The system and the cell: A systems perspective on prisoner health

BRIEFING PAPER

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Healthcare for people in prison is a human right. Yet pre-existing inequalities, combined with prison-specific barriers, leave prisoners with health outcomes consistently worse than the general population. Good prisoner health is not only a moral issue but it can also deliver wider benefits, including improved public health and reduced reoffending.

Drawing on research and insights from academics at The University of Manchester, this briefing provides a high-level overview of the key health challenges in British prisons today, with a particular focus on physical health, mental health, women's health, older prisoners' health, and the health of young people.

KEY POINTS

- Physical health problems are widespread, including high rates of infectious disease, long-term conditions, and drug-related harms. The average age of death is 56, compared with 81 in the wider population.
- Poor mental health is common and under-treated. Evidence from the House of Commons Justice Committee shows that while around 70% of prisoners need support, only 10% receive treatment.
- Women face acute and often unmet health needs, including high rates of self-harm and sex-specific needs, in a system largely designed for men.
- Older prisoners have complex, chronic health needs, and the ageing prison population is increasing demand on a system already under strain.
- Young people in custody have disproportionately high health needs, often linked to childhood adversity. Meeting these needs is crucial to reducing long-term involvement with the criminal justice system.

RECOMMENDATIONS

1. Support effective prison healthcare through sustainable funding.
2. Prioritise prevention and support targeted, practical interventions.
3. Improve coordination and integration across health services.
4. Strengthen cross-departmental oversight of prisoner health in government.

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INTRODUCTION

Healthcare in prison is a fundamental human right. Under international standards, as established by the United Nations, all people are entitled to good-quality healthcare, regardless of their legal status. In the UK, this is reflected in the 'principle of equivalence' – which means that prisoners are afforded healthcare consistent with the quality and standard as that provided to the general population in the community.[1]

The health of prisoners is also a matter of public health. As extreme and isolated as prison life may be, prisons are not sealed off from the rest of society. They exist within the wider health ecosystem, and investment in the wellbeing of prisoners carries public health dividends. People enter custody from the community, and they return to it when their sentence ends. The conditions in which they live, their access to healthcare, and the quality of support during their sentence therefore shapes outcomes long after release.

The Department of Health and Social Care (DHSC) and Ministry of Justice's (MoJ) joint report on prisoner health, published in November 2025, has emphasised the point.[2] As the Chief Medical Officer for England, Professor Chris Whitty, highlighted, offending and reoffending are strongly linked to health, and the greatest risks occur at moments of transition: entry into prison, transfers between facilities, and after release. Supporting people's underlying health needs is identified as a critical component of reducing reoffending. A separate Justice Committee report on reoffending, also published in November last year, concluded that it is "imperative" that prisoners have access to good health services to help them engage with rehabilitation.[3]

The challenge is that health outcomes for people in prison are consistently poorer than for the general population. Part of the explanation is that prisoners often face complex health needs and deep-rooted inequalities long before entering custody. Individuals in prison are much more likely to have experienced deprivation, which takes a heavy toll on public health and has high risk factors for disease.[4] They are more likely to have been homeless or in temporary accommodation and to have experienced unemployment[5]. They are also more likely to have been abused as a child and live with trauma.[6] These forms of disadvantage have a cumulative impact on health and ensuring that people in prison receive appropriate care is therefore not only a matter of health policy, but of social justice.[7]

Another reason for prisoner ill health lies in the prison estate itself. The principle of equivalence is simple in theory: people in prison should receive the same standard of healthcare as anyone else. In practice, however, the prison environment – unlike 'normal' healthcare settings – presents distinct challenges, and delivery often falls short.

In recent years, these shortcomings have become increasingly visible in the media and in government policymaking, most notably through the ongoing prison capacity crisis.[8] Such pressures – overcrowding, deteriorating conditions, and staff shortages – make it difficult to manage the health of prisoners. The continued impact of

austerity further places the health and safety of prison population at risk.[9] The harsh reality of prison life compounds these problems, from limited opportunities for exercise and poor diet to high levels of violence and substance abuse.

The result of all this is a prison healthcare system under sustained pressure to meet the needs of prisoners and uphold the principle of equivalence. In partnership with Policy@Manchester, The University of Manchester's policy engagement unit, this paper sets out an overview of the health challenges facing British prisons.[i] Drawing on research literature, including studies from The University of Manchester, insights from interviews with Manchester academics – Dr Katrina Forsyth, Dr Jane Senior, and Professor Jenny Shaw – and a roundtable event held in Westminster in December 2025, it offers a summary account of the key issues, pressure points, and potential solutions.

The purpose of this briefing is not to provide an exhaustive account of every challenge within prison healthcare. It does not, for example, explore disability or neurodivergence, nor does it fully address issues like substance misuse, gambling addiction, or the effects of ethnic inequalities. Instead, it offers a high-level overview of the system as a whole, providing systems-level recommendations to improve the health of people in prison. As well as a brief summary of how prison healthcare is delivered, this paper focuses on five core areas, each discussed in turn below: physical health, mental health, women's health, older prisoners' health, and the health of young people.

THE DELIVERY OF HEALTHCARE IN PRISONS

All prisons in the UK are required to provide access to healthcare services, and prisoners should receive care equivalent to that available in the community.[10] This includes primary care (for instance, GPs, optometry, dentistry, mental health, and drug and alcohol services); secondary care, social and end-of-life care, and public health interventions like screening and vaccinations. Where care cannot be delivered in the prison setting – such as some forms of specialist care or secondary care – prisoners should be referred to external services, typically hospitals, to receive treatment.

