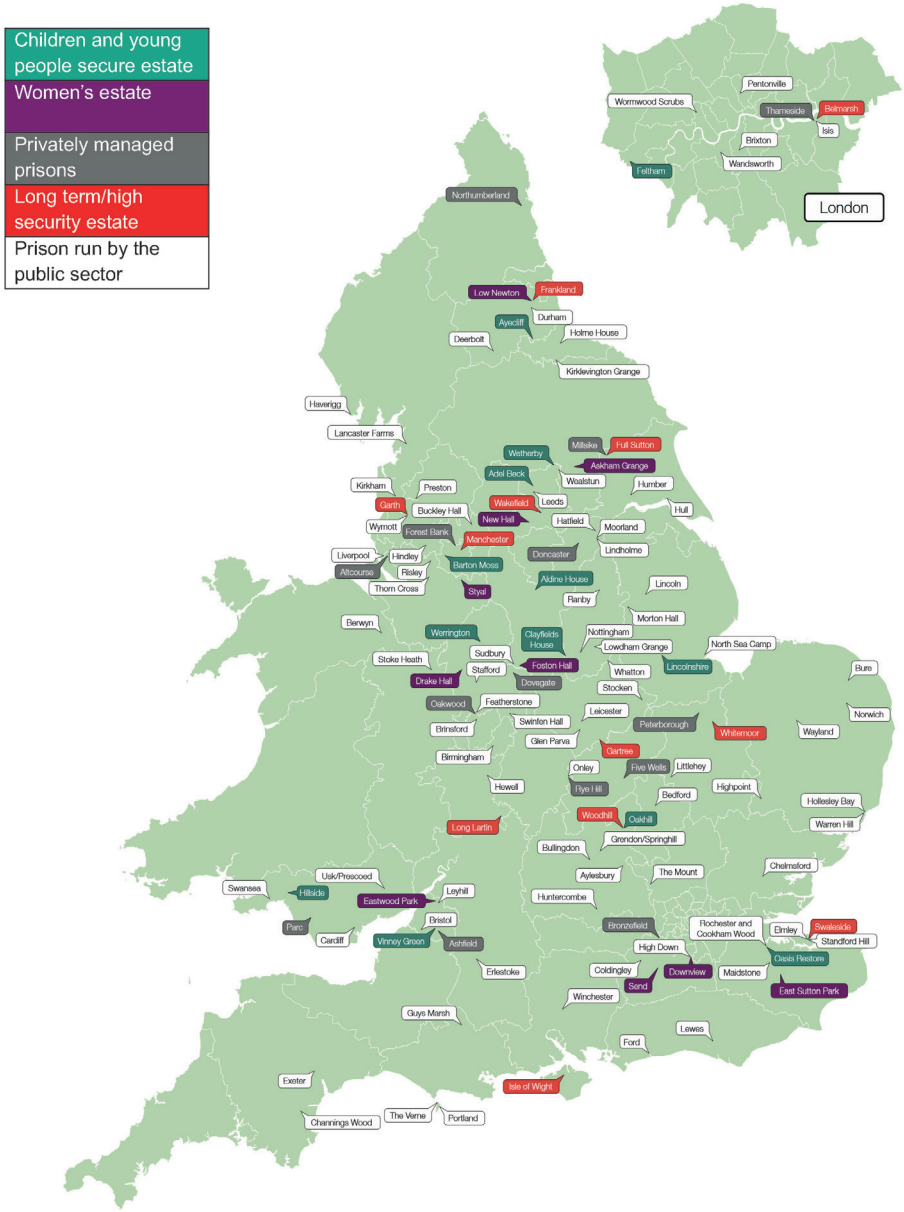
The health of people in prison, on probation and in the secure NHS estate in England

Executive summary



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 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 are 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.

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 recommendations[1]. 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 healthcare[2]. 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 historical and current prison health and care

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 and families

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 – Prison leavers

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 prison. 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 baby. 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 difficulties 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 health. 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 2024.

