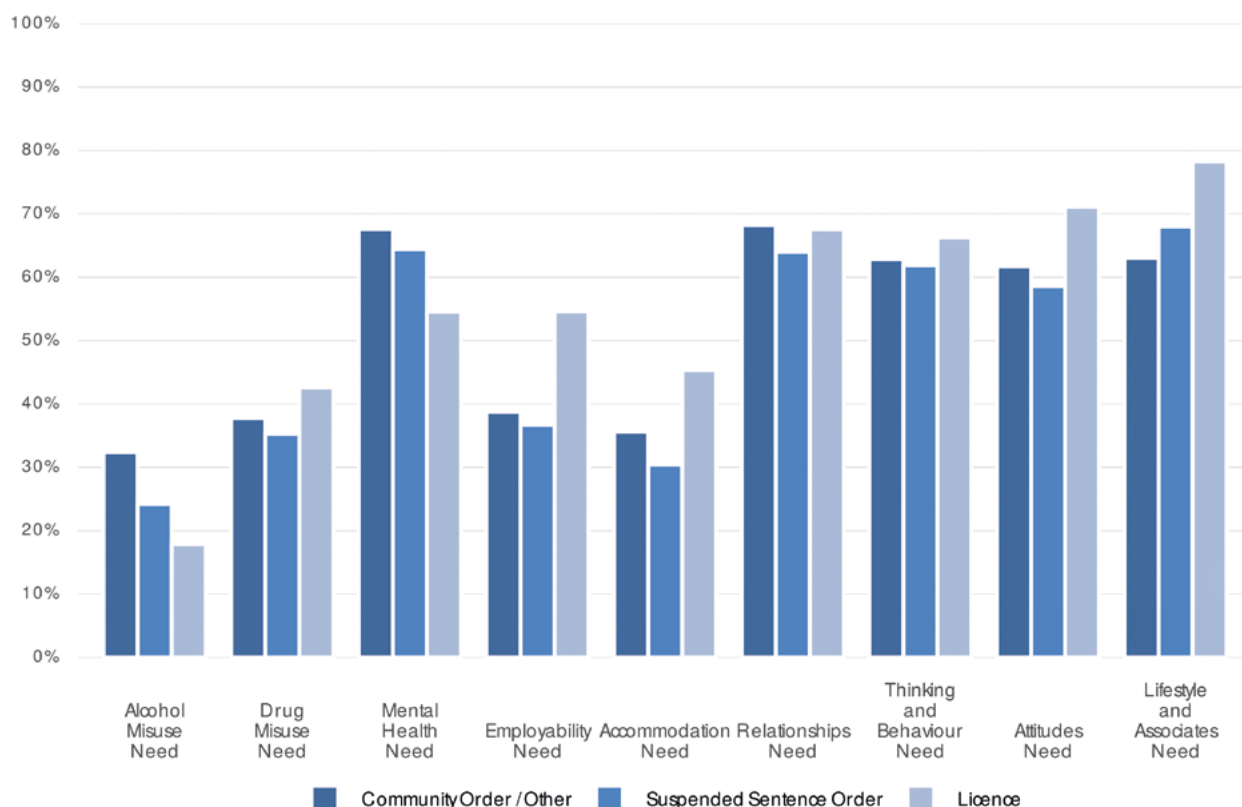
Respondents highlighted a significant gap in community service provision for addressing mental health needs of those who are not on MHTRs or have never been into prisons. While community pathways such as self-referral to Improving Access to Psychological Therapies (IAPT) are available in all areas, people on probation may struggle to access these or be systematically excluded based on perceived risk. People with both MHTR and DRR and/or ATR requirements are often required to engage with drug and alcohol treatment first, due to shorter waiting times and perception of readiness to engage with mental health services. This, however, fails to address the high proportion of drug and alcohol use because of trauma and poor mental health. Also, a key cohort that are felt to be especially overlooked are the ageing people on probation who have significant health and social care challenges, which are currently unmet by any community service provision.

Practitioners have also reported increasing numbers of people on DRR scheme for cannabis use that are self-medicating for neurodiversity conditions such as ADHD. Concerns were raised about the number of people presenting who have a lapsed diagnosis or no diagnosis or who have fallen off treatment pathways between youth and adult services and then require intervention and diagnosis much later in life. It is a gap in the system where diagnosis and treatment are lengthy processes with assessments subject to lengthy wait times, which is not available to many or those who don't wait to engage.

Wider determinants of health

Criminogenic needs are risk factors that contribute to an individual's likelihood of engaging in criminal behaviour, such as lack of housing, unemployment, bad relationships, lifestyle and associates, drug and alcohol use, thinking and behaviour and attitudes⁶⁶. These factors are also the social and economic circumstances that underpin and determine quality of health⁶⁷.

Figure 7: criminogenic needs in the community, by sentence type, 31 October June 2024



Source: Ministry of Justice⁶⁸

Most of those on a community sentence were in settled accommodation at 3 months after starting their sentence (85.2% in the year to March 2024)⁶⁹. Settled accommodation outcomes for those sentenced to a community order have steadily been increasing and are currently at their highest level since the start of the time series in 2020^{70 71}. Housing is a social determinant of health as unstable accommodation can lead to stress and the physical conditions of housing such as cold and damp can negatively impact on the health of people on probation^{72 73}. People on probation who experience homelessness or unstable housing often face higher rates of physical and mental health issues and may turn to drugs or alcohol as a coping mechanism for stress, trauma and instability associated with homelessness, which can lead to wider health concerns and increased offending^{74 75}.

Currently in the community, Ministry of Justice (MoJ) and HMPPS commission the Creating Future Opportunities service, which works with those people who are furthest from the labour market. The service works to improve employability and support people into work among a range of other offending needs. Meanwhile, the Department of Work and Pensions (DWP) provides employment support through their Jobcentre work-coaches and programmes such as Restart and Sector Based Work Academies. Originally developed in the USA, Individual Placement and Support (IPS) is an intensive employment support intervention to help people in treatment for alcohol and drug dependence and mental health issues. A recent study⁷⁶ found that IPS helped more participants achieve employment in the open job market than standard employment support. Alongside devolution of employment services and wider reforms to supporting people with health conditions into work, the government's Get Britain Working

white paper⁷⁷ committed to looking at how employers can be supported and encouraged to hire people with convictions and how work coaches are able to provide personalised support to people with convictions in reformed Jobcentres.

Just under half of people on community sentences were in employment 6 months after the commencement of their sentence (46.4% in 2023 to 2024)⁷⁸. While this marks an improvement from 44.5% in 2022 to 2023⁷⁹, it is still far below the national employment rate. Evidence shows that employment is beneficial for health and wellbeing, including important psychosocial needs. There is extensive evidence of the links between unemployment and poorer physical and mental health and mortality⁸⁰. Furthermore, employment is recognised as a source of 'recovery capital', the conditions which support successful recovery and ongoing abstinence from substance misuse⁸¹. Employment reduces the chance of reoffending significantly⁸², so improving these outcomes is critical to reduction of recidivism, resulting in a safer and more cohesive society.

Research evidence highlights benefits in the offer of place-based employment. One example is Individual Placement Support (IPS for adults in treatment for alcohol and drug dependence) in local anchor institutions who are large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Offering appropriate and meaningful employment opportunities is likely to improve health and wellbeing, including important psychosocial needs. This in turn may result in reduced reoffending and addressing health inequalities. This is aligned to the learning emerging from the work of the Coastal Navigators network⁸³.

Current challenges supporting wider determinants

Engagement for this report identified provision of housing as a key factor affecting physical and mental health inequalities of people on probation. Reluctance to offer housing to those with histories of offending has been widely discussed in academic literature⁸⁴. Studies^{85 86} have reported that place-based service provision is not necessarily conducive for those in transient accommodation, as frequent moves lead to changes of service and uncertainty about address on release makes putting in place treatment or general health appointments difficult. However, accessing accommodation for people on probation is challenging due to a lack of social housing, affordable housing and private rented sector accommodation. Lengthy and complex processes to navigate housing and financial support in the community has been highlighted as a major barrier. Probation practitioners report that lack of a fixed abode presents a significant barrier to accessing health services. For example, invitations for health appointments may not be received, exacerbating health needs. Some people have difficulties in accessing benefits including issues with identification, opening bank accounts, securing employment and navigating complex benefit systems, which can lead to financial instability and increased risk of reoffending. Practitioners report that the process of claiming and receiving benefits can be complex and time-consuming and individuals may face delays or even be denied benefits due to bureaucratic hurdles or lack of understanding of the system.

Lived experience: continuity of care

In the Core20PLUS5 surveys of people with lived experience of probation reflected on the impact of frequent moves on access and continuity of care:

“Being able to get help when you’re homeless is much harder, you don’t always know where you’re going to be and so physically getting somewhere can be difficult. There are some outreach services, but you need to be in the right place at the right time.”

“I didn’t have much support living in the first area where I was on probation. I had to move to another area for a fresh start after being told by my friend I couldn’t stay with him anymore, so I was homeless. I was on the waiting list for a mental health assessment in the first area but when I asked about this I was told the case was closed because I moved.”

Lack of financial support and access to funds may prevent people from engaging with healthcare, including use of public transport to attend multiple appointments at hospitals or community health services, which are not joined up. Additionally, low income is found to be preventing consumption of a healthy diet, which potentially worsens their pre-existing health problems.

Wider determinants of poor health are replicated in the wider determinants of offending and reoffending and therefore integrated approaches that combine mental healthcare with support housing, finances, social inclusion and wider social services are found to be useful by both people on probation and probation practitioners.

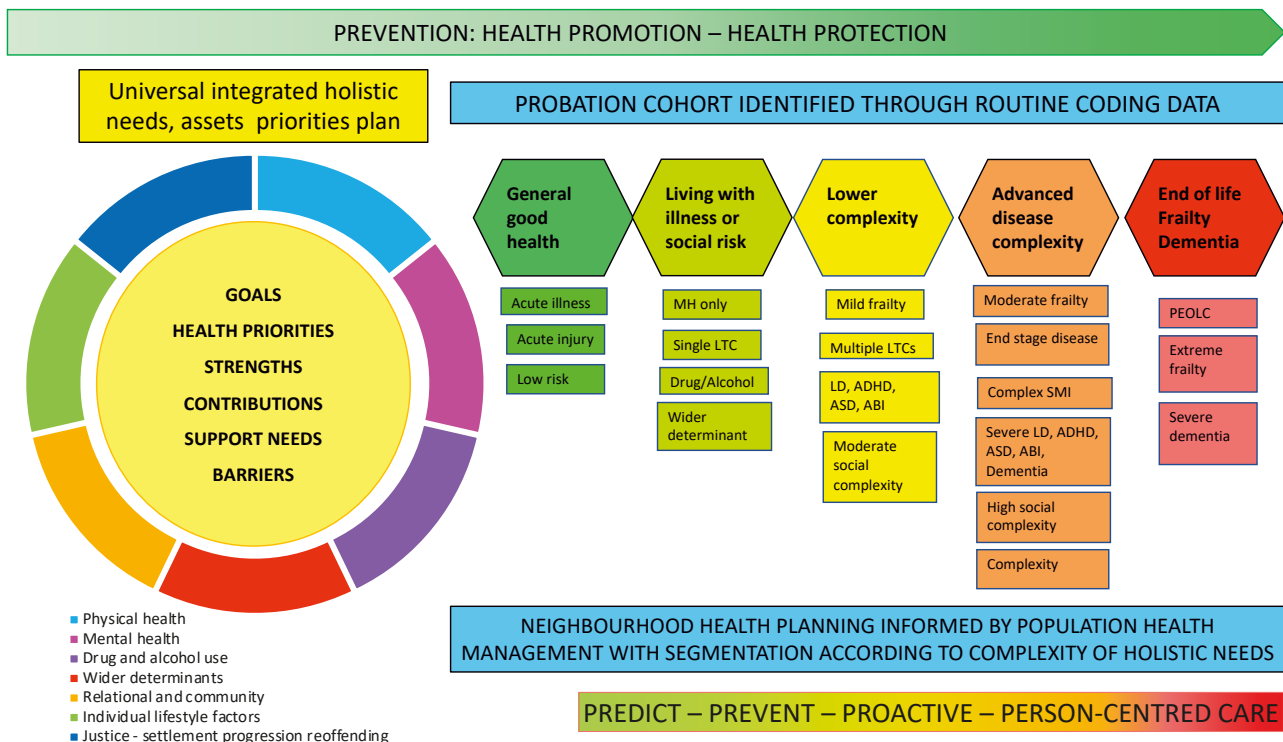
Potential opportunities to support holistic health needs in the community

Improvements to visibility in data

Chapter 7 on information and data sharing suggests the possible development of a ‘digital flag’ to apply to the GP electronic health records of people identified as experiencing multiple disadvantage and social exclusion, including people in contact with the CJS. The purpose of the ‘digital flag’ or increased use of codes in routine electronic health records would be to identify specific cohorts of the population requiring a trauma informed, more flexible approach to service provision with enhanced support. When combined with a systematic process to identify health and care needs and wider determinants needs, at the point of engagement with probation, this could support proactive person-centred trauma informed care and reduce health inequalities within neighbourhoods. This could also support workforce planning at the local and ICB level and facilitate targeted care and a co-located multidisciplinary approach within probation and community health settings.