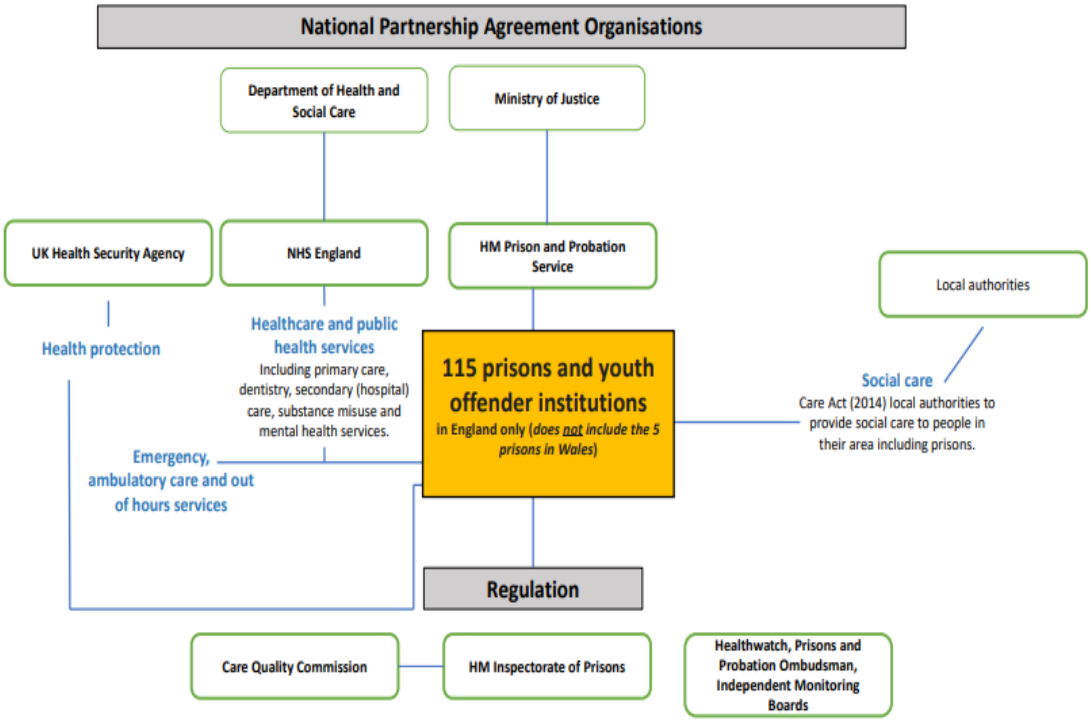
Like the legal and health systems they fall under, responsibility for prison healthcare is devolved, and the structure of provision of healthcare therefore varies across the UK. In England, multiple organisations are involved in the oversight and commissioning of prison healthcare through the National Partnership Agreement, which includes NHS England, HM Prisons and Probation Service (HMPPS), and local authorities.[11] In Wales, despite sharing the same criminal justice system overseen by the MoJ, prison healthcare is the responsibility of the Welsh Government and is

[i] Most UK prison research and data focus on England and Wales, which share a single, integrated criminal justice system and benefit from centrally compiled, regularly published Ministry of Justice statistics. Scotland and Northern Ireland have devolved justice systems and collect prison data separately. As a result, this briefing mostly draws on England and Wales data. However, given broad similarities across prison systems, many of the issues discussed are relevant and can be extrapolated to elsewhere in the UK.

delivered by NHS Wales through local health boards.[12] In Scotland, where prisons are overseen by the Scottish Prison Service, NHS Scotland and regional health boards provide services.[13] Northern Ireland's prisons are run by the Northern Ireland Prison Service and their healthcare is overseen by the South Eastern Health and Social Care Trust.[14]

While prison healthcare in Wales, Scotland, and Northern Ireland is more centralised, provided by the respective health services via health boards, and thus more tightly integrated, England operates under a fragmented governance model with multiple providers.[15] NHS England is primarily responsible for commissioning healthcare services, however, delivery is shared by a mix of NHS providers, private companies, community interest companies,[ii] and different providers can be responsible for different services within a single prison.[16] Not every provider delivers the full range of care, and this fragmentation creates challenges in coordination and continuity, as discussed throughout this paper. Across all nations, justice and healthcare oversight remain separate, adding a further layer of complexity.

Diagram 1: Organisations involved in overseeing, commissioning and regulating prison healthcare in England



Source: Department of Health and Social Care and Ministry of Justice

[ii] Community interest companies are limited companies that operate to deliver benefits to the communities they serve. While they function like other companies, they cannot exist solely for private financial gain, and their assets must be used for community benefit.

PHYSICAL HEALTH

Physical health can involve common ailments such as flu, infections, nutrition, exercise, or pain. It can also cover more serious or chronic conditions like diabetes, infectious diseases, or problems related to addiction. As we have discussed, the determinants of health are very different for people in prison, which means the risk of poor health is disproportionately higher than in wider society. Box 1 below illustrates the stark impacts of imprisonment on physical health:[17]

Box 1: Physical health and excess harm among the prison population

- People in prison experience higher rates of infectious disease alongside poorer vaccine coverage.[18] This was highlighted during the Covid-19 pandemic, when infections spread more rapidly among prisoners than in the general population.[19] The prevalence of HIV, hepatitis C, and tuberculosis are significantly higher in prisons, as are rates of sexually transmitted infections.[20]
- Long-term conditions such as respiratory disease and cardiovascular disease are more common among people in prison.[21] Literature from The University of Manchester, supported by international studies[22], has highlighted higher rates of non-communicable diseases including hypertension, diabetes, asthma, and arthritis, as well as various cancers.[23]
- Substance misuse, including alcohol and tobacco, is more widespread in prisons. The 2021 Black Review found that people with serious drug addictions occupy 1 in 3 prison places.[24]
- There is evidence that gambling prevalence is higher among prison populations than in the general public, with individual studies suggesting that 45% of prisoners gamble while incarcerated and 23% of prisoners believe they have a gambling problem. [25]
- Mortality in prisons exceeds that in the community. Shockingly, the average age of death in custody is 56, compared with 81 in the general population. Suicide rates are also higher. The National Confidential Enquiry into Patient Outcome and Death notes that “this significant reduction in life expectancy is far from ‘natural’”.[26]

In other words, prison considerably compromises a person’s physical health, amplifying disease, addiction, and premature death. As we discuss below, these outcomes reflect not only individual vulnerabilities but also the systemic, environmental factors that shape prisoners’ health outcomes.

The prison environment contributes to poor health

The poorer health of people in prison is partly explained by pre-existing disadvantage. But it also stems from the harmful effects of imprisonment itself, and systemic inadequacies within the prison system. Many individuals entering custody

already experience poor health, which is then exacerbated by the physical environment and limited access to healthcare.