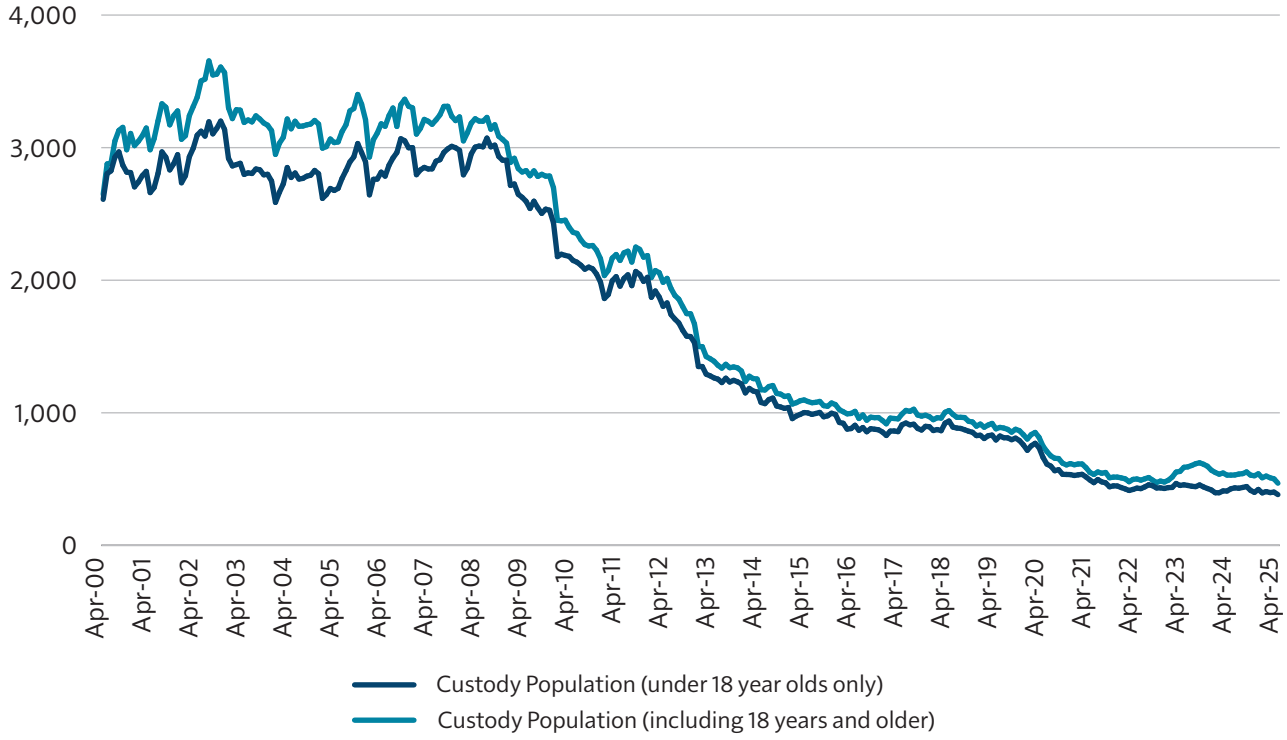
Three main challenges we identified which can be improved are:

- 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 data

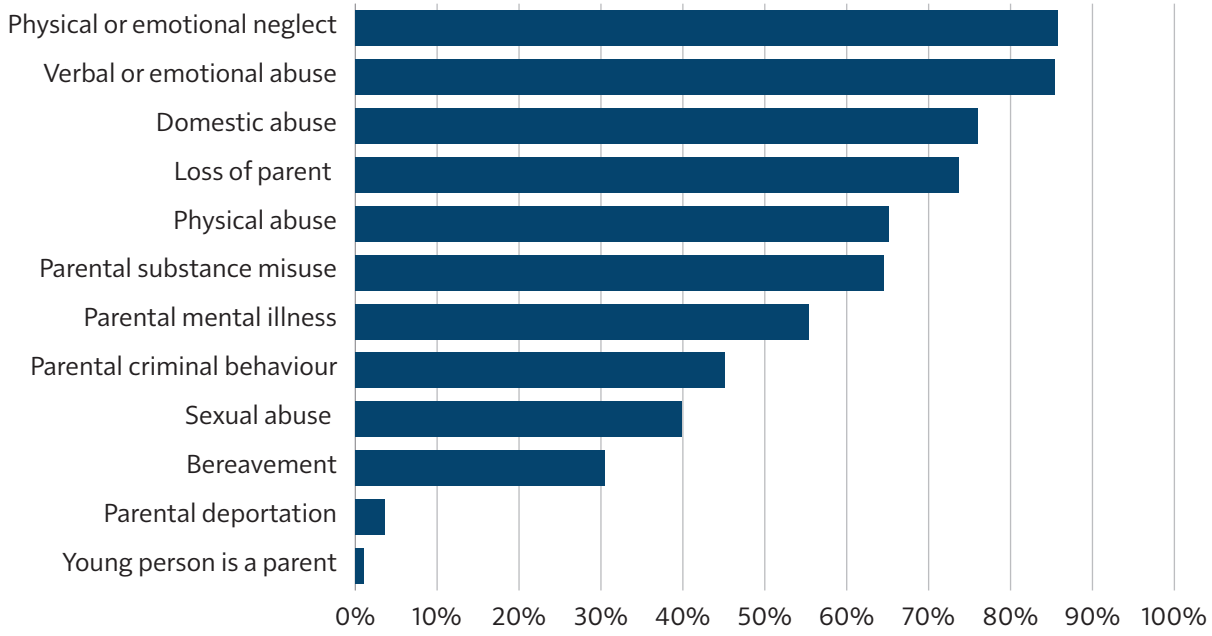
As figure 1 shows, 383 children aged under 18 were accommodated in April 2025, down from a peak of 3,145 children in July 2002.

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 Child Experiences (ACEs) 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 grounds. 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 prison. 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 abuse and over half experiencing emotional, physical or sexual abuse as a child. 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 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.

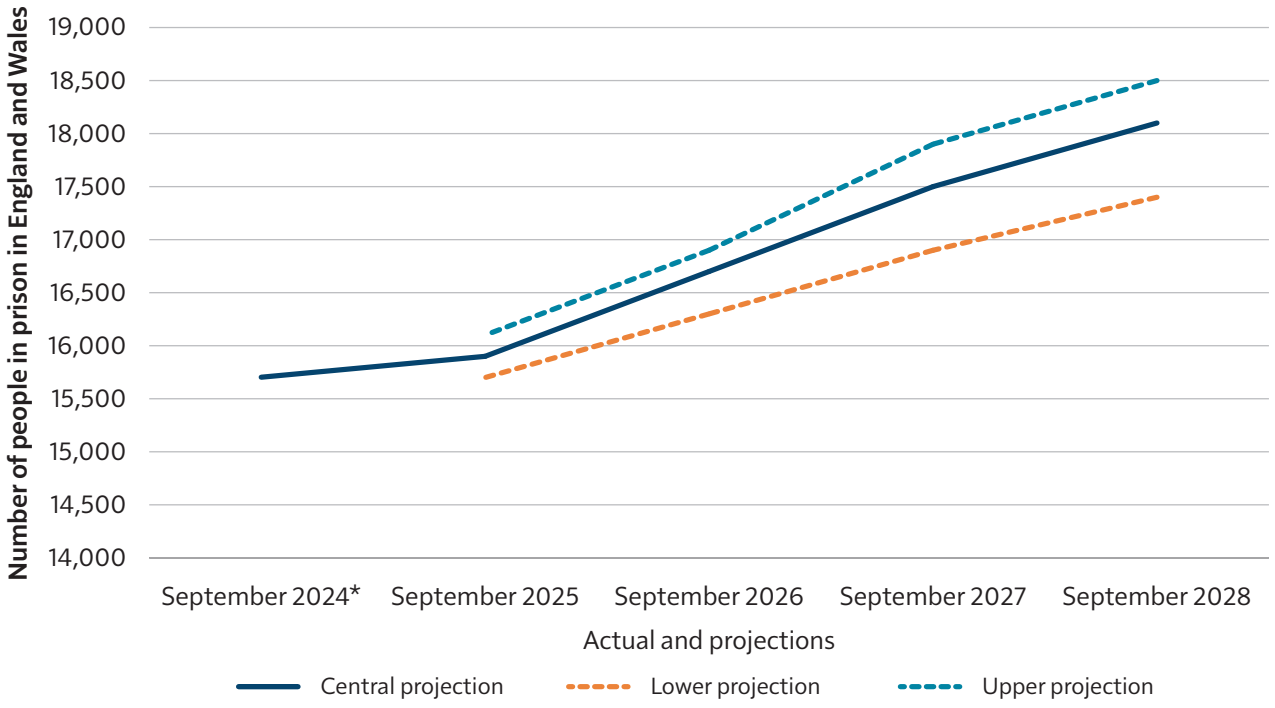
There are further opportunities to ensure this good practice is shared and supported at a regional and national level, building upon the integrated pathways of care that have been developed for women's health hubs. The 2025 government commitment to neighbourhood