An example of systematic health and care needs identification using a population health management approach with inclusion health digital marker is shown in the figure below.

Figure 8: the potential for a systematic health and care needs identification using a population health management approach using routine data



Improvements in accessible, integrated, co-ordinated care

Probation provides an opportunity to improve health access while people are engaged. Since an individual's supervision and support within probation is time limited, the aim is to improve people's engagement with existing neighbourhood health services, including general practice and primary care teams, community health services, mental health services and third sector organisations. The model of 'best fit' for integrated care for people on probation will depend on the local population. There are existing frameworks to evaluate and support service planning including the NHS England Integrated Framework for Inclusion Health. This framework sets out the roles and responsibilities and principles for action, with examples of good practice⁸⁷. The newly developed integrated frameworks for neighbourhood health have an initial focus on people with complex health and social care needs⁸⁸. This requirement provides an opportunity to consider the needs of the population on probation and in other inclusion health groups to ensure a targeted, person-centred, multi-disciplinary approach. Case-finding and local knowledge will be required to supplement the data driven approach. Some of the current models and practice for the probation population are described below, as well as exploring the role of organisations in supporting this care.

Lived experience: regional variation in specialist provision

Healthcare and probation staff attending our workshop on health and justice workforce reflected on the regional variation in specialist provision for inclusion health groups.

“You need the provision that the population you’ve got need. So, in some areas you may need a specialist service like the one we have in the city in southeastern England. In other areas you need a surgery, which identifies themselves as the place where people can go...So, there are different things that you need in different places. I think we’d all agree that the ideal would be for people to be in mainstream practices and all of those practises to be able to give people the support and care that they need. But in some areas, that’s just not possible. And I think that’s when you need specialist services either just for one group of people or to be part of a general practice to take on that responsibility.”

Peer health navigators

Evidence for the role of health navigators for people in inclusion health groups is described in chapter 17. Within probation there are practice examples of NHS lifestyle advisers in probation officers and use of lived experience navigator probation roles with anecdotal positive impacts. Where possible, probation navigators could join an inclusion health navigator network within a neighbourhood or place, linking with health navigators from other inclusion health backgrounds, to ensure support for service engagement beyond probation, where this is required.

Lived experience: health navigators to support people on probation

Healthcare and probation staff reflected on the need for integrated care, which combines community healthcare with specialist inclusion healthcare. This could be achieved through support to navigate to services:

“...So, they need somebody who’s going to be able to help them to let’s say navigate the system, push back a little bit if they’re being turned away, and to say, actually these services are, you know, are for me...”

“We also work with specialist services on Manchester Navigators who support with our homeless side of things. Supporting people on probation with appointments with community mental health teams and GP appointments just you know, having that connection there has really supported our people on probation of no fixed abode, making sure they continue to have that access and that link to healthcare...”

Co-located health services, with services that support wider determinants and probation in community hubs

While there is limited independent evaluation, engagement for this report identified positive reports around the impact of co-locating health and probation services. One example is provided below. There are also many examples of co-locating substance recovery and treatment teams with probation and the rate and number of people experiencing continuity of care has improved.

Practice example: North East community hubs

In the North East, the community hubs are integral to the delivery model and offer a multi-agency approach to offering support to low, medium and where appropriate, high risk of harm people on probation in a less institutional setting. Currently there are 15 across the region with some well-established ones in Cleveland (Hartlepool and Middlesbrough) identified as Core20PLUS areas.

The community hubs are not in probation buildings and the Probation Service rent delivery space alongside partner agencies to generate a more welcoming single reporting location for people with complex needs on probation who can engage with their probation officer and receive specialist support without the need for further signposting. The community hubs serve as critical reference points for integrating people on probation into supportive environments that continue beyond the conclusion of their probation supervision. They conduct probation appointments with people on probation who pose a low to medium and where appropriate high, risk of harm. This generates a rehabilitative and supportive environment that is designed to promote social reintegration and the development of personal social capital. The hubs are located within easy walking distance of town centres and provide multiagency attendance, which streamlines referrals. This includes housing, health, family support, employment (DWP), education, training and employment. There are private breakout spaces for delivering toolkits and space for community meetings and activities. Information is provided on local public services, work clubs and employment advisors. Access to library services, free access to the internet and Wi-Fi, photocopying and printing services and tea and coffee facilities are available. Services are delivered either as group projects or individual placements.

Improved accessibility to mainstream GP practices

It is important to explore ways to lower the hurdles to access GP and primary care services, facilitate care navigation and where required, support attendance at specialist and community health appointments for this group. Depending on patient needs, access and experience, there is a need for combination of offers. Specialist inclusion health GP practices, where available, or specialist inclusion health general practitioners and primary care nurses, working as inclusion health leads within mainstream practices, are found to support people on probation, particularly those recognised to have long experience of social exclusion, stigma, discrimination

and poor experiences of health services. Specialist GP services support engagement of people in inclusion health groups through principles identified in homeless and inclusion health standards⁸⁹ and National Institute for Health and Care Excellence (NICE) guideline NG214⁹⁰ by supporting:

- co-design and co-delivery of services with people with lived experience
- easy registration, including use of GP practice address as postal address where homeless
- enhanced access: drop-in, low threshold, outreach, flexible opening and appointment times, co-located 'one-stop shop' services
- multi-agency working, with protocols and systems for communication and information sharing to promote integrated working and wrap-around health and social care
- peer support, advocacy, care navigation
- person-centred, trauma informed, non-judgemental empathetic approach, understanding diverse experience and the impact of trauma and past experiences on behaviour and engagement
- promoting shared decision making and strengths-based approach to build self-reliance
- individualised approach to communication and information needs and choices, taking into account language and literacy barriers and access to phone and internet
- longer appointments and continuity of care to build and maintain trust
- long-term commitment to care and active support of re-engagement to promote recovery, stability and persisting positive outcomes that reduce health inequalities and avoid perpetuating past trauma of being 'let down' or 'rejected' by services and authority figures.
- providing services in psychologically informed environments

Social prescribing

In England, social prescribing is a key component of Universal Personalised Care⁹¹. It is an approach that connects people to activities, groups and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. As an approach, it has been found to address health inequalities and the wider determinants of health by supporting people with their non-clinical needs and by connecting them to sources of help and support within local communities, thereby increasing social capacity⁹². People on probation may benefit from social prescribing through the broader range of holistic support, connecting with a range of services and events in their local community and support to access these services. For example, walking groups, mental health counselling, debt management advice and employability skills. There is a lack of national or research evidence evaluating the impact of social prescribing specifically for this population. Evidence from practice examples is shown below.

Practice example: social prescribing link worker in Kent, Surrey and Sussex

Background

Kent, Surrey and Sussex Probation Delivery Unit is keen to focus on specific and measurable actions that reduce health gaps between people in CJS and the wider population with the aim of achieving equivalence of care.

Details

The 18-months pilot project is looking at the wider-term benefits of social prescribing in collaboration with Surrey County Council and the charity organisation Voluntary Action. It involves 2 link workers working alongside probation practitioners in the Guildford office to better support people on probation to improve access to health provision and reintegrate into society. They take referrals directly from the Guildford probation office to support health and wellbeing of people on probation. The service:

- provides people on probation with one route of referral into community assets
- works with referred people on probation to identify community support that could benefit them and steps and support needed to access this
- offers services in accessible locations and venues that are suitable to service users taking into consideration the geographical, demographic and cultural characteristics of the population
- helps build relationships that encourage and facilitate the involvement of community support organisations in the probation service

Expected outcomes

The pilot has not yet been evaluated but is expected to increased GP registration rates, improved collaboration and reduced stigma and increased awareness among participants of community-based support and increased confidence to access these services.

Clarity of responsibilities

There is a need for improved links between health and probation in the community, and greater understanding of health of people on probation. There are recommendations in the executive summary of this report that aim to facilitate closer links between Directors of Public Health, ICBs, HMPPS and other key agencies linked to the health and justice.

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17 A health and care workforce for the future criminal justice population

Authors: Dr Caroline Watson

Contributors: Cath Hadfield, Neisha Betts, Dr Lucy Wainwright, Donna Gipson

Introduction

This report has identified a health and operational workforce that is passionate and resilient. Often, this is in the face of adversity, working with individuals with complex health and social care needs, in settings that are themselves acute environments. This means unique challenges arise in ways of working both within, and between, professions and organisations. For this chapter, to identify and discuss solutions to workforce challenges, experienced clinical and public health leaders were interviewed and 2 workshops were held. The workshops were attended by front line health professionals and practitioners (nurses, pharmacists, psychologists and psychiatrists, primary care, peer support workers), heads of healthcare, prison leaders, probation officers and probation leaders. Expert patient perspective was also explored. The challenges and potential solutions identified by individuals and within the groups are explored in this chapter.

Healthcare provision for prisons in England is delivered by NHS providers, private providers and community interest companies. On-site provision usually consists of a 'team of teams' delivering primary care, public health, mental health, drug and alcohol services, dental and optometry services. These roles sit under the leadership of the head of healthcare, who is part of the prison senior leadership team and is responsible for ensuring the delivery of the healthcare contract against key performance indicators aligned with local interpretation of service specifications, set by regional NHS England commissioners.

HM Prison and Probation Service (HMPPS) is responsible for enabling health care delivery, for example by providing adequate numbers of rooms for healthcare clinics and health related activities, providing sufficient prison staff to escort patients to health appointments, both inside and outside the prison and enabling attendance at health and wellbeing activities. The primary concern of health care providers is provision of healthcare services whereas priorities for HMPPS include security, safety and supporting the justice system. To ensure each organisational need is met, local prison leaders and operational staff need a basic working knowledge of the health system and health staff need a basic working knowledge of security policy and an understanding of the pressures of the justice system. Good collaboration and communication between healthcare teams and prison partners is also essential to deliver and support healthcare, enable an agile response to risk and emerging issues within the prison environment and focus on learning lessons and restorative practice.

The health and care workforce in each prison is nuanced according to the category, size, estate challenges, age profile and health needs assessment of the population held there.