The most visible example is overcrowding – an issue that has recently pushed the UK system into crisis. Between October 2022 and August 2024, capacity in the adult male estate was as high as 99.7%, despite HMPPS conceding it is unable to run prisons effectively above 95%.[27] Persistent staff pressures, intensified by overcrowding, limit the ability to provide healthcare services, while shortages of available escorts to outpatient appointments mean appointments are frequently cancelled, missed, or delayed.[28]

At the same time, the prison estate is literally falling apart. There have been multiple official and news reports documenting deteriorating conditions across UK facilities in recent years – HMP Wandsworth being the prime example – with cramped and dirty cells, poorly maintained sewage systems, and rodent infestations.[29] Until as recently as 2011, an "outdated" medieval castle, Lancaster Castle, was still in use as a functioning prison.[30] Overcrowded and crumbling buildings have clear implications for the health and wellbeing of prisoners, and while not all are as extreme as Lancaster Castle, the estate as a whole requires significant investment to meet contemporary standards for those in custody.[31]

Another concern is the lack of time prisoners spend out of their cells, thereby limiting movement, exercise, and fresh air. HM Inspectorate of Prisons' (HMIP) 2022/23 annual report found that only 16% said they were unlocked for the recommended minimum of ten hours per day.[32] Prolonged long periods indoors – especially in deteriorating or Victorian prison facilities more likely to be cold, damp, or poorly ventilated – carry well-evidenced health risks, including infections and long-term respiratory and cardiovascular problems.[33]

Diet and nutrition, one of the strongest determinants of ill physical health, are frequently reported as insufficient in prisons. In 2022/23, HMIP found that only 41% rated the quality of food as good, while in 2023 the Independent Monitoring Boards revealed that, in one prison, 94% described the food as bad or very bad.[34] For 2023/24, prisons were allocated just £2.70 per person per day to provide three meals, including a breakfast pack, one cold meal, and one hot meal.[35] As described in another report by HMIP, "too often the quantity and quality of the food provided is insufficient, and the conditions in which it is served and eaten undermine respect for prisoners' dignity.[36] This does little to improve, what for many prisoners, is a history of an unhealthy lifestyle. It also potentially jeopardises prisoner and staff safety".

Meanwhile, prices in prison canteens – which cover items such as groceries, hygiene products, and other essentials – are inflated compared with the community, even though prisoners rely on them to supplement their basic meals and maintain a basic standard of living.[37] Forthcoming research by the SMF indicates that these high costs, combined with meagre pay from prison jobs, contribute to poor living conditions. This can lead to debt, which in turn drives violence, substance misuse, and self-harm among prisoners – problems that are severely detrimental to good physical health.[38]

These are just some of the environmental determinants of poor health in prison. Additional systemic factors also include poor sanitation and limited access to hygiene facilities, which heighten the risk of infection, undermine general cleanliness, and contribute to various other health problems.[39] The sheer stress of prison life – often hostile, unsafe, and inherently isolating – can take its toll on cardiovascular health.[40] Substance use, already prevalent among those entering custody, is entrenched by the chaotic culture and "epidemic nature" of drug use within prisons.[41]

Based on the evidence, it is clear that simply being in prison and living in the prison environment can be detrimental to physical health. On top of these challenges – as if maintaining the health of prisoners were not already difficult enough – healthcare in prisons is often under-resourced and difficult to access, compounding the many problems people faced while in prison.

Strained healthcare services are poorly equipped to meet the health needs of prisoners

Under the principle of equivalence, prisoners must have access to healthcare of the same quality and standard as the general public. In practice, however, there are persistent barriers that prevent prisoners from achieving good health outcomes – let alone equitable ones.

In 2018, the House of Commons Health and Social Care Committee on Prison Health – much like this briefing paper – examined not only prisoners' experiences of healthcare services, but also how the prison environment affects their health and wellbeing.[42] The findings were scathing.

Identifying deteriorating standards within English prisons following cuts to public spending, the Committee noted "a system struggling to cope with budget reductions, staffing shortages, and outdated establishments", and highlighted that "short-staffed, overcrowded prisons severely limit access to healthcare and the ability of prisoners to lead healthy lives". It also observed that "even the most basic needs of people detained, such as their diet and living conditions, continue to be compromised in some English prisons". Ultimately, the Government conceded that it was "failing in this duty of care towards people detained in prisons in England". This was seven years ago, long before the current prisons crisis.[43]

Recent reporting suggests little sign of improvement. In 2025, the criminal justice and rehabilitation charity Nacro published its *Physical Healthcare in Prison Report*, revealing several inadequacies in the system with regard to access to care.[44] Using a survey of people released from prison,[iii] it found that large proportions – ranging from 35% to 70% – of former prisoners waited for months at a time for appointments, did not get one at all, or did not get the treatment they needed from medical professionals. Strikingly, it suggested that 75% were aware of people not getting the

[iii] The survey had a sample size of n=101. While this is relatively small, it is not unusual for research involving current or former prisoners, who are considered a hard-to-reach population. Such studies still provide valuable qualitative and indicative insights.

medication they needed while in prison, with 64% saying they knew people who used illegal substances in order to self-medicate.

The inability to access medication only to then result in substance abuse is a clear illustration of the link between healthcare shortcomings and prisoner ill health. But no outcome reflects this relationship more starkly than death. A 2024 report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), based on data from people who died in prison or in hospital while detained, identified multiple areas for improvement in the care of those who died in custody.[45] Among its findings, 27% of patients with advanced chronic conditions were judged to have received healthcare with significant room for improvement, while 44% had scope for better health assessments. The report also found that clinical deterioration was not managed appropriately in 27% of cases prior to emergency hospital transfer, and that 14% of such transfers were considered preventable or avoidable.

The University of Manchester has explored the nature of avoidable deaths in prison. In one study, conducted in partnership with Cardiff University in 2023, researchers aimed to define avoidable healthcare-associated harm and identify the key factors that arise from, or are exacerbated by, barriers unique to the prison environment, such as security protocols.[46] It recognises that while healthcare in prison should aspire to equivalence with community settings, the prison setting imposes additional constraints that make it difficult to uphold established standards and norms.

That said, it found that many issues, while aggravated by the prison context, *are* avoidable. As discussed above, it cites limited budgets and staffing as particular challenges – "systemic issues [which] can stymie healthcare". Poorly trained or changing staff can undermine equivalence. Other issues, such as poor IT infrastructure, medication management, and prison overcrowding also increase the risk of harm, contributing not only to preventable deaths but also to self-harm and substance misuse.

Looking to understand the scale and nature of avoidable healthcare-associated harm in England prisons, a team of academics led by The University of Manchester's Professor Jenny Shaw analysed patient healthcare records to assess the safety of care provided to people in custody.[47] Speaking to the SMF about this research, Professor Shaw identified problems at "the interface between care and custody" as a central and recurring challenge, describing how the delivery of healthcare frequently comes into conflict with the security demands of the prison regime. For instance, lockdowns can result in missed healthcare appointments, both within prisons and in external settings such as hospitals. Staffing shortages further exacerbate these tensions, with limited numbers of prison officers restricting the availability of escorts for outpatient appointments, directly compromising access to care. As Professor Shaw explained, "there's not enough prison officers. The governor will always be looking at [if they] could only do two escorts without [considering] the healthcare reason why you need five."