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 2024.

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 2024

Figure 3 shows that a further 15% rise in the older prison population is projected by 2028. 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. 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 frailty, much higher than the general population. Frailty can affect ability to climb stairs, wash independently and walk unaided. 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 intervals. 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 nationally used 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.

Data and information sharing

Health data are 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 'siloed' 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.

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 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.

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 population. 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 release. Similarly, improving mental health after release from prison reduces reoffending.

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 days. 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-offending. 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.

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.

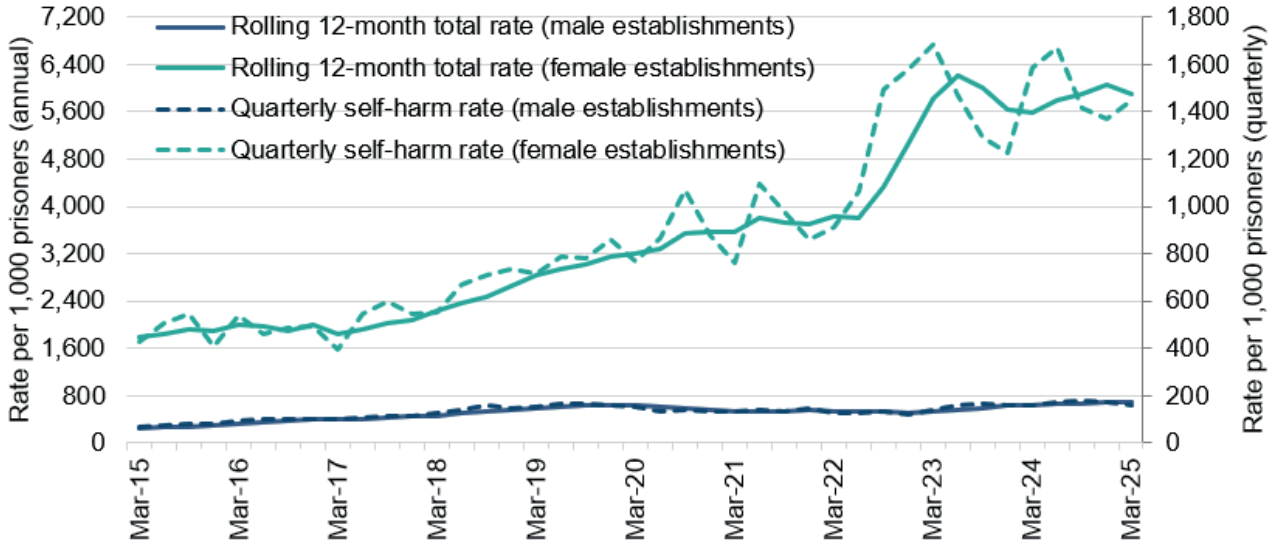
For many, where the appropriate awareness and needs-based support is provided by all agencies within a prison, or reasonable adjustments for people on probation, this lack of diagnosis does not significantly reduce their ability to engage with justice and healthcare systems. However, for others, this 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