Core prison healthcare practitioner roles have been developed around a community model of care delivery, with general practice and primary care, dental and optometry services, drug and alcohol clinical and psychosocial services and an integrated primary and secondary mental health team, working alongside prison staff, as a 'mini neighbourhood' health system under one roof. This relies on access to community-based and hospital diagnostic and treatment services, and local authority social care. Allied health practitioners and specialist clinical roles tend to span a cluster of prisons, depending on the provider organisation and geographical footprint.

Core health practitioners within a prison may be organised into teams to support the function of the prison, for example in a remand or resettlement prison, practitioners may be organised into 'early days in custody' (EDIC) and 'release and transfer' teams, 'planned care' and 'urgent care and emergency response' teams. This is to meet the aim of safely supporting the high numbers of people arriving into and leaving prison that require continuity of care, alongside meeting the needs of ageing populations living with multimorbidity, increasing frailty and complex health and care needs, and supporting management of incidents and injuries within the acute environment.

General core prison healthcare practitioner roles include:

- general practitioners and pharmacists: similar skills to community with enhanced skills in primary care, drug and alcohol, mental health, trauma-informed complex care, complex prescribing and risk management
- pharmacy technicians
- primary care: primary care nurses similar to the community who may have additional skills such as prescribing, minor illness, long-term condition care, healthcare support workers
- drug and alcohol: specialist nurses, healthcare support workers, recovery practitioners
- dentistry and optometry
- mental health: nurses, psychiatrists, psychologists, assistant psychologists. Link practitioners may be employed in a joint prison/health role. Can include specialist forensic mental health.

Allied health professional and enhanced and specialist roles include:

- allied health practitioners include paramedics, physiotherapists, podiatrists, occupational therapists and speech and language therapists
- enhanced and specialist roles: providers may directly employ or support training for nurses to develop:
 - specialist skills to provide single or cross-prison site cover for diabetes, respiratory, sexual and reproductive health, palliative care
 - dual qualification for primary care and mental health; substance misuse and mental health; sexual health and substance misuse

- independent prescribers and advanced nurse practitioners

Wellbeing and prevention roles include:

- wellbeing and recovery practitioners, health coaches, social prescribers. With accredited training, health and wellbeing practitioners offer support to promote a healthy lifestyle, including psychosocial support, health promotion and coaching, and social prescribing activities

Non-clinical roles include healthcare operational managers, administrators and information and data analysts. These roles are essential for supporting efficient care delivery.

Lived experience healthcare and health support roles include patient engagement leads, health champions, reception and induction orderlies, listeners, informal peer support. Peers with lived experience act as advisors, advocates and, in some prisons, support with building health literacy and agency.

Individuals that need more specialised services can access them by a variety of routes that vary between prisons. All patients will have access to hospital care face-to-face appointments. Depending on the local hospital and commissioning arrangements, telemedicine and in-reach consultations may be provided, for example Sheppey cluster visiting urology consultant and HMP Peterborough visiting hepatology nurse specialist. Interim specialist advice and guidance from consultants and clinical nurse specialists is helpful for supporting patients with complex needs. Other teams may also provide in reach services. These services are not part of prison healthcare, or providing inpatient hospital level care, but providing specialist care. The government's 10 Year Plan includes a focus on moving services from hospital to community. This may offer potential to further develop specialist in-reach services to prisons within an integrated care system or primary care network locality.

Figure 1: prison clinical care pathway example

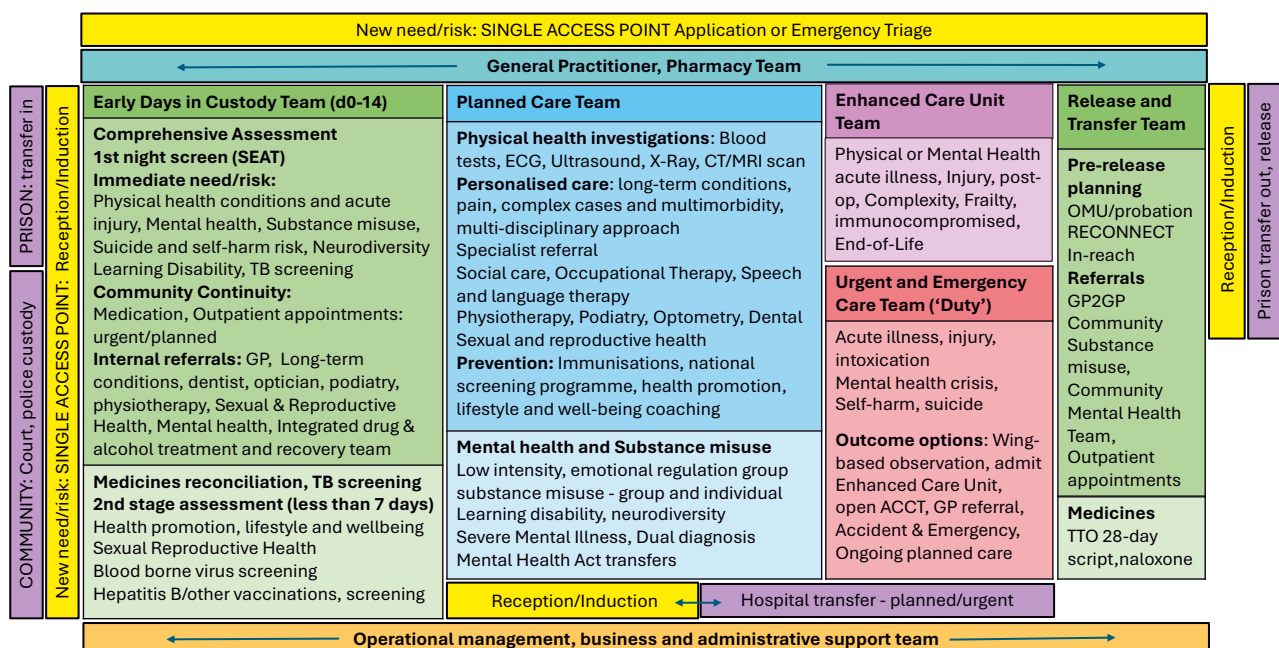


Figure 2: Local prison team configuration example

General Practitioner, Pharmacist				
Early Days in Custody	Planned Care	Enhanced Care	Urgent/Emergency/Duty	Release and Transfer
Primary care nurse Mental health nurse Substance misuse nurse Healthcare support worker Pharmacy technician Peer support worker	Advanced Clinical Practitioner Primary care nurse Substance misuse nurse Mental health nurse Healthcare support worker Pharmacy technician Peer support worker	Primary care nurse Healthcare support worker Mental health link nurse Social care support worker Peer support worker Allied Health/Specialist	Paramedic or primary care nurse Mental health nurse Substance misuse nurse	Primary care nurse Mental health nurse Substance misuse nurse Healthcare support worker Pharmacy technician Peer support worker
Operational and clinical management, Patient Engagement Lead, Business support roles				
Head of Healthcare, B7 clinical and non-clinical leads, Data and performance manager, administrative support, Patient Engagement Lead				
Cross-site Allied Health Practitioner and specialist roles		Care Quality and Safety Enablers		
Primary Care/Enhanced Care Physiotherapist Podiatrist Occupational therapist Speech and language therapist Palliative Care Clinical Nurse Specialist Tissue viability nurse Respiratory nurse Sexual health nurse Infection prevention/control nurse		Mental health Psychiatrist Psychologist/assistant psychologist Learning Disability nurse Dental and eye care Dentist Dental nurse Optometrist Non-clinical People specialists, Finance		
		Leadership and Governance: Good clinical and operational leadership and management; effective governance structures, reporting and accountability, policies and procedures, independent review Workforce and culture: skill mix and staffing levels for high quality effective personalised care with equivalent outcomes, compassionate, neurodiversity and trauma-informed Learning and improvement: high challenge/high support, continuous learning to adapt, enhance and innovate. Integrated whole-system approach: Multi-disciplinary teams, good prison partnership, cross-service/system collaboration Information systems and digital enablement: transformation to align with NHS 10-year plan and support community equivalence		

Healthcare services for people in contact with the criminal justice system in the community in England are the same local services that are accessed by all patients^a. Integrated care boards (ICBs) commission primary care, mental health, ambulatory, emergency and hospital services, and local authorities commission public health and social care services, including drug and alcohol services. Health and wellbeing boards develop joint strategic needs assessments (JSNAs) to inform health and wellbeing strategies which in turn inform local commissioning of services. It is important therefore that data and information is available to support understanding of the needs of people in contact with the criminal justice system.

Current workforce issues for healthcare working with justice services

The workforce that is providing and enabling health and care for people in contact with the justice system is unique in its need to work closely, across multiple organisations with differing, and at times, opposing priorities. Given the almost complete synergy between drivers of poor health and drivers of offending, improving health and wider determinants of health is mutually beneficial and thus a shared goal between justice and health partners.

Workforce wellbeing

The ability of a workforce to deliver care that meets clinical and professional standards impacts on both patient health and staff wellbeing.

^a Except for the Offender Personality Disorder Programme which exists in prisons and the community and is commissioned by NHS specialised commissioning.

High capacity, high churn and competing priorities can lead to delayed, disrupted care which creates risk to patient health, staff moral distress and, if prolonged, can lead to staff moral injury and contribute to burnout. More than 1 in 3 people in prison in England and Wales receive a sentence of 6 months or less and recalls to prison have increased from less than 100 in 1993 to nearly 13,000 in 2024¹. Short sentences, fixed term licence recalls for either 14 days or 28 days, and rapid movement of people through reception prisons to create space for new arrivals reduce effectiveness of healthcare teams. In the worst cases, this leads to poorer health outcomes, when investigations, referrals or patient treatment is disrupted and new arrangements must be made.

Further challenges with enablement of care are described in chapter 11 on complex care. For example:

- high numbers of new patients received daily into reception prisons, sometimes during the evening and late into the night. Small healthcare teams work quickly to identify risks and complex health needs within tight time constraints
- limited number of prison escorts to accompany individuals to hospital appointments outside the prison mean that clinicians may have to decide which patients' hospital appointments can be deprioritised and rescheduled

While there is limited data to support these experiences, they were reflected during the workshops, prison visits and roundtables held for this review. They are in the context of increasing demand for healthcare, for multiple reasons including an ageing prison population and initiation of new health services as explored below. However, it remains that without effective supervision and support, these repeated experiences can create acute challenges for the healthcare workforce.

The current capacity challenge also impacts on the ability of healthcare organisations to support succession planning, offer vibrant and supportive health and care placements and have capacity to lead, conduct and participate in research.

Impacts of an acute environment

There are concerns over the capacity of the healthcare workforce to deliver the expected range and quality of patient care to meet the principle of equivalence, within the context of escalating demand, rising violence and self-harm and both health and operational staff shortages. Particularly but not exclusively in reception prisons, patient volume and throughput mean that health prevention, planned primary care and proactive mental health and substance misuse interventions are hard to achieve. Reactive, crisis-led service and process driven care can prevail. These factors also impact the operational workforce.

Staff wellbeing is impacted by this acute work environment. Staff have described feeling unsafe or unable to provide the standard of care that they would like to contribute. This has been exacerbated by the financial pressures within the NHS that have led to operational delivery teams being under pressure to reduce overall expenditure and outlay on locum and agency staff, while required to deliver the same range of care. The combination of compromising on

professional contribution, putting quality and safety of patient care at risk and working in a high-risk, low support context, has resulted in staff experiencing moral distress, moral injury, compassion fatigue and burnout. One healthcare provider is considering rotating staff through a cluster of their local prisons to support wellbeing and keep professional values fresh.

There are environmental factors that also impact on strategic workforce planning and patient safety outcomes. Healthcare teams often must build workarounds to these. For example, the number and placement of hatches from which medicines are administered influences the number of health care staff needed to manage them. The size of clinical spaces and rooms available to provide care and the maintenance and condition of clinical areas influence the number of individuals that can be seen, the types of procedures that can be undertaken and infection prevention control.