These pressures are particularly damaging because routine appointments are often where early signs of deterioration are detected. When appointments are missed,

opportunities for timely diagnosis and intervention are lost, increasing the risk of avoidable harm and poorer long-term health outcomes for prisoners.

Continuity of care is key

This paper primarily focuses on health in prison. However, post-release care is also crucial to positive, long-term outcomes, and it would be remiss not to mention it here. For many people, release from prison is a crisis point at which they leave a secure environment where their basic needs, such as health and housing, are met. As noted by the Nuffield Trust, the transition into the community is a critical period, and steps must be taken to ensure continuity of care, particularly where people have started programmes or treatment within prison.[48]

Evidence shows that post-release healthcare is poor and many released individuals lose contact or never engage with community treatment. For alcohol and drug treatment, of the 31,000 people that left treatment in secure settings between April 2023 and March 2024 just 53% of adults released from prison successfully started community treatment within three weeks in 2023–24.[49] A London 'deep dive' found even lower rates locally, with only 21% accessing treatment.[50] Not all who start treatment complete it, and a smaller proportion are discharged free of alcohol and drug dependence.

The Centre for Mental Health has conducted multiple reviews of prison mental healthcare, highlighting persistent gaps in continuity of care, with many prison leavers often failing to access the support they need.[51] Regarding housing, the University of Plymouth reports that 56% of people released without settled accommodation, while recent MoJ data shows 14.3% were not housed at all.[52] Employment is also crucial prisoners post-release outcomes, yet between May 2024 and March 2025 just 34.5% of former prisoners were employed at 6 months after leaving custody.[53]

Such discontinuity of care has clear implications for the health of prisoners and for reoffending. As we have discussed, crime, poverty, and health are inextricably linked, and breaking this cycle requires a coordinated, systems-based approach. Ensuring prisoners can access stable housing, consistent healthcare, and employment opportunities upon release is essential to reducing recidivism and supporting successful reintegration into the community.[54]

MENTAL HEALTH

While closely connected to physical health, mental health relates to a person's emotional, social and psychological wellbeing.[55] Good mental health underpins how people think, feel, behave, and cope with everyday challenges, and is central to overall wellbeing. Mental health also encompasses a wide range of conditions and illnesses which, like physical health conditions, can vary significantly in severity.[56] Commonly recognised conditions include anxiety, depression, eating disorders, obsessive compulsive disorder and psychosis.

Poor mental health is common among the prison population

The true extent of mental health need in prisons is poorly understood. A 2017 report from the National Audit Office found that government data collection on mental health in prisons was insufficient and of such poor quality that "there are no reliable data on the prevalence of mental illness in prisons".[57] This problem has continued to persist. In evidence given to the House of Commons Justice Committee in 2021, the MoJ acknowledged that it did not have "a complete understanding of the overall prevalence of mental health needs of prisoners".[58]

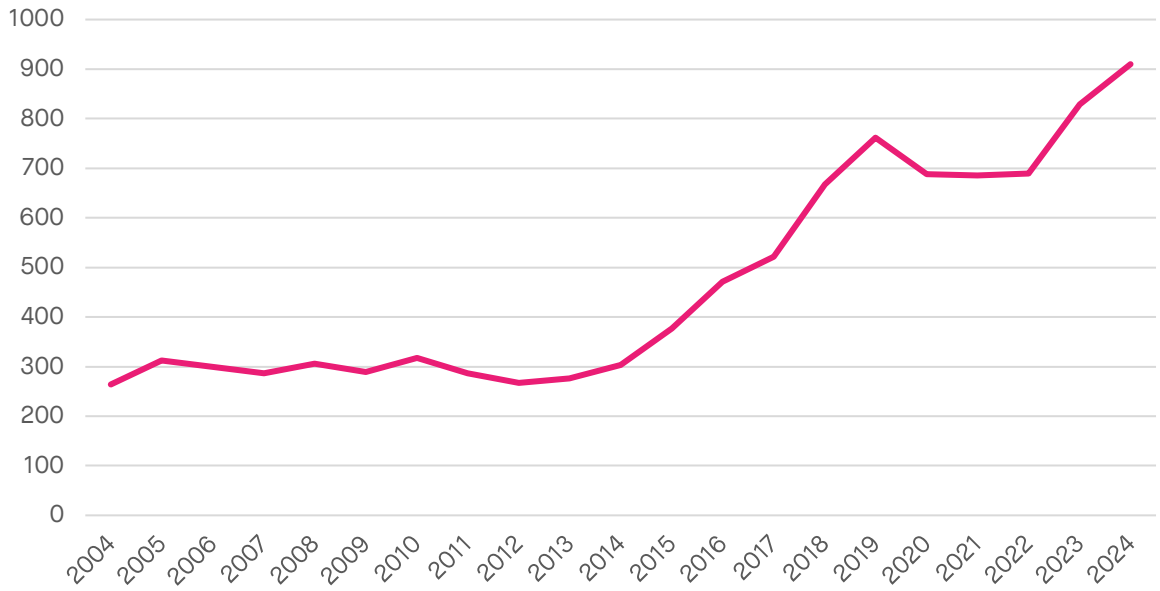
This lack of understanding is partly the result of weaknesses in how mental health needs are identified. While all prisoners should receive a mental health assessment on entry to the prison, followed by a further assessment approximately one week later, this does not always happen in practice.[59] Initial screening relies in part on self-disclosure, yet some prisoners may be unwilling to identify mental health problems, fearing disclosure. Others can be suffering from "entry shock" and feeling overwhelmed or dazed upon entering prison and therefore unable to report mental health problems.[60] Assessments are typically undertaken by primary care staff, such as nurses or healthcare support workers, who do not always have specialist mental health training, increasing the risk that conditions go undetected. 'After this initial assessment, mental health needs are not regularly re-screened, despite the fact that mental health difficulties can (and are likely to) emerge or worsen at any point during a sentence. For these reasons, significant unmet need may remain unidentified, and as a consequence care is never provided.[61]

Available data indicates that mental ill health in prisons is much higher than in the wider community, with HMIP's 2024-25 annual report finding that 56% of men and 74% of women in custody reported they had mental health problems.[62] A 2024 report from Nacro, citing estimates from the Institute of Psychiatry, suggests that 15% of the prison population have specialist mental health needs, and 2% have acute and serious mental illness.[63] Between 60% and 70% of prisoners are thought to have a personality disorder, compared with 4% to 11% of the general public.[64] Certain groups face particularly high risks, including older people, who are more likely to experience conditions like depression, anxiety and schizophrenia, and women, who are significantly more likely to self-harm.[65]

The prison environment can actively undermine prisoners' wellbeing. As discussed in greater detail below, identifying and treating mental health is challenging, while prisons themselves are incredibly difficult places to live.[66] They are often noisy, bullying and violence are common, and drug use is rife.[67] Prison is designed to fundamentally restrict the freedom of individuals convicted of crimes, and long periods of isolation, limited autonomy, and a lack of purposeful activity leave many prisoners feeling powerless and disconnected.[68] Prisons offer little privacy, and in a culture shaped by violence those perceived to be vulnerable can be at greater risk of bullying, intimidation, and abuse from other prisoners.[69] Taken together, these conditions do little to support mental wellbeing and can directly contribute to its deterioration.