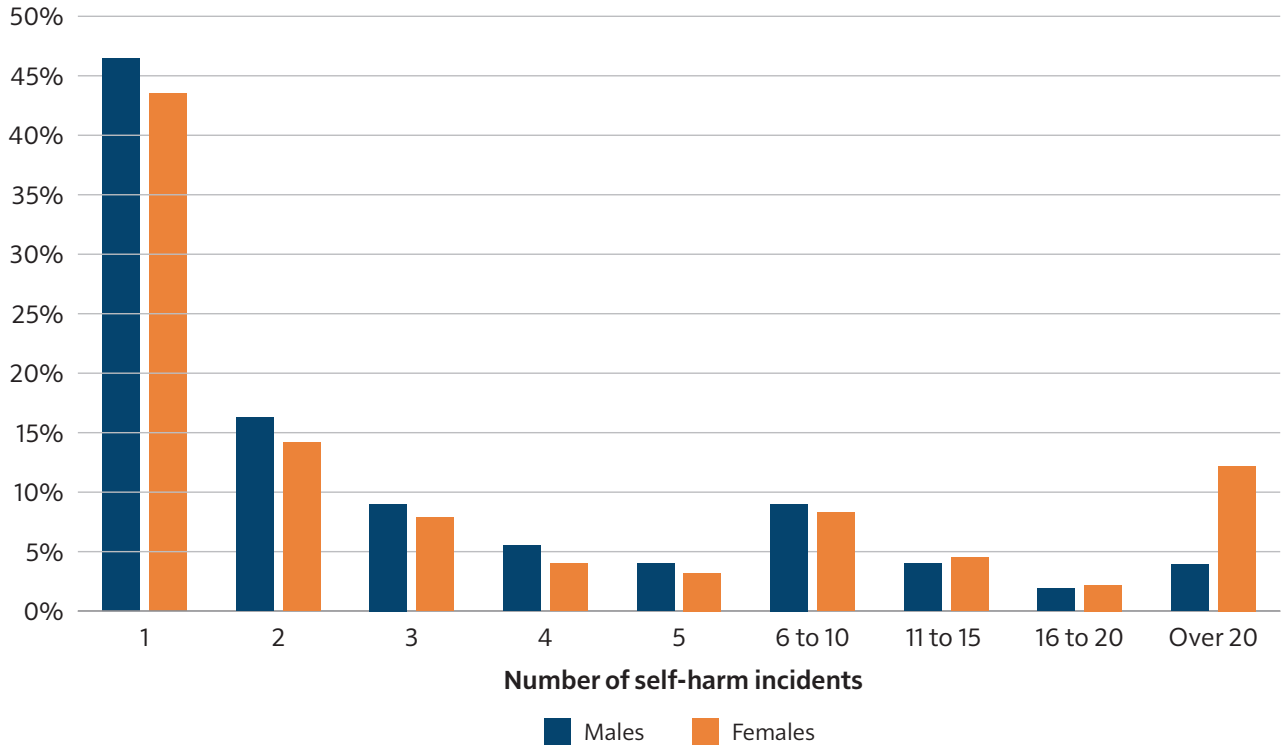


Source: Ministry of Justice

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 Justice

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 prison. 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-harm 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 prison. People in prison on remand have higher rates of self-inflicted deaths than those sentenced.

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 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.

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).