Lived experience: healthcare staff reflect on the prison environment

Healthcare staff and providers currently working in prisons described how the needs of the population meant there was greater focus on reactive care:

"I'm interested in neurology and want to do my minor injuries and prescribers' courses and then do some extra training so I can provide good epilepsy care...but we need to cover reception or hold the emergency response." (prison nurse)

"One HCA (health care assistant) has gone part-time, and others have left. We've been too busy to offer smoking cessation..." (prison healthcare)

Without sufficient support and a restorative approach, this can impact staff wellbeing:

"I've worked with rats and cockroaches and broken windows for years...and worked in reception clinics that finish after 11 at night, having been there since the start of the day – and with a good team, you pull together in adversity for a common goal...but what has brought me close to burnout has been when concerns have been minimised, seeing colleagues in tears due to low staffing levels..." (clinical lead)

Clinical leadership and support

Prison-based clinical leadership is demanding owing to the need to understand risk and emerging issues as described above, and due to the complexity of navigating effective partnership working. Effective clinical leadership and operational management is essential for safe, high-quality care delivery within prisons. Fragmented (0.1 to 0.2 whole time equivalent (WTE)) roles and locum roles frequently preclude medical leaders from using their leadership skills and clinical nurse leaders are often too thinly spread to provide strategic leadership and quality improvement while supporting frontline demands.

Lived experience: healthcare team members reflect on clinical leaders

Healthcare staff and providers currently working in prisons expressed varying opinions about the scope and value placed on clinical leaders. Medical leaders in the workshop described their leadership capabilities being underused and being required to provide transactional clinical care.

Challenges of providing clinical leadership within existing models of care were described:

“We had a really good GP who’d been here for a long time, and she was included as a member of our team, we all had the same employer. So, she would be involved in our senior management things. She was actively involved in helping our service planning.” (advanced clinical practitioner)

“...when we have GPs that are locums, we tend to lose that MDT (multidisciplinary team) approach with complex case meetings. We need that leadership and in order to have that leadership from the GPs we need them present at those complex case meetings...” (clinical lead)

“Where we have a model that gives you 0.15 of a psychiatrist to a prison where you get a clinic out of them and that’s it, that doesn’t help support them to develop as a leader. And if you’ve got a consultant, they’re a leader. They’re not just somebody to dip in and do a clinic and dip out... Just being there for some advice and support so your value is being underused massively ...it’s hard to pull data from how much you add value as a leader.” (consultant psychiatrist)

“There is a huge scope and also a huge importance placed on clinical leadership...we all can see how much of an integral part our clinical leads across medical, nursing, pharmacy and social care play a part but we are far too thinly spread as a workforce profile and all too often have insufficient operational and strategic leadership head space to be in a position to ... support QI (quality improvement) initiatives as well as manage the frontline demands”

“The head of healthcare role is in my view far more challenging and demanding than say many other mainstream community clinical lead posts such as a lead for a community nursing team... owing to being based in a prison and forming a part of a prison governor’s SMT (senior management team).” (chief executive)

The support available to health care and prison staff varies between prisons. Reflective supervisions and reflective practice have been introduced to help clinicians understand the difficult experiences they can encounter with patients. This practice can also support staff to understand their moral distress, the risk and signs of compassion fatigue and to identify and reduce the likelihood of experiencing burnout. Professional nurse advocates have been introduced into some prison teams to support restorative supervision for nurses and advanced clinical practitioners. One-to-one, group and peer supervision models are used by other

clinicians including GPs and psychiatrists. Some prisons engaged for this report had clear structures for regular peer and senior support proportionate to the intensity of the work, including the use of outside facilitators. Other prisons had no true provision that staff were able to engage with.

Where there is inter-professional training between prison and healthcare staff it is effective at improving shared understanding of challenges and priorities and can improve effective team working. Our engagement identified that this provision varies between prisons. In some this included regular training by both internal and external providers, which staff were encouraged and released to attend. This was on topics such as trauma informed work and compassion fatigue. In others, this was absent.

Wider support for clinicians working in health and justice settings is available through the Royal College of General Practice Secure Environments Group, the Royal College of Nursing Justice and Forensic Nursing Forum, the Royal College of Psychiatrists Quality Network for Prison Mental Health and Faculty of Forensic Psychiatrists. The Health and Justice UK collaboration between these groups has been set up to provide a network of clinical support and interprofessional, inter-provider learning and sharing of good practice. This is through web-based resources, regional interprofessional inter-provider clinical communities of practice and a national annual health and justice summit. The purpose of Health and Justice UK is to provide support for multi-professional teams, to break down barriers between provider organisations and to build effective collaboration through learning together and sharing good practice. Where this has been understood and teams have engaged, it has provided rich learning and supportive experience.

Workforce planning and strategies

Currently, the detailed population health and workforce needs are hidden from wider systems. Strategic workforce planning relies on population health needs assessment data and workforce skill mix profiling to understand the current and future health needs of a population and identify the current workforce capabilities and any gaps in staffing levels and skill mix.

Due to challenges with prison health data quality (described in chapter 7 and appendix) and rapid population changes, health needs assessments for workforce modelling are often outdated on publication. This results in inadequate understanding of the immediate and evolving health needs of the prison population, hindering agile workforce adaptation. Currently, prison population health needs assessments data is not included within integrated care services (ICS) joint strategic needs assessments (JSNAs). Prison workforce profiling information is also not included within ICS data sets. While the health needs of people in contact with probation will be included within local JSNAs (if they are registered with a GP) their data will not be currently identifiable as a specific health cohort. The health and justice workforce within an ICS should be identifiable as a workforce with skills for inclusion health and included in the people alliance, workforce plans, and people strategies.

Lived experience: the need for an agile workforce

Healthcare staff currently working in prisons reflected on the need for agile models of healthcare given the acuity and dynamic nature of the setting:

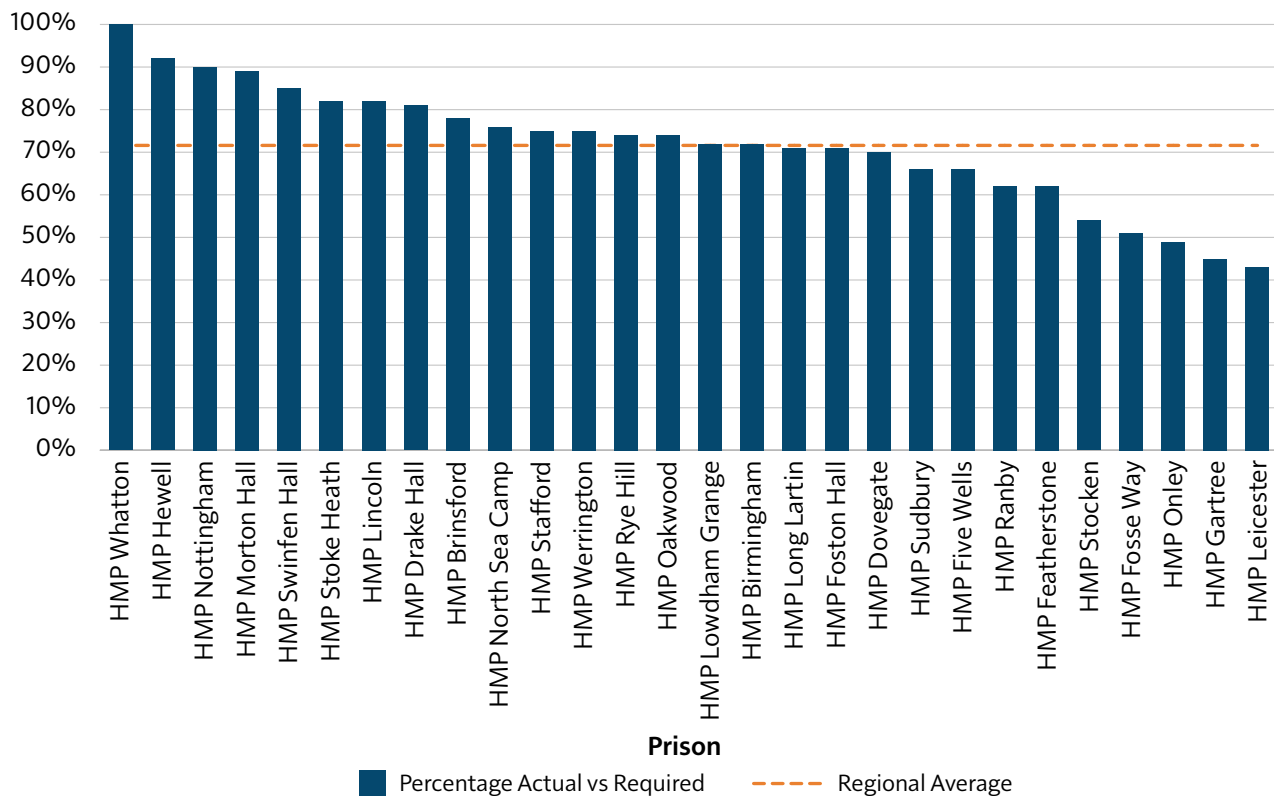
“We have no data on how to predict the high healthcare users in prison. If we could predict this then we could have a dedicated team like urgent care or assertive outreach, but we can predict what leads to things like self-harm – bullying, drug use, debt, no regime, sometimes poor staff behaviour and if we could address this, we could reduce the level of care needed – it’s so interwoven.” (consultant psychiatrist)

“It’s the dynamic nature of our roles within the prisons, it’s very tricky to find those safer staffing levels and numbers because they do change.” (lead nurse)

“Most models don’t have a buffer, so they don’t cover for sickness, they don’t cover for leave and I get it’s a money thing...but actually incorporating a buffer would be helpful.” (lead nurse NHS provider)

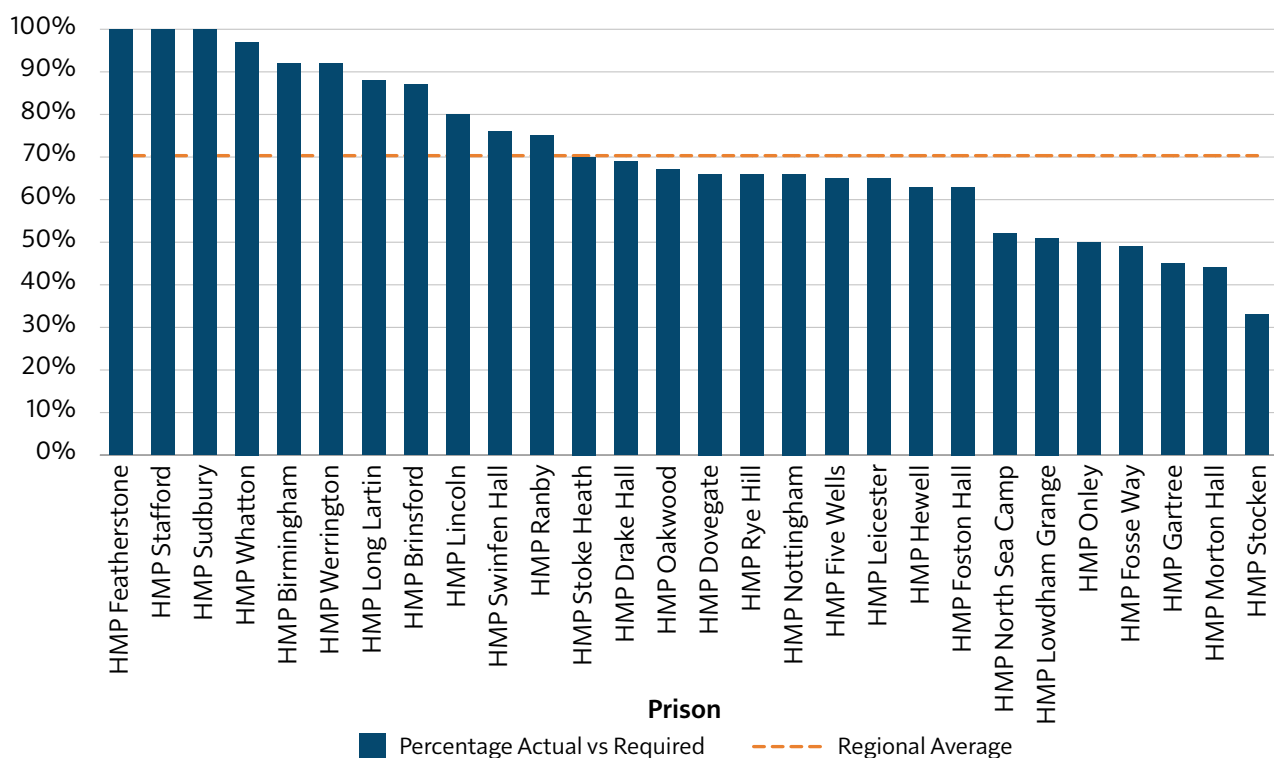
Health and justice workforce vacancies are high. East Midlands regional commissioners provided their workforce data from 2024 to 2025 as an example of this problem. This showed that across all the healthcare workforce there was a vacancy rate of between 6% and 52%, with an average vacancy rate of 22%. Vacancy rates varied between staffing groups, with an average of 28% vacant posts for primary care and 25% for mental health (figure 3 and figure 4). Vacancy figures vary significantly between prisons and can be as high as 55% for primary care and 69% for mental health (figure 3 and figure 4). Vacancy figures largely reflect nursing vacancies, since the numbers of WTE medical, dental, allied health professionals are much smaller.