There are signs that mental health outcomes in prison are worsening. As shown in Figure 1 below, incidents of self-harm are at record levels, with 899 incidents per 1,000 prisoners across the estate.[70] This represents an increase in both the total number of people self-harming and in the number of incidents of self-harm per person. Rates are particularly high among women, where self-harm incidents are 8.5 times higher than in men's prisons.[71] Self-inflicted deaths have also begun rising in recent years, with 91 deaths recorded in the 12 months to March 2025, (the most recent data available at the time of writing) as compared to 79 self-inflicted deaths in 2021-22. These trends are a stark indicator of the grim reality of mental health in prisons and a prison healthcare system struggling to meet the scale of need.[72]

Figure 1: Self-harm incidents per 1,000 prisoners



Source: Ministry of Justice

Insufficient resourcing means prisoners do not get the mental healthcare they need

Mental healthcare for adults in the justice system is delivered through two main routes. The first is provision within the prison estate itself, where individuals serving custodial sentences should be able to access mental health support through both primary and secondary care services. The other route is through secure psychiatric services (SPS).[73] Individuals may be placed in SPS by court direction as part of sentencing or transferred from prison after becoming acutely unwell.[74] SPS operate at high-, medium-, and low-secure levels, depending on the level of risk an individual poses to themselves or others. While admission to SPS is not limited to those in contact with the criminal justice system, they constitute the majority of patients.

As with physical health, mental healthcare in prisons is guided by the principle of equivalence: people in custody should have access to the same standard of care as they would in the community.[75] In practice, however, provision often falls short. Across both academic and grey literature, recurring themes of insufficient

resourcing, limited specialist training, and poor coordination between services point to systemic shortcomings in the delivery of mental healthcare in prisons.

Mental health conditions are frequently unidentified

As mentioned above, a significant challenge is the lack of dedicated mental health expertise within prisons. There is no guarantee that each wing has staff with specialist mental health training – only about 23% have received such training, and in evidence submitted to Parliament reported that around 40% of prisons do not provide refresher training for existing staff.[76] While prison officers may receive introductory training, this is not mandatory, and where training is provided, there is no requirement for it to be refreshed or updated.[77] As a result, prison staff may lack the confidence or skills to identify emerging mental health problems, meaning that issues often go unnoticed until a prisoner reaches crisis point.

Training is also insufficiently tailored to the needs of specific groups. For example, research from The University of Manchester has highlighted the absence of mental health training focused on older prisoners (aged 50 and over) in the criminal justice system, highlighting that mental health conditions may present differently in older adults than in younger prisoners.[78] Without appropriate training – such as on how depression manifests in later life – staff can fail to recognise symptoms. As one study concludes, "healthcare services have not been developed with their unique needs in mind".[79]

High demand stretches capacity to treat mental health need

Gaps in training and specialist staffing are themselves symptomatic of broader resource constraints. Mental health services in prisons are routinely overstretched, with primary and secondary care teams facing high demand, staff shortages, and long waiting lists for psychological support.[80] The House of Commons Justice Committee has described a "high unmet need for treatment". Its 2021 report found that while only around 10% of prisoners were recorded as receiving mental health treatment, an estimated 70% may require support.[81]

Resource pressures are evident within secure psychiatric services. Transfers from prison to medium secure services (MSS), which provide specialised care for individuals with severe mental health needs, have increased year on year since 2013, placing growing strain on capacity.[82] Studies coming out of The University of Manchester has examined the consequences of this pressure, particularly in relation to the rapid return of patients from MSS to prison. One paper describes how limited bed availability has driven the development of "optimised provision", including ward models designed to facilitate quick turnaround for prison admissions.[83] While this approach can be effective for some patients, clinicians have expressed concern that it may prioritise throughput over individual need, potentially reducing the effectiveness of care.

Further research examines the planning of aftercare for those returned to prison and highlights persistent problems of insufficient resourcing and poor coordination across the system. Concerningly, it is reported that individuals transferred back to prison face higher risks than transferred into the community, yet appropriate and

proportionate aftercare is often available in the prison estate.[84] In one study, 88% of the cohort examined were legally entitled to aftercare following discharge from SPS and were expected to have their support managed through a dedicated Care Programme Approach (CPA) – a package of support used by mental health services to promote recovery). However, only 18% had a CPA in place. Even where CPAs exist, resource constraints within prisons frequently prevent them from being implemented effectively. The same study found that prison mental health services were "not adequate to meet patients' support needs following remittal, concluding that the use of CPA for this group is neither practical nor widespread.[85]

Continuity of care is hampered not only by gaps in provision, but also by problems with the timely transfer of medical records. While some issues with information and data sharing were addressed in response to the coronavirus pandemic, making access to medical information quicker, shortcomings remain.[86] In its 2025 report on rehabilitation, the House of Commons Justice Committee noted that in one prison it visited had no electronic records at all relating to prisoner health, relying instead on handwritten files.[87] The Committee warned that this archaic approach "hinders effective transfer of health information within the prison itself and between prisons, which given the frequent moves of prisoners, is harmful to their health."

Beyond healthcare, failure to detect and provide appropriate and complete mental health treatment has consequences for the wider criminal justice system. Good mental health and effective treatment where needed is central to keeping people engaged, stable, and hopeful during custody – and to supporting rehabilitation. It helps individuals build the foundations needed to rebuild their lives on release. When mental health needs go unmet, the likelihood of poor outcomes increases, reinforcing cycles of disengagement and reoffending.

WOMEN'S HEALTH

Women make up 4% of the overall prison population.[iv] They are often imprisoned for shorter sentences and for non-violent crimes, like theft.[88] Women in prison are among the most vulnerable in society, with many having themselves been victims of crime and experienced trauma. According to the Chief Medical Officer's report on prisoner health, over half (53%) of women report childhood abuse, while 68% are victims of domestic abuse.[89] The health profile of women in custody is generally worse than that of men, yet it receives comparatively little attention (see below).