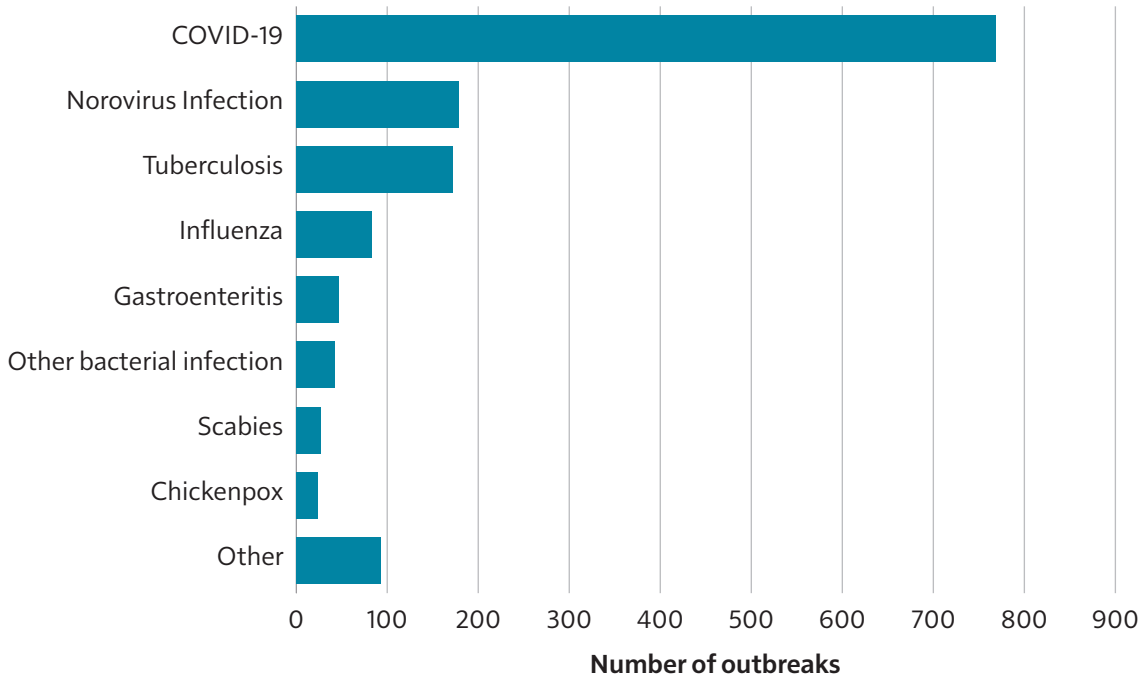
Prisons can present an opportunity to improve future health outcomes, such as:

- 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. 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.

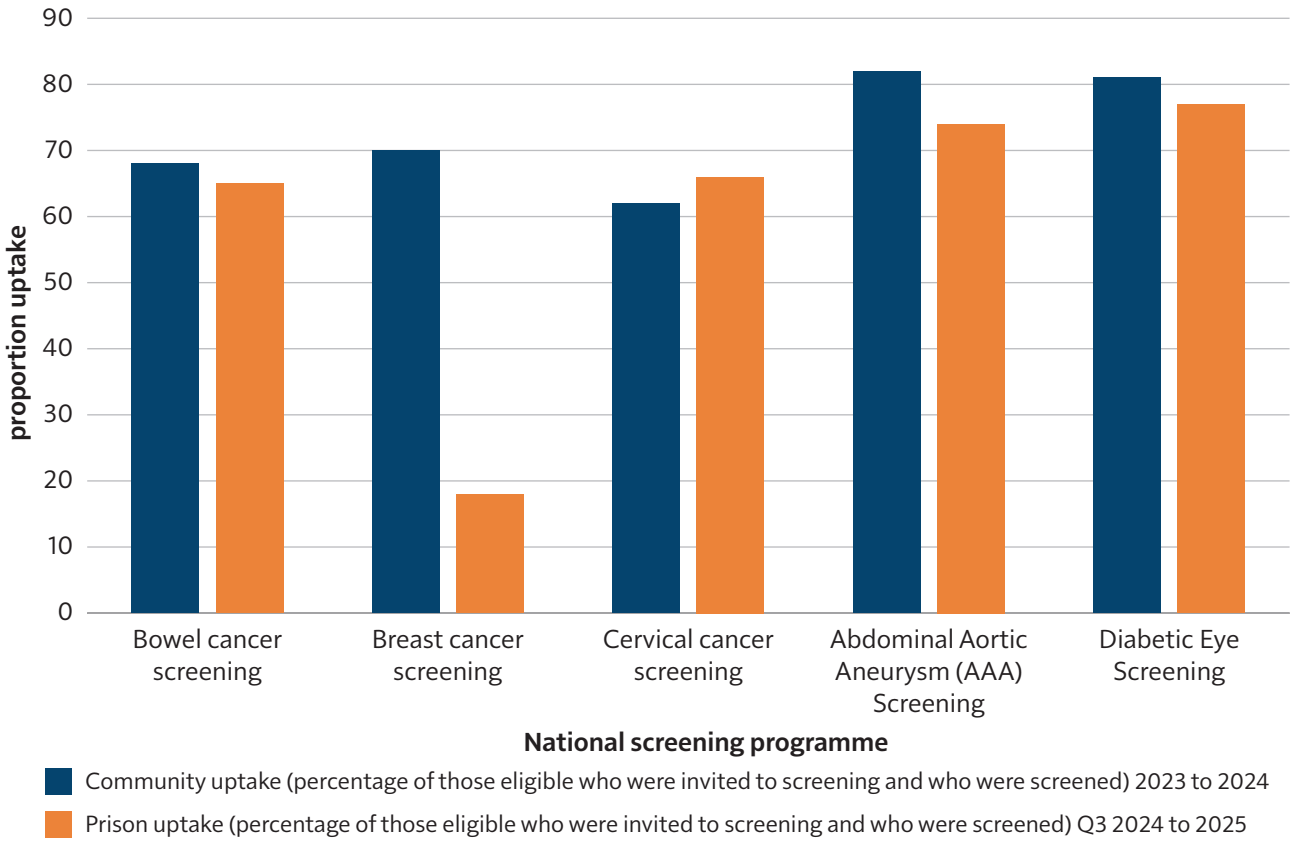
The role of probation settings in supporting health protection initiatives is currently less well defined. There are some examples of good practice such as bloodborne virus testing in some probation services but probation staff report there are limited routine procedures for managing infectious diseases 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 population. 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. 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%, 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 no support to stop vaping in prisons. International evidence suggests that most prior smokers return to smoking on leaving a smoke-free prison. 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 prison, 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