Figure 3: monthly average proportion of required primary care posts that are filled across East Midlands prisons in 2024 to 2025



Source: NHS England Health and Justice, Midlands (East)

Figure 4: monthly average proportion of required mental health (MH) posts that are filled across East Midlands prisons in 2024 to 2025



Source: NHS England Health and Justice, Midlands (East)

There have been initiatives to improve workforce recruitment and retention. The Health and Justice Inclusive Workforce Programme² was created to tackle issues relating to workforce recruitment and retention. The programme aimed ‘to improve the recruitment and retention of a larger, more diverse, inclusive and representative workforce for all health and justice services and programmes.’ A suite of resources was designed to enable health and justice commissioners, providers and other stakeholders to address clinical workforce issues and to improve access for people with lived experience to enter the health and justice workplace. Resources included: an NHS England Health and Justice ‘We are the NHS’ campaign to encourage more prison healthcare nurses; an awareness module on e-learning for healthcare; tools and reviews to support commissioners with workforce planning; bespoke health and justice workforce related training on topics such as race and overcoming barriers to recruitment to secure settings; a series of recruitment events.

ICB people strategies and workforce plans have also been developed to improve staff experience, offer new flexible ways of working, embed equality, diversity, inclusion and belonging, and grow the workforce to meet changing health needs. Given that people in contact with the criminal justice system in prison and on probation will access care in the community within local neighbourhood health systems and will require a trauma-informed, inclusion health approach for equitable access, excellent experience and optimal outcomes, it is mutually beneficial for ICBs and health and justice commissioners and providers to:

- ensure visibility of criminal justice population health and care needs within local population health data
- identify the health and justice workforce within ICS footprints, recognise their skills in inclusion health and experience of partnership working across multiple organisations, and include them in people alliances, workforce plans and people strategies.

However, health and justice workforce data is not usually visible or included within ICS region or place-based data currently and regional recruitment and retention strategies are not joined up.

There are examples of health and justice providers aligning with local health education institutions, for example City University and Teeside University and developing a masters level specialist professional qualification in health and justice nursing, developing rotational placements and co-producing nursing career apprenticeships. One organisation provided university lectures and increased student nursing numbers by 30%. This proactive approach contributed to a reduction in nursing vacancies from 28% to 17% within the organisation.

There are examples of general practice training rotations and medical student placements in prisons and an integrated pharmacy training programme has recently been introduced. In the first year, there were 16 foundation trainees taking up 13-week rotation placements, there were 27 during 2024 to 2025, and there are 21 for 2025 to 2026. There are now plans to include pharmacy technician training placements into prisons and to train for cross sector working.

It is important to identify that, while training rotations and apprenticeships are an excellent way to recruit and grow the future workforce, investment is required to employ staff and release

them from frontline roles to undertake training for supervision, teaching and research, and to ensure adequate clinical space is available to accommodate trainees.

There have been initiatives to improve career development. Career and competence frameworks to support workforce planning and development of new roles, including lived experience roles, in custodial and non-custodial services were commissioned as part of the Inclusive Workforce Programme³. The frameworks articulate the range of cross sector roles and key competences, knowledge, skills and behaviours required to provide services for justice populations. Examples of new roles in prisons include: patient engagement leads, neurodiversity leads and health and wellbeing coaches. New community justice roles include RECONNECT workers. Senior clinical or medical roles, such as clinical nurse specialists, advanced clinical practitioners, general practitioners, pharmacists, psychiatrists or psychologists are not included in the frameworks.

Currently, health and justice workforce frameworks are separate from wider neighbourhood health system workforce approaches to support the health and wellbeing of inclusion health groups. The advantage of a joined-up inclusion health framework approach would be to improve integrated pathway working and facilitate continuity through the gate to support effective resettlement, or to support integration of care for people serving community sentences, including those on structured treatment requirements. Evidence for the effectiveness of inclusion health approaches is set out in National Institute for Health and Care Excellence (NICE) guideline NG214⁴ and Homeless and Inclusion Health Standards for Commissioners⁵.

Lived expert roles

Embedding lived and living experts in all parts of the justice system was widely reported as beneficial, in all workshops, focus groups and surveys, involving not only people with lived experience but also staff. Experts by experience were recognised to be essential in the design of services, a core part of the workforce and a valuable source of informal support for people in contact with the criminal justice system. Prison employment was seen as key meaningful activity for developing practical and relational skills and supporting a person's wellbeing but also valuable to the effective running of a healthy prison community and aligned with goals for neighbourhood health systems and healthy communities. There is some evidence that peer roles can be effective in disease detection, improving prisoner mental health and pre and post release behaviour⁶.

Prison-based peer roles that were suggested to support delivery of healthcare included:

- reception peer workers to assist people arriving in prison to navigate the system
- wing-based health champions and health trainers to provide peer support for health literacy development and practical support such as ambulatory blood pressure monitoring
- care navigators and peer advocates to support people with applications and appointments
- gym-based healthy living peers to encourage healthy eating, weight loss, smoking cessation

- listeners to support safety of people in distress or with poor mental health
- Shannon Trust volunteers to support reading skills to enable access to health information
- social care peer support for people with mobility or complex needs

There have been examples of accredited training programmes to support the development of peer roles such as the public health training course for health champions and social care training by RECOOP. Further accredited training opportunities, including key working, care navigation and health coaching training courses, would benefit individuals, improve the health assets of the prison community and provide transferable skills for reintegration into the community. People living in prison with long-term conditions or cancer survivors could be engaged to provide expert patient support to others within the prison community living with similar conditions. Emerging social prescribing provision within prisons provides an opportunity to expand the use of wing-based peer health champions to fulfil link worker roles.

A lived expert programme in prisons that was identified as an excellent example of improving access to healthcare and breaking down stigma through peer engagement was the peer-led Hepatitis C programme of testing and treatment. Peer roles such as RECONNECT workers were seen as essential for prison leavers, to facilitate access to community appointments, to provide liaison and advocacy, to build agency through health literacy and provide emotional support. Both paid and voluntary peer roles have benefits within the integrated neighbourhood approach to healthy communities.

In the community, health navigators for people experiencing homelessness have been shown to engage people to build trust and support a flexible approach to healthcare access. For example, as part of an East of England cancer alliance programme⁷, health navigators are trained in health coaching, cancer awareness, phlebotomy (blood taking), point-of-care testing for blood borne viruses and to provide basic health checks. They were attached to a specialist GP surgery for people experiencing homelessness and had links to the hepatology clinical nurse specialists at the local hospital. Linking in with lived expert peer workers in the justice system, where they had patients who were homeless and also in contact with the justice system was vital to engagement. A joint apprenticeship was suggested by one senior staff member, and another suggested an inclusion health navigator network, linked with social prescribers.

Lived experience: the importance of peer support

Probation staff reflected on the importance of peer support.

“In terms of peer support, I think I’d really be advocating for some kind of cross-organisational peer support training to enable peer supporters (with) lived experience to experience a range of different services within an apprenticeship. So rather than just being a probation lived experience apprentice to actually go across, maybe even to sit in with a GP practice”. (probation lead)

The Lived Experience Charter⁸ status enables NHS England Health and Justice services and integrated care systems to benchmark their organisational maturity in developing, supervising

and supporting paid and unpaid lived experience roles. The award demonstrates quality standards, best practices and a commitment to improving the inclusive recruitment and retention practices of people with lived experience.

Voluntary, community, faith and social enterprise partners

Over 1,700 voluntary community faith and social enterprise (VCSFE) organisations work alongside statutory health and care agencies in the criminal justice system, both inside and outside prison, with some providing through-the-gate support. VCSFEs identify and respond flexibly to unmet social need, providing direct support for individuals, families, and communities, advocating for change in the justice system and offering local volunteer-run self-help groups. Examples include Clinks (prison community links), Prison Advice and Care Trust (PACT), Partners of Prisoners and Families Support Group (POPS), C2C Social action, Glasshouse and Fix Your Cycle. Many VCSFE organisations are locally based. Some VCSFEs reach specific groups such as older people or women, some focus on specific issues such as debt advice or substance misuse, and others provide specific interventions, such as physical activities, arts and culture, nature-based or practical activities to improve health and wellbeing and care outcomes.

VCSFEs are well-placed to be part of the emerging social prescribing provision within prisons, offering health and wellbeing support and opportunities to develop and use the skills and assets of the whole prison community. They can also respond to the changing and often complex needs of individuals working with community probation, providing support within community hubs and receiving referrals from social prescribing link workers. Due to their local connections, VCSFE organisations are well-placed to support people on probation to re-integrate within the wider community and to provide continuity beyond probation. VCSFE organisations are currently facing significant difficulties due to the mismatch between available funding and increasing numbers of people in the criminal justice system with complex unmet needs. This has led to some VCSFE organisations merging and others having to stop functioning.

Partnership working, leadership and effective interagency collaboration

Partnership working, collaborative delivery and system working are key skills and cultural factors to be fostered and grown in the prison and community justice and healthcare workforce and its leaders. That includes working across acute trusts, mental health, primary care, substance misuse and VCSFE organisations. Workforce or people alliances that are found in many ICBs to support workforce plans would benefit from hearing and involving the prison health workforce, given their insights and skills in inclusion health.

Many chapters in this report have explored the essential role of HMPPS in enabling health. Both NHS and HMPPS are hierarchical organisations, each with differing priorities. At the prison

level, multidisciplinary partnership working and collaborative clinical and professional leadership are essential. When working well, this can be a collaborative, mutually beneficial opportunity to troubleshoot concerns, identify and work towards joint strategic priorities. This might include joint attendance at regular senior leadership meetings, agreed information sharing protocols and operating effective local health delivery boards.

Engagement for this report identified that when this doesn't work well, for example there is an imbalance of power, or lack of joint working or goals, then this substantially impacts on health and healthcare and the ability to train and recruit a sustainable workforce.