Mental health needs of women in prison are often more acute than both male prisoners and women in the community.[90] To reiterate our earlier point, the rate of self-harm in women's prisons is more than eight times higher than in men's, with

[iv] Note that throughout this section, 'women' is used to refer to prisoners within the women's prison estate. The majority of this group will be cisgender women, but it will also include a small number of trans women with their own unique health challenges. Data in this section includes a mix of studies looking at both sex and gender, please refer to the references provided for more information. While outside the scope of this briefing, more information on transgender prisoners specifically is available here: https://assets.publishing.service.gov.uk/media/685bf9050433072fce0e1010/Guidance_on_Prisoners_who_are_Transgender_-_External.pdf

women accounting for more than a quarter (27%) of all self-harm incidents in the secure estate in 2023.[91] Women in prison also have higher rates of sexually transmitted infections than the general population and are disproportionately affected by conditions like osteoporosis.[92]

Many women have sex-specific health needs, including menstrual health and associated conditions[93], pregnancy and childbirth, menopause, breast and gynaecological cancers.[94] However, as highlighted in the Women's Review, health services are not always gender specific, meaning these needs too often go unmet.[95] The impacts can include low uptake of screening programmes, poor management of menstrual problems (such as painful periods, endometriosis, polycystic ovary syndrome), and untreated conditions such as incontinence – issues that make time in custody more uncomfortable and undermine dignity.

Women's healthcare in custody is often not reflective of need

One of the goals of the MoJ's 2018 Female Offender Strategy was to create better conditions for women in custody, including adapting healthcare to reflect differences in need.[96] However, since the launch of the strategy, multiple reports have noted considerable variation and inconsistency in women's healthcare provision. These includes a 2021 report by the Justice Committee, the National Women's Prisons Health and Social Care Review in 2023, the Chief Medical Officer's report in 2025, and again the Justice Committee in 2025.[97]

This inconsistency means that women's health needs are simply not being appropriately met. Research from The University of Manchester found that a lack of capacity, training, and gender-specific provision meant older women, particularly those with complex needs, were not receiving adequate care.[98] Specifically, it found education and support for older women around menopause were largely absent, leaving many women unable to manage symptoms. The same paper also found that health screenings for cervical and breast are underdeveloped, while take up of services when offered remain low. NHS England data shows that breast screening uptake in prison is at less than 20%, compared to 70% in the community.[99] The CMO's report noted that guidance on national screening has not been translated to prisons, creating inequitable access.[100]

Pregnancy is a particularly concerning issue for women living in prison. While only a minority (6%) of women in prison are pregnant, their healthcare needs are significant.[101] All pregnancies involve health risks, however pregnancies in prison are considered especially high risk due to limited access to routine and emergency care. The Royal College of Obstetricians and Gynaecologists has noted that pregnant prisoners are more likely to miss appointments, while delays in antenatal care increase morbidity and mortality.[102] One personal account of giving birth in custody, published by The Guardian in 2022, describes severe gaps in care, including being restrained during transport to the hospital in breach of prison policy and no communication over next steps.[103] For pregnant women, the consequences of inadequate care can be catastrophic: at least two babies have died in prisons since 2019, with both mothers giving birth without medical assistance.[104]

Compared with the general population, women giving birth in custody face higher rates of pre-term labour, low birth weight, and are seven times more likely to experience stillbirth – though these comparisons do not adjust for underlying health and disadvantage.[105] Pregnancy and the postnatal period are also high-risk times for mental ill-health, compounded by the immense environmental stress of being in prison.[106] Yet, suitable perinatal mental health services are not available in all prisons.[107]

Despite the strategy's aim to reduce the female prison population, numbers are expected to rise in coming years, due to the same drivers of growth across the estate, increasing demand on already overstretched health services.[108] Without serious reform, these services will continue to struggle to meet women's needs. For Dr Katrina Forsyth, Senior Research Fellow at The University of Manchester, effective strategic planning requires clear messaging and distinguishing between different groups, which may entail implementing changes that are specific to women.

OLDER PRISONERS' HEALTH

All people face health risks as they age. Older prisoners – defined by HMPPS as those aged 50 and above, to reflect evidence that the health needs of people in prison are brought forward by around ten years – are no exception.[109] However, due to the multiple systemic determinants in the prison environment discussed throughout this paper, as well as experiences prior to custody, age-related illnesses can emerge earlier in this group than in the general population. In effect, disadvantaged and unhealthy lifestyles before imprisonment, coupled with the harsh reality of the prison environment, can accelerate the ageing process.[110]

Meanwhile, the prison population as a whole is ageing. Because of general changes to sentencing policy, as well as the length of sentencing served by individuals – one of the contributors to the current overcrowding crisis – there has been significant growth in the number of older people sentenced to prison.[111] The proportion of prisoners aged 50 and over has grown from 10% in 2011 to 24% in 2024, with projections indicating a further 15% rise by 2028.[112]

Managing healthcare needs is more difficult among older people in prison. This group in prison is much more likely than other prisoners to experience chronic disease, disability, reduced mobility, and sensory impairment than other prisoners.[113] While each condition is challenging on its own, their combination – 'multimorbidity' – becomes increasingly common with age and creates additional risks. Frailty also develops earlier when in custody, affecting basic movement, personal care, and independence. Older men are more likely to have long-term conditions such as kidney disease and cancer, while older women have distinct needs including depression.[114] In 2020, 184 people aged 50 or over died of natural causes in prison – more than double the figure ten years ago.[115] Palliative and end-of-life care, while a relatively small aspect of prison healthcare, is becoming an increasing necessity.[116]

As noted by the House of Commons Justice Committee, there is a high prevalence of mental health conditions among older prisoners. It states that more than half have a mental health disorder, 30% have been diagnosed with depression, and those aged

50 to 59 is the age group with the highest risk of suicide.[117] Dementia is also a particular concern. Although dementia in prisons remains understudied and its prevalence not fully understood, recent work by The University of Manchester's Dr Katrina Forsyth and colleagues represents the first comprehensive study of dementia and mild cognitive impairment among older prisoners in England and Wales. [118]The research estimates that 1,020 older adults in prison in England and Wales show symptoms of dementia – yet service provision for this group remains inadequate.