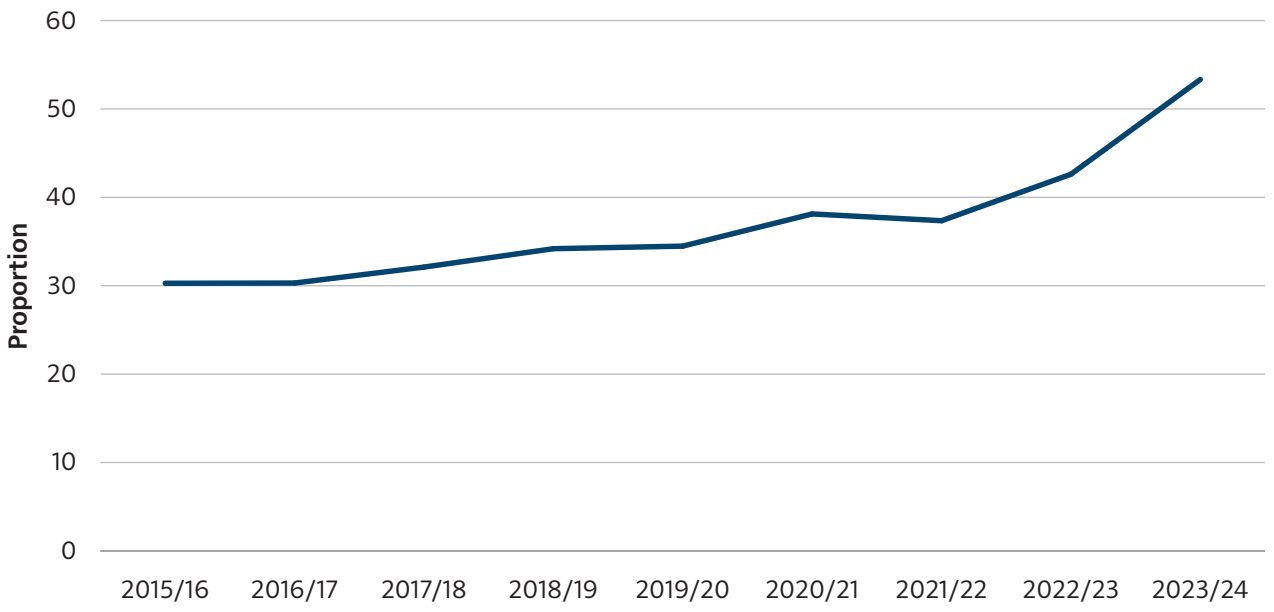
In 2024 57,277 people were released from custody. There are many factors that have an impact on subsequent health on release from prison, including:

- 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 years. 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 2020. 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 2024