At a local level, each prison governor, or director of a privately managed prison, is responsible for enabling access to healthcare services as well as promoting wellbeing. They are responsible for:

- vetting new staff
- ensuring the work environment is fit for purpose
- providing adequate numbers of rooms for healthcare delivery
- providing sufficient prison staff to escort patients to health appointments, both inside and outside the prison
- enabling attendance at health and wellbeing activities

Governors are therefore responsible for deciding the priority of health and social care within their prison estate and setting the regime that enables this priority. HMPPS does not routinely capture information on how well healthcare is enabled within prisons because it is not a benchmarked performance metric. There are many external independent scrutiny boards that do provide feedback to governors, commissioners and providers such as HMIP, Care Quality Commission (CQC), Health Inspectorate Wales, Prison and Probation Ombudsman, and the Independent Monitoring Board. The commissioner and provider report healthcare activity and delivery via the local delivery board. The governor is responsible for reporting and addressing the prison officer enabling requirements. Data should be 'pooled' through the Local Delivery Board so there is a whole system view of healthcare delivery. When concerns are identified, these should be reported to the local delivery board, which is often lead by the governor. Where this is unsuccessful due to problems with power imbalance or local prison culture, healthcare leaders should be empowered to escalate concerns to NHS commissioners who will raise this with the prison group director.

Lived experience: the importance of effective leadership

Healthcare provider reflected on the importance of effective communication and leadership.

“One of the key things that makes a better environment in a prison is communication and it varies hugely on governors. I’ve been here for a while, so we’ve had a lot of governors. I mean, I’ve had 3 different healthcare providers and the level of communication makes a huge difference to how well we work into together as a team. At the minute we’ve got some fabulous governors, and they speak to me. They’re, ‘Oh, could we catch up about so and so?’. We catch up and we do MDTs, and we probably end up doing MDTs about different people a good few times a month, just so that we’re all singing from the same hymn sheet...” (advanced clinical practitioner – complex care lead’)

Current workforce and partnership working to support prison leavers

Leaving prison is a time of high risk, loss of structure, instability of accommodation and new demands on people. There are many challenges with access to healthcare for people in inclusion health groups that are described in chapter 16. In addition to statutory services, peer support models and VCSE sector are particularly important in providing care and continuity during this time.

RECONNECT and Enhanced RECONNECT services support integration between health and community justice for continuity of care on leaving prison. The service is provided by peer support workers, psychologists, social workers, and substance misuse workers. Prison healthcare teams are required to support continuity of care post release and some have employed medical or primary care liaison roles to ensure continuity. This is especially important for people with complex multimorbidity, life-limiting illnesses (for example cancer), or conditions requiring ongoing specialist treatment or medicines support such as HIV or Hepatitis C.

HMPPS Health and Justice partnership co-ordinators ensure continuity of care for substance misuse from prison to probation by collaborating with health and substance treatment services. They aim to improve care pathways for people leaving prison and promote engagement with community services. Additionally, they serve as probation contacts for NHS healthcare providers. Community drug and alcohol practitioners offer outreach services to probation delivery units and community hubs. Effective joint working examples include collaboration between probation delivery unit peer link workers, drug and alcohol treatment providers and RECONNECT services to provide advocacy, liaison, and attendance at health appointments.

Joint working to provide continuity of care for substance misuse services is more established than for mental health or physical health. Chapters 8 and 15 on mental health and prison leavers

describe the importance of continuity for mental and physical health. While there are positive practice examples, such as East of England probation office working in partnership with their ICB to commission a pilot on-site mental health support for the approved premises in Bedford, this is often challenged by short-term funding. One team described having had to apply 4 times for year-on-year funding. They identified the challenge of trying to build a good team with short-term funding. It was also suggested that this could replicate the experience of being 'let down by the system' for patients in inclusion health groups, who have often had a poor experience of health services.

Summary: a health and care workforce for the future criminal justice population

In summary, there is a need for improved integration of care across prisons and regions. This requires better data integration and analysis, integration of health and justice leaders into ICBs and use of health and justice population data and workforce profiling to support strategic workforce planning. There is a need for improved workforce wellbeing through improved working conditions, training opportunities to develop an inclusion health workforce, recognition as inclusion health specialists, flexible and portfolio working opportunities within neighbourhood health systems and ICBs, reflective supervision and restorative practice. The role of HMPPS and governors to enable this is vital. Further principles for these points are described in the appendix.

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18 Health research with people in prison and on probation in England

Authors: Dr Nathan Newbould, Dr Callum Campbell

Contributors: Professor Emma Plugge, Dr Donna Arrondelle, Dr Thomas Munday, Enrique Cadenas, Kelsy Dyer, Jacob Jeffrey, Amy Summerfield, Karen Morgan, Nita Bhupal, Giles Stephenson, Martin Fisher, Sehrish Khalil, Alison Tingle, Professor Kathryn Oliver, Dr Mario Moroso, Donna Gipson

Introduction

Health research plays a vital role in directing health policy by providing robust evidence-based insights to government policy makers. It informs decisions about what health services are provided and where, as well as how much funding should be made available. Therefore, it directly impacts the care and treatment that individuals receive as well as the healthcare system as a whole.

Health research is conducted by a range of organisations, including universities, research institutes, public health bodies and the NHS. Much of this research is funded and co-ordinated by government backed bodies such as the National Institute for Health and Care Research (NIHR) and UK Research and Innovation (UKRI). There is a 2-way relationship between health research and policymaking: the findings from health research can influence the design of health policy, while evidence gaps identified by policymakers can lead to the commissioning of targeted studies, through direct collaboration with researchers or by making targeted funding available.

Research with people in prison and on probation

Conducting health research with inclusion groups (such as people in prison and on probation) is crucial to identify their unique health needs and any barriers that stop them from accessing and benefitting from care. For many, prison may be the only point at which their health needs could be systematically assessed and addressed, making it a critical window for prevention, early intervention and long-term health improvement. Research focused on the health of people in prison and on probation can identify more effective healthcare solutions and support rehabilitation and reintegration into society.

Conducting health research with people in prison and on probation can present more challenges than when conducting similar research with the general population. This results in less research being done with these populations, which is a barrier to understanding what interventions are needed to meet their health needs and improve their outcomes. Additional

challenges include the need to engage with (and gain approval from) both health and justice organisations before conducting and delivering research, as well as challenges in delivering research in busy justice environments, where access to potential participants and information is often limited by complex security and data protection arrangements.

This chapter seeks to build a picture of the current state of health research conducted by independent researchers (for example, those outside of government departments) with people in prison and on probation, the unique challenges of conducting such research and steps that could be taken to facilitate more health research with these populations. It starts with a review of health research conducted with people in prison and on probation over the last 10 years, to help us understand if there are any important gaps that need to be addressed. It then explores some of the challenges and facilitators of conducting health research with these populations, by considering perspectives of independent researchers and organisations who enable health research with people in prison and on probation. Finally, this chapter presents some high-level recommendations that aim to increase the quantity, quality and impact of health research with people in prison and on probation. As findings and insights emerged, they were shared with a lived experience expert, whose perspectives are quoted throughout the chapter. Definitions, methods and limitations are recorded in the appendix.

This work was conducted on behalf of the Chief Medical Officer for England by the Ministry of Justice (MoJ) Science Office. Collaborators at the University of Southampton informed the development of the survey and conducted the content analysis of the survey results.

Recent health research conducted with people in prison and on probation

We reviewed 6 databases to identify health research projects involving people in prison and on probation in England that were approved between 2015 and 2024. This included projects delivered in adult establishments as well as in the children and young people secure estate. We defined ‘health research’ as any study involving the systematic collection or analysis of data from a population to determine the causes of ill health, health and social care needs, effectiveness of new treatments, or how existing treatments are best implemented (see appendix for full definitions). We included projects that were led by independent researchers (who work outside of government departments or their agencies) in our review, including those working in universities, the NHS, private companies and charities. While MoJ and HM Prison and Probation Service (HMPPS) staff also conduct health research with people in prison and on probation, the focus is predominantly on forensic psychology and service evaluation. These projects were not included in this review, as challenges (such as funding and access) are likely to be notably different.

The 6 databases reviewed included 2 from national funding bodies and 4 from MoJ and its agencies. The databases reviewed are listed below.

Funding bodies:

- National Institute for Health and Care Research (NIHR)
- UK Research and Innovation (UKRI)

MoJ and its agencies:

- National Research Committee (NRC), an approval body which considers all applications to conduct research within HM Prison and Probation Service (HMPPS)
- Data Access Panel (DAP), an approval body which considers applications for access to data from the HM Courts and Tribunals Service (HMCTS)
- MoJ internal research and evaluation database (RED), recently implemented by MoJ to record research conducted across the justice estate
- Data First, a data-linking and research programme that makes data available for external accredited researchers to access¹

Given that databases of both funding bodies and approval bodies will be considered in this chapter, the term ‘approval’ is used to refer to research projects that have either received approval for funding (as is the case for those identified from NIHR and UKRI databases) and/or received approval to access the justice estate and/or data (as is the case for those identified from DAP, NRC and RED databases). Duplicate entries within and between databases were identified to prevent double counting. No relevant projects were identified from Data First database, which was unsurprising given its focus on justice data rather than health data.

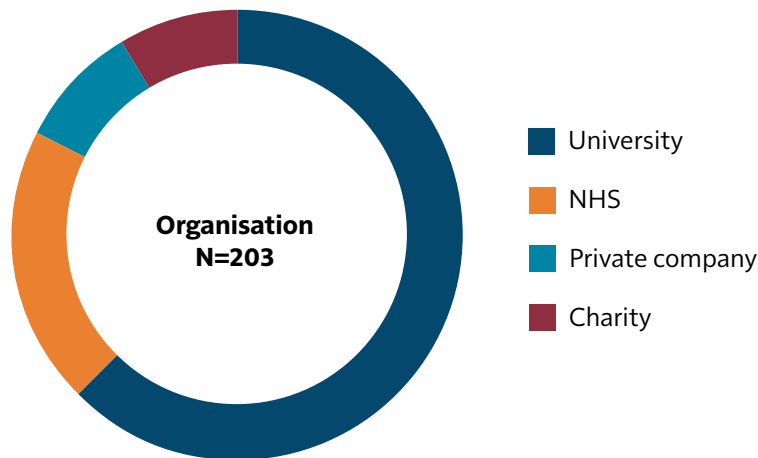
Current research: who, where and what topics

Over a 10-year period, between 2015 and 2024, a total of 203 health research projects with people in prison and on probation received approval from NIHR, UKRI and/or MoJ and its agencies. The number per year varied between 12 and 27. By contrast, in just the 2023 to 2024 financial year, NIHR Clinical Research Network alone supported over 6,000 studies with the general population in England².

Figure 1 shows the organisation in which the lead research applicant was based. Most of the research projects were led by university academics (63%), followed by NHS staff (20%), private companies (9%) and charities (8%). Figure 2 shows the criminal justice setting in which the research took place. Most health research was conducted in prisons (78%), compared to 13% in probation services, 3% spanning both settings and 4% in the children and young people secure estate. The low number of probation focused studies was surprising, given that there are nearly 3 times more people on probation than in prison³.