These issues mean there is increasing demand for healthcare within the prison system. Yet the prison estate itself is also ageing, and was never designed to meet the needs of elderly or disabled prisoners. The Nuffield Trust has reported that this group can face considerable difficulties moving around prisons – including to attend healthcare appointments – compounded by architectural problems like broken lifts and a lack of wheelchair-accessible spaces.[119] In conversation with clinical-academic Dr Jane Senior (Senior Lecturer, Health and Justice Research Network, The University of Manchester), the challenges of providing care to older prisoners were made clear. As she and other researchers have noted, the physical prison infrastructure itself often creates barriers, not only to moving around the prison but even to performing basic self-care. Features such as bunk beds are impractical for people in their 70s and 80s, and the lack of accessible showers or toilets with hoists further complicates the ability of older prisoners to maintain basic hygiene.

Taken together, inadequate services and staff pressures mean prisons are not well equipped to address these needs and, as a result, older people's health is often overlooked. Research by The University of Manchester has identified additional barriers to managing long-term health conditions among older prisoners, including difficulties preparing for prison release, security restrictions that hinder external hospital appointments, and the lack of healthy prison environments needed to prevent long-term illness.[120] With regard to mental health, Manchester academics also note that consistent and effective provision for older prisoners is lacking.[121] The Independent Monitoring Boards have also stated, "dementia patients cannot be well cared for in a prison environment".[122]

The ageing prison population poses a considerable – and largely underprepared for – challenge to the prison system. As the number of older prisoners continues to rise, the demand for specialist healthcare will also increase. Yet much of the prison estate remains physically unsuitable for people with mobility issues or chronic conditions, while healthcare services remain under considerably strain. Addressing the health needs of older prisoners is therefore not only a question of dignity and equity, but it is also essential to ensuring the sustainability of the wider prison system. Solutions to this growing challenge are discussed in the recommendations section below.

THE HEALTH OF YOUNG PEOPLE LIVING IN CUSTODY

As much as possible, children under 18 are diverted away from custody. Where custody is deemed necessary, they may be held in secure children's homes, secure training centres, or young offenders institutions (YOIs). The number of children and young people in custody has fallen sharply over the past two decades.[123] As of April 2025, 383 children under 18 were held in the secure estate, down from a peak of

3,145 in July 2002. Most children in custody are boys, and almost all are aged 15 or over.[124]

There has been a deliberate shift toward diversion and reduced use of custody as alternative approaches to youth justice, including care placements.[125] While this can provide safety for children who have been harmed, the Children's Commissioner has warned that entering care can make children "more vulnerable to exploitation or involvement with criminal behaviour."[126] Children in care are significantly overrepresented in the criminal justice system, and nearly half (49%) of children in custody first come into contact with the criminal justice system after entering care.

Children and young people in custody typically have complex and overlapping health needs that are more prevalent than in the general population. Neurodiversity, speech and language difficulties, and mental health conditions are all common. The vast majority (83%) are prescribed mental health medication on entry to custody. Many also have unmet physical health needs, including missed preventative care such as immunisations.[127] Histories of trauma are widespread. Among children placed in secure homes for welfare reasons between 2021 and 2024, over 80% had experienced neglect or emotional abuse, and more than 70% had experienced domestic abuse.[128]

Within the youth justice system, girls make up a small proportion of the youth custodial population (less than 2%), but their mental health outcomes are significantly worse than boys'. Girls account for over half of all self-harm incidents in the youth secure estate, and 42% report a previous suicide attempt, compared with 11% of boys.[129]

Despite the high level of need and vulnerability, healthcare provision for children and young people in custody is – much like the rest of the estate – inconsistent. Responsibility is spread across multiple agencies and programmes, with no single, integrated approach.[130] While individual services can be effective, practitioners often work in silos, leading to fragmented care that does not reflect the complexity of children's needs. Evidence from the Nuffield Trust highlights difficulties accessing healthcare in custody. Emergency care is prioritised, often at the expense of routine and preventative services.[131]

HMIP's 2025 report on children in custody found that 43% of children in YOIs and Secure Training Centres felt unsafe, 61% had experienced violence or victimisation, and 30% had been assaulted by peers. In the absence of effective behaviour management, staff frequently relied on separating children, sometimes resulting in very limited time out of cell and conditions that, in effect, resembled solitary confinement.[132] Needless to say, this is wholly inappropriate for children and risks causing significant harm to their mental health, development, and prospects for rehabilitation.

Although the custodial population is now small – which can be considered a significant policy achievement, reflecting efforts to divert vulnerable children away from custody wherever possible – the complexity of need among those who remain presents a serious challenge. As the Chief Medical Officer has noted, this creates an

opportunity to adopt a whole-pathway approach that addresses children's physical, mental, social and emotional health needs, helping to prevent their continued involvement in the criminal justice system as they transition into adulthood.[133]

DELIVERING SYSTEMIC CHANGE IN PRISON HEALTH

This briefing has explored some of the key challenges faced by people in prison as well as by prison staff responsible for managing health. While far from exhaustive, it provides an overview of the problem, demonstrating that although certain groups face specific, acute health needs, a set of underlying structural challenges contribute to poor health outcomes across the prison population. It is these systemic pressures that this paper seeks to address.

A wide of range of organisations have already set out detailed, issue-specific recommendations for improving prison health in the UK. The National Institute for Health and Care Excellence (NICE) has underlined the need for better management of medicines.[134] NCEPOD has discussed the impact of substance misuse on long-term conditions.[135] The NAO has called for improved understanding of mental health needs in prison.[136] The Prison Reform Trust argues that the placement of older prisoners should better reflect physical spaces and age-related health needs.[137] Academics from The University of Manchester have identified numerous healthcare interventions for monitoring and managing chronic diseases in custody.[138] Professor Chris Whitty's report on the health of people in prison and probation suggests a range of solutions, including specialist assessments of pregnant and postnatal women.[139]

It is not within the scope of this paper to regurgitate or consolidate all of these recommendations. Instead, it remains focused on high-level systemic issues which, if addressed, have the potential to drive positive, top-down change across the prison health system. With this in mind, we discuss four key areas: resourcing and funding, prevention, services and commissioning, and departmental oversight.

Support effective prison healthcare through sustainable funding

Prisons are under great strain. Throughout this paper, we have highlighted the range of challenges that stem from inadequate resources and funding, which together limit the effective delivery of healthcare services. While prison spending has increased in recent years, funding overall has undergone significant decline over the past two decades.[140]

Between the 2000s and throughout the austerity era of the 2010s, justice spending was subject to severe cuts. In England and Wales, the MoJ's day-to-day resource budget fell by one third (33%) in real terms between 2007-08 and 2016-17 (departmental budgets fell by 22%, meaning justice fared worse than the average 'unprotected departments'), while capital funding was cut by 70% in the early 2010s.[141] The Institute for Fiscal Studies has noted that more recent funding – particularly capital investment aimed at building prisons and easing the capacity crisis – "come on the back of, and in most cases do not offset, severe budget cuts in the 2010s".[142] It has said that real-terms day-to-day justice spending in 2025–26 will

be no higher than in 2002–03 and around 16% lower per person terms once growth in the prison population is taken into account.