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 providers. 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 complex. 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 appointments. 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 prisons – 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 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 practice. 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

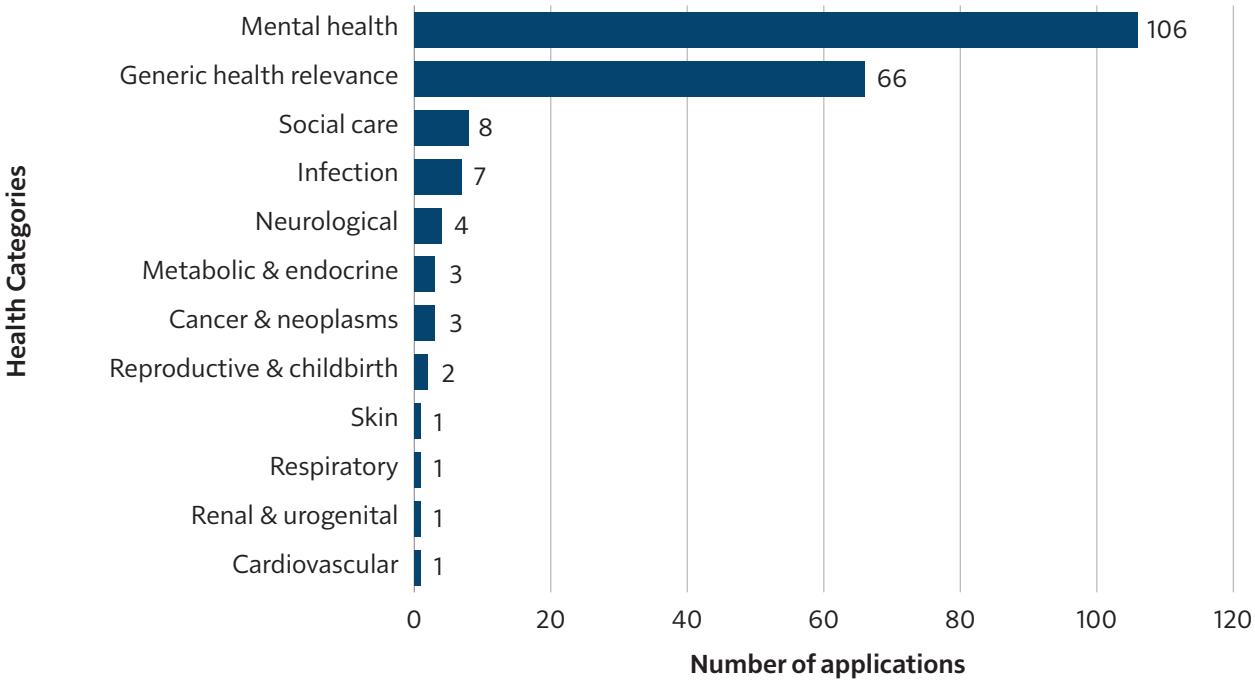


Figure 9 shows that 52% of research was on mental health topics. Other areas include generic health (33%), whereas research on social care (4%) and specific physical health topics like cancer and cardiovascular disease was rare (less than 2% each).

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 areas. 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 misuse, 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).

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 prison. 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 misuse 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 misuse 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 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/ DHSC and 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 and 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, DPH 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 is 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 27/4 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

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 heath 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 ■ guidance on approval processes	

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2. **Health and care of women through pregnancy, birth and the postnatal period in prison and on probation**
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4. **Women and families**
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5. **Older people in prison**
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6. **Palliative care and end of life in prisons**
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7. **Mental health of people in prison and in contact with the criminal justice system in the community**
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8. **Supporting neurodivergent people and those with neurodevelopmental conditions within prison and on probation**
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9. **Self-harm and suicide in prison**
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10. **Complex care in the criminal justice system**
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15. **The health needs and barriers experienced by people on probation**
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16. **A health and care workforce for the future criminal justice population**
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17. **Data and information sharing for health in the criminal justice system**
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18. **Health research with people in prison and on probation in England**
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References

Full references are included in the HTML version of the executive summary and the version in the full report which can be accessed on the Chief Medical Officer (CMO): annual reports page on GOV.UK.

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