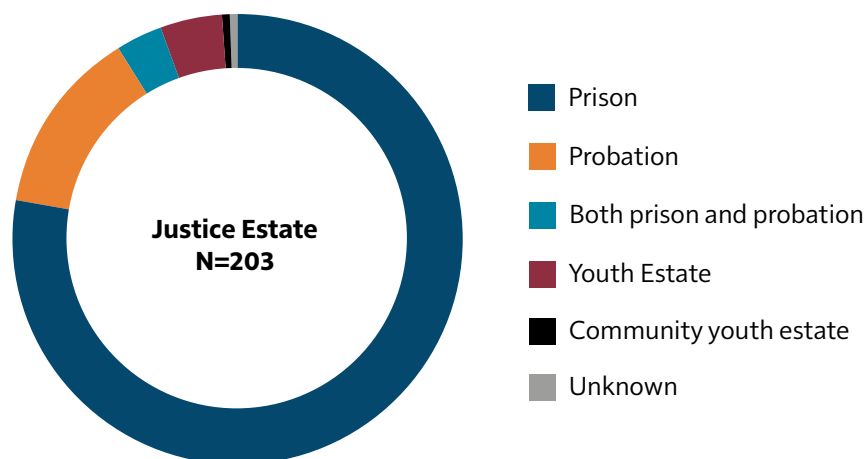
Figure 3 shows the sex of the research participants. Of the 126 projects where the sex of participants was stated, 51% were with males, 16% females and 33% of projects included both males and females.

Figure 1: organisation of lead applicant in research projects conducted with people in prison and on probation in England between 2015 and 2024



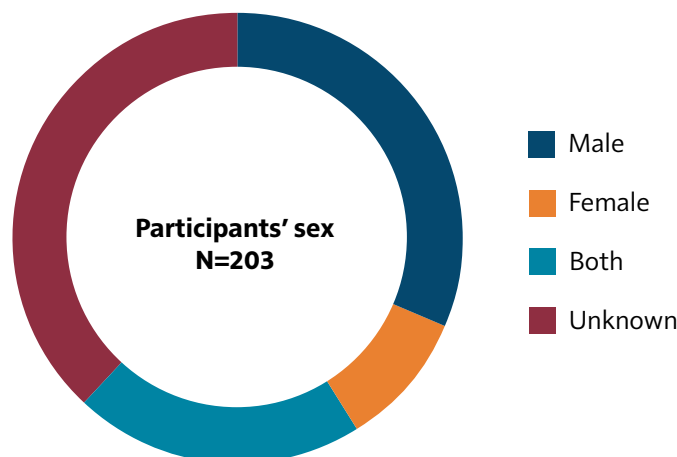
Source: database review undertaken for this chapter

Figure 2: criminal justice setting of research projects conducted with people in prison and on probation in England between 2015 and 2024



Source: database review undertaken for this chapter

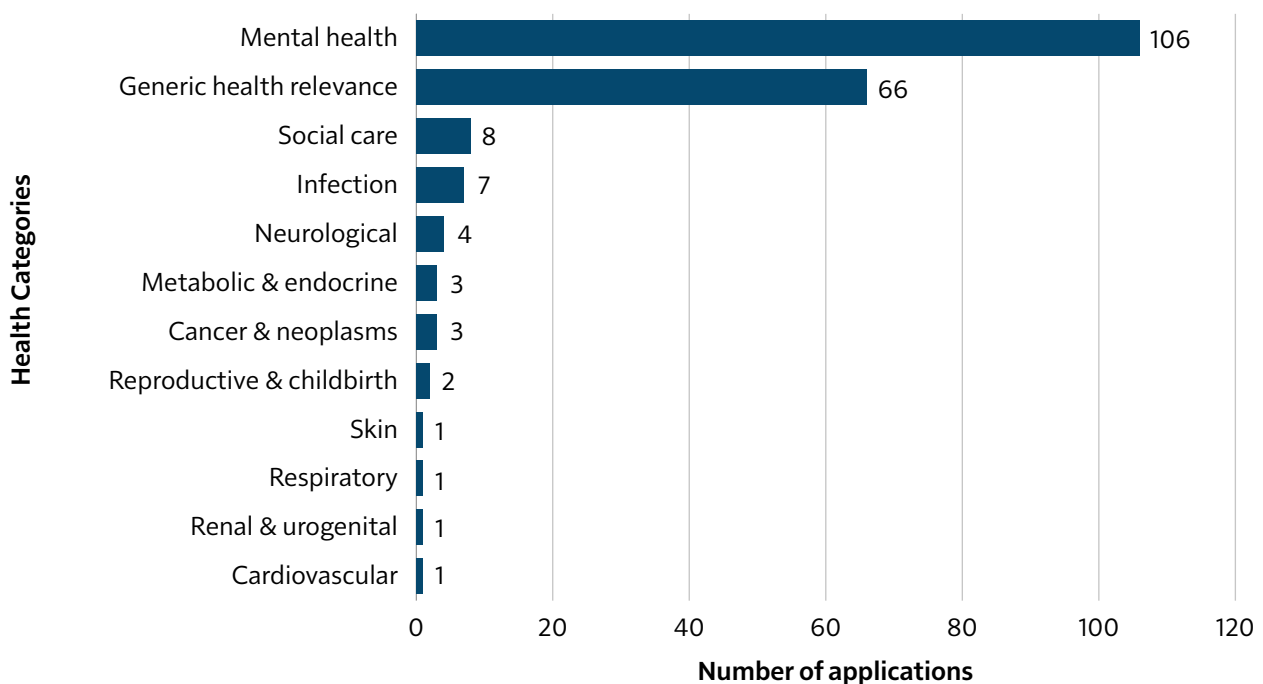
Figure 3: sex of participants in research projects conducted with people in prison and on probation in England between 2015 and 2024



Source: database review undertaken for this chapter

We assigned each project a health category based on UK Clinical Research Collaboration's health research classification system⁴ with the addition of our own 'social care' category. The results are shown in figure 4. Over half (52%) of the approved projects focused on mental health and of these, 27% focused on self-harm and suicide while 14% focused on substance use and recovery. Thirty-three percent of projects focused on topics of generic health relevance, which were mostly concerned with improving healthcare services in prisons. Only 4% of projects focused on social care and very few targeted specific areas of health. From the past 10 years, only 3 projects were identified that focused on cancer and only one focused on cardiovascular disease. This is surprising, given that the leading causes of natural death in prisons are understood to be cancer and cardiovascular disease⁵. These (and other specific areas of physical health) are commonly investigated in the general population⁶, suggesting that there is a dearth of research focused on specific physical health conditions with people in prison and on probation. Given that the approach to screening, diagnosis and treatment of such conditions will likely differ in prisons, this area should be subject to a greater research focus.

Figure 4: the health category of study of research projects conducted with people in prison and on probation in England between 2015 and 2024



Source: database review undertaken for this chapter

Who funded the research and how much was spent

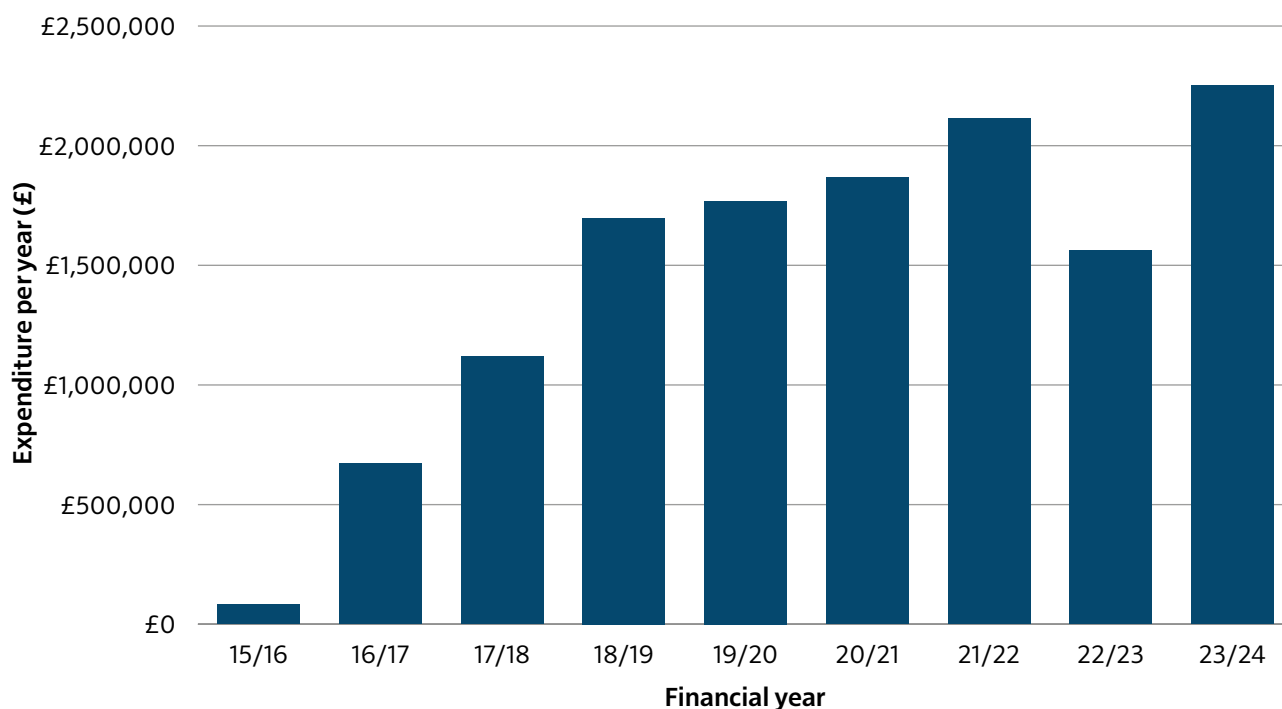
We were unable to identify the funder in 46% of the projects and the funding amount in 53%. The NIHR and UKRI databases list this information for each project while those of the MoJ and its agencies do not. This limits how far we can interpret spending patterns.

The NIHR was the leading source of funding (38%) among the projects where funders were identified. UKRI funded 14%, followed by the MoJ and HMPPS (12%) and the NHS (10%). Of the projects where the funding amount was identified, 64% were for less than £300,000 and 9%

received large grants of between £1 million and £3 million. These amounts represent funding for the whole lifetime of projects. These figures must be taken as an approximation only, given that the costs of over 50% of the included projects are unknown.

The NIHR provided us with details of their expenditure (money that was spent) per financial year on health research projects with people in prison and on probation (included in this review) and their overall spend on health research programs in general (excluding investment into expertise, facilities, research delivery support and training). Figure 5 shows that the NIHR increased the total value of its expenditure on research with people in prison and on probation between 2015 and 2024. A total of £82,320 was spent on such research (0.03% of the NIHR's total research expenditure) in the 2015 to 2016 financial year and this figure had risen to £2,251,661 (0.45% of the NIHR total research expenditure) by the 2023 to 2024 financial year. It was not possible to access similar data for other funders within the timeframe of this review.

Figure 5: expenditure on health research with people in prison and on probation in England by the NIHR per financial year from 2015 to 2024



Source: data provided by NIHR for the purpose of this report

To put these figures into context, the total value of NIHR expenditure on health research with people in prison and on probation in the 2023 to 2024 financial year equates to approximately £7.34 per member of this population. This compares to approximately £7.30 per member of the general population for the rest of the NIHR's expenditure on health research in the same year (please see the appendix for calculations). While approximately the same amount is spent per person in prison and on probation, it should be noted that delivering research in these settings is more costly (for reasons discussed in the following section). As such, less research is delivered for the same amount of money. Also, people in prison generally have much poorer health than the general population (dying on average 25 years earlier⁷), so it is reasonable to expect that more should be spent per person on investigating their health needs and how these can be met.

However, interpretation of these figures is difficult as the comparison is only approximate and does not take into account the benefit people in prison and probation may gain from research conducted with the general population.

Researcher and organisation perspectives

Engaging with health researchers and representatives of organisations who enable their research (such as government departments, healthcare providers and research funders) can provide insight into what helps and hinders health research with people in prison and on probation. Understanding the perspectives and needs of these groups can help us identify realistic steps that could be taken to make the delivery of health research projects with these populations easier. This in turn could lead to a higher volume and better targeting of health research with a greater impact on health policy and practice for these populations.

We conducted an online survey of independent researchers who had experience with planning and/or conducting health research with people in prison and on probation. This included researchers based in:

- universities
- the NHS
- private companies
- charities
- social enterprises

We sought views on what facilitated health research with people in prison and on probation, what challenges the researchers associated with delivering health research with these populations and what improvements they thought could make delivering health research in justice settings easier. The survey was sent to over 50 individual researchers along with several academic and clinical organisations, with a request to pass the survey on to relevant colleagues. Ninety-four responses were received. As the respondents self-selected, we cannot comment on whether the responses are representative of all independent health researchers working in prison and probation settings. It should also be noted that the survey was prepared and circulated by an MoJ team, which may make the responses more likely to lean towards MoJ and HMPPS processes. Further details of the survey methods, questions, results of survey tools and limitations are presented in the appendix.

The responses from the survey were analysed and the key points shared with representatives from organisations who enable health research in prison and probation settings. These organisations included:

- MoJ and HMPPS
- NHS England and the UK Health Security Agency (who use findings from independent health research to inform decision-making)

- the NIHR and UKRI (who organise and fund independent health research)

After circulating the survey findings, the representatives were invited to a workshop to discuss them and to consider whether any steps could be taken to ease any of the challenges raised by the researchers. The list of organisations represented at the workshop was not exhaustive and follow-up engagement was conducted with the Health Research Authority (HRA; part of the NHS). The full list of organisations we consulted can be found in the appendix. The sections below provide an overview of the prominent themes that came out of the survey responses, along with relevant points that were shared during the workshop and during follow-up discussions with the organisational representatives.

There were 5 main themes identified by the survey that are further explored below:

- processes for gaining approvals to conduct research
- gaining access to health and justice data
- gaining access to the justice estate and working with justice staff
- engaging with people in prison and on probation
- funding health research with people in prison

Gaining approvals to conduct research

The key points raised by survey respondents in relation to applying for the approvals they need to access prisons and probation settings included:

- there are challenges of navigating multiple research and ethical approval processes across different organisations
- people who have been in prison or on probation and people who have conducted relevant research should be included in decision-making panels

Survey respondents reported that they must give the same information on different forms to different organisations when applying for research and/or ethical approvals (such as HMPPS, the NHS, the Home Office and universities). Some respondents put forward that there is a lack of transparency regarding these processes and that they are too time-consuming, leading to significant delays (and sometimes abandonment) of research projects. Some respondents suggested there should be one application form to apply for approvals across multiple organisations. They would also like guidance to be improved with clear information on expected timelines and to receive progress updates. Some respondents suggested that contact details for relevant staff should be made available to help them navigate the process. Some respondents suggested including people with lived experience with research would increase understanding of the unique challenges in justice-based health research and improve the decision-making process.

In relation to the above points, organisational representatives raised that:

- there is a clear need for thorough and robust research approval processes

- there is a single application form across HMPPS and the NHS for those wishing to conduct health research with people in prison and on probation
- the HRA and MoJ already provide guidance and support to navigate the IRAS application process

While acknowledging that there are challenges in the system and improvements that need to be made, organisational representatives explained that approval processes are important to ensure that participants, staff and the researchers themselves are properly safeguarded. Research approval processes also ensure that any additional demand on prison or probation resources is manageable. The integrated research application system (IRAS, owned and administered by the HRA) enables researchers to submit a single form to both NHS and HMPPS approval panels. IRAS is currently being reviewed and redesigned with the aim of streamlining the process, making it more user friendly and improving the available information for applicants. There is guidance on navigating the NRC process on the 'Research at HMPPS' gov.uk webpage⁸. This includes information on how to submit an NRC application, the IRAS process for health-related research and directs enquiries to an NRC email address. The IRAS website also has guidance specific to HMPPS-related application questions⁹. However, representatives acknowledged that some of this guidance may not be easy for external researchers to find.

Gaining access to health and justice data

The main points raised by survey respondents in relation to applying for and using data was that obtaining existing data about people in prison and on probation from health and justice organisations can be challenging. Having access to and being able to link health and justice data stored across multiple platforms is crucial for data-based health research projects. However, respondents reported variability in data availability and quality, as well as complex governance rules that make it difficult or even impossible to obtain and link the information they need.

In relation to the above points, organisational representatives raised that the data required to conduct health-justice research spans across organisational boundaries (including the MoJ, Home Office and NHS). Accessing such data requires separate applications and governance arrangements. Even once data from the MoJ, Home Office and NHS is accessed, it may be difficult to join up individuals' data to form conclusions as there is a need to anonymise data to protect the privacy of individuals. More details can be found in chapter 7.

Gaining access to the justice estate and working with justice staff

The main points raised by survey respondents relating to gaining access to prison and probation settings and working with justice staff included:

- gaining entry to prisons and other parts of the justice estate can be challenging, even with research approvals in place
- it can be difficult to get people who work in the justice system to support the health research process

Some respondents also reported difficulties accessing private interview spaces in the field when conducting research and that daily time on site to collect data is often restricted for operational reasons. Such challenges contributed to delays and increased costs.

Some respondents reported difficulties in gaining buy-in from staff of all levels, which they believed was due to operational pressures and a lack of understanding of how health research is conducted and its value. However, there were several points raised by respondents which they indicated reduces this barrier. This included early engagement with prison governors and front-line teams, identifying HMPPS staff who have clear responsibilities for and/or an interest in supporting health research and having people with prior experience of working in the justice system on the research team.

In relation to the above points, organisational representatives raised that:

- frontline leaders in the prison and probation services will always have to prioritise operational needs and safety above research
- HMPPS Psychology Services Group (PSG) staff can offer advice and guidance in respect of research projects

Even once a project gains approval through IRAS, prison governors may have to deny access due to concerns about resource constraints and the impact on the safety of people in prison. This could also be the case for probation settings. Organisational representatives emphasised the importance of researchers understanding the pressures and challenges encountered daily by frontline operational staff and that these factors can contribute to delays. This may require flexibility in the duration and running of projects.

Nominated HMPPS PSG team members can support certain aspects of the conduct of research in prison and potentially probation settings. This includes signposting researchers to relevant HMPPS teams and liaising with governors and other prison staff. While this support is not currently explicitly stated in externally available guidance, researchers can contact PSG team members via the NRC's email address to find out what advice, guidance and support is available for their projects¹⁰.

Engaging with people in prison and on probation

The survey respondents' main point was embedding people with lived experience into research teams provides invaluable perspectives and expertise. Some respondents stated that drawing on the expertise of people with experience of being in prison can improve the quality of the research.

Lived experience: involving people with lived experience in research

There are very valid and ethical reasons to involve people with lived experience throughout the research process. Good practice would be to include people with lived experience in the:

- design of research
- delivery of research
- development of research outputs
- dissemination of learning
- decision making panels

“Health research in prison and probation needs to consider the trauma that these populations experience... what it feels like to be a participant in research, ethical and trauma informed approaches and the... safeguarding of researchers but particularly participants.”

Ethical delivery of research in prison helps overcome these barriers also. It is important that consent forms and information sheets are as simple as possible and written in plain English. Researchers should always ‘close the loop’ back to participants to show them how their contributions have been used. Additional care is required to consider recruitment of participants, given the power imbalance between prisoners and operational staff, and risk of ‘cherry picking’ of participants. There are processes in place within the NRC to review recruitment plans and information sheets to try and mitigate this.

Patient and public engagement is very central to research prioritisation and design. We should try to replicate involvement of patients and public in prison and on probation, in the same way that we do other cohorts of the population. Wherever possible, people with lived experience should be involved in the prioritisation and planning of research.

In relation to the above point, organisational representatives raised that:

- a lack of trust may prevent people in prison and probation participating in health research
- there are more barriers to engaging people on probation in research than those in prison

A lack of trust may be particularly true for children, young people and adults in custodial settings as many of them have experienced very difficult circumstances compared to their peers in the general population. They suggested that this could be overcome by involving lived experience and advocacy organisations in the research process.

People in prison are physically available and so are relatively easier to engage in research than those on probation, who may be hard to identify in community health services. They explained that this is important because people on probation are generally underserved by healthcare.

It is also vitally important that people engaged with research give informed consent to do so, this should consider the literacy and understanding of the participant to consent and appropriate ways to convey this information.

Funding health research with people in prison and on probation

The survey respondents' main point was that dedicated funding programmes are needed which recognise the unique challenges of conducting health research with people in prison and on probation. Some respondents recommended creating dedicated funding programmes that focus on the health of people in prison and on probation and account for the higher costs and potentially time associated with conducting research in justice settings.

In relation to the above points, organisational representatives raised that the funding needs of health research with people in prison and on probation are greater compared to equivalent projects with the general population. Organisational representatives recognised that health research in prison and with people on probation in the community requires additional resources compared to similar projects with the general population, due to the need to gain research approvals from multiple organisations and the need to arrange access to the justice estate.

Recommendations

Recommendations are set out below which aim to increase the quantity, quality and impact of independent health research with people in prison and on probation. They have been informed by the findings from the database review, as well as the insights we gained from engaging independent researchers and organisations who enable health research with these populations. These recommendations are intentionally broad and high-level and should be seen as a starting point from which more definitive actions could be developed.

Policymaking organisations and funders should adopt a joined-up approach to agreeing and promoting shared health research priorities

Our review suggests there are gaps in research, especially around physical health, people on probation and children and young people. Building upon the MoJ's 'Areas of research interest' document¹¹, government departments, funding bodies, the NHS, researchers, frontline justice staff and people with lived experience should work together to agree on priority areas. A formal working group led by the Department of Health and Social Care (DHSC) and MoJ could co-ordinate this work and connect agreed priorities to NIHR research programmes (including public health, evidence synthesis and policy research). This joined-up approach would help focus research on real-world needs, such as understudied physical health issues like cancer and heart disease and could help ensure that people on probation are included in community-based studies.

Research infrastructure, such as a researcher network and/or online research directory, should be assessed for feasibility

Our engagement highlighted the benefit of peer support when scoping and planning health research projects with people in prison and on probation. To enable this, a dedicated online network would help researchers share advice, funding opportunities and practical tips on navigating approvals. Alongside this, a live directory listing ongoing and completed research would make it easier for policymakers, funders and researchers to learn from past work, spot gaps and avoid duplication. Such initiatives could be established as part of the work on shared research priorities (see above), improving collaboration and supporting research into both mental and physical health in justice settings. The Worldwide Prison Health Research and Engagement Network (WEPHREN), run by the UK Health Security Agency, provides a good example¹².

Make research approval processes simpler and provide clear, accessible guidance for researchers

Research in justice settings is often delayed by complex and overlapping approval systems needed for access to participants and data. Organisations involved (including the HRA, MoJ, HMPPS, Home Office and universities) should review their processes to reduce duplication, aligning with the work the HRA have already started to review the IRAS process. At the same time, they should ensure that guidance for independent researchers is clear and accessible, providing step-by-step instructions, timelines and contact points for support.

Make it easier to access and link data across organisations

Health research is often slowed down by difficulties in accessing data. Justice and health organisations should work together to explore simpler, joined-up systems for data access and linkage, such as shared application forms (like the IRAS form for in-person research) or a common identifier for people in the system. More details regarding these matters can be found in chapter 7, 'Data and information sharing in the criminal justice system'.

The additional costs of delivering health research with people in prison and on probation should be considered when targeted funding is offered

Research in prisons and probation settings takes longer and faces more hurdles than similar research with the general population. Funders should offer dedicated funding that recognises these unique challenges. This should include flexible timelines, extra support for gaining approvals and lived experience involvement and specific calls for under-researched topics like physical health. Funders should also better promote the help they already offer researchers applying for funding, such as application support services and funds.

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