Although government health spending has been less affected by austerity, and prison healthcare funding commissioned by NHS England has remained relatively stable, the delivery of healthcare in custody depends heavily on a functioning prison regime.[143] That regime is in a state of longstanding deterioration, and it has been reported that the consequences of austerity has been linked to reduced access to healthcare, degraded living conditions, and increased levels of violence – all of which undermine health outcomes and the ability of services to operate.[144]

In an interview with the SMF, Dr Jane Senior from The University of Manchester spoke of the funding cuts to prisons. In particular, she noted what in her view is a political reluctance to address the funding shortfall and increase prison budgets. By their nature, prisons are hidden from and the realities of prison conditions may not be fully understood by most of the public. Given that negative attitudes towards prisoners are common – the Secret Barrister, a well-known barrister, blogger, and author, calls this a "regressive prison fetish", where prisoners, regardless of their background or crime, are seen as deserving of punitive treatment – including some support for harsher environments in prison, arguments to increase funding would likely not be seen as a vote winning topic.[145]

In prisons, healthcare delivery is dependent on the wider prison system[146]. Unlike community settings, it does not function independently of regime stability, physical infrastructure, and operational capacity. Delivery also relies on non-health justice budgets, such as prison officers to unlock and escort patients, safe environments in which care can take place, and smooth everyday prison operations that allow appointments to run on time. Healthcare funding alone cannot compensate for these elements, and service quality and availability can therefore vary.

Staffing pressures are central to this challenge. As set out above, staffing shortages affect delivery across the prison system, contributing to longer waiting times, reduced access to services, and heightened security constraints at the expense of other priorities.[147] In an interview with the SMF, The University of Manchester's Dr Katrina Forsyth emphasised that overstretched prison officers and healthcare workers are among the most significant barriers to delivering care in custody. She noted that, under current circumstances, even the basic elements of the prison regime – from enabling prisoners to shower to ensuring safety – can be difficult to sustain, let alone preventative healthcare or longer-term health planning. Dr Forsyth suggested that greater involvement of people with lived experience (people currently living in prison) in health initiatives could help ease capacity pressures. While such approaches show promise, she warned that the evidence base remains limited and such initiatives require appropriate training, support and supervision.[148]

Resource constraints are a deeply embedded, systemic feature of the prison system, shaping decisions and operations at every level. In this respect, prison healthcare faces challenges common to many public services. However, the extent of deterioration across the estate – described by Parliament itself as a crisis, driven by

declining resources and rising capacity pressures – means that additional funding is particularly urgent.[149]

Setting political considerations aside, we acknowledge there are likely to be concerns about increasing prison spending given the wider constraints on public finances. However, the reality is that sustained investment in prisons and prison health services is essential to improving outcomes. It also carries wider public health dividends and the potential for considerable returns through reduced reoffending. This is not a groundbreaking point to make, but it is no less important: if government is serious about improving the health of people in prison – and realising the wider benefits this entails – greater overall investment in the prison estate is crucial.

Prioritise prevention and support targeted, practical interventions

The most effective way to reduce poor health is to prevent it from arising in the first place. One important route is addressing health inequalities beyond the prison estate. As set out above, prisoners are more likely to experience deprivation and poor health prior to entering custody, meaning prisons inherit complex and long-term health needs from the outset.

Policies that tackle the wider determinants of health – not to mention crime itself – like poverty, unemployment, access to services, and structural disadvantage are hugely important for improving outcomes. There is no quick fix for these issues, but it is a point worth making. A genuinely systems-level approach to prison health must consider the conditions people experience before entering custody and after release, and it would be remiss not to mention such policies here in this paper.

Prevention within prisons is also important. This means addressing illness, harm, and risk as early as possible, rather than responding as they occur. In a custodial setting, this might include early health screening on entry, prison education, vaccination as disease control, and trauma-informed approaches to mental health support.[150] It also includes the provision of decent living conditions – cleanliness, pest control, and access to sanitation – which, in the context of an ageing and deteriorating prison estate, are not always guaranteed. While these measures represent the bare minimum of health support, delivering them consistently is not entirely straightforward in prisons. They depend on joined-up services, adequate staffing, and sustainable funding – recommendations discussed in this section.

Alongside longer-term prevention, there is also scope for more immediate, practical interventions. Given funding pressures, Dr Katrina Forsyth of The University of Manchester this could include measures that are feasible to implement relatively quickly and can deliver tangible benefits, such as measures to improve diet and physical activity.

With regard to diet, the Love British Food campaign notes that while prison food budgets are constrained, the centralised, simple nature of prison procurement offers opportunities for introducing positive change.[151] For instance, prisons could reintroduce prison farms - until 2005, prisons were largely self-sufficient in pork, bacon, eggs, salad crops, and milk, produced on prison farms – and bringing back this model could improve nutrition while offering educational benefits. The

Sustainable Food Trust has highlighted the rehabilitative potential of growing, cooking, and eating good food in prisons, while the Food Behind Bars charity reports that such programmes are consistently linked to improvements in mental health, self-esteem, social skills, and confidence.[152] Prison farms and horticulture initiatives would be unlikely to solve underfunding of themselves, but they could offset costs while improving quality and delivering skills and rehabilitative benefits.

Increasing access to exercise and outdoor space also presents a relatively low-cost opportunity to improve health outcomes in custody. Research shows that spending time outdoors and in nature tend to be happier, and that green spaces within and around prison infrastructure can reduce levels of violence and self-harm, ease stress, and support rehabilitation.[153] While some initiatives, such as The Conservation Foundation's 'Unlocking Nature' programme delivered at HMP Wandsworth, require upfront investment to 'green' prison environments, better use of existing outdoor spaces is often feasible at relatively low cost.[154]

One example is the nationally popular Parkrun, which has extended its events into custodial settings.[155] While Parkrun is not yet widespread, they are considered positive and as of November 2024 was adopted by over 30 male and female prisons and YOIs across the UK, Ireland, and Australia. There is also scope for smaller-scale innovation, such as The 180 Project's CrossFit community at HMP Lancaster.[156] Non-clinical social prescribing interventions such as these offer promising, preventative approaches to improving physical and mental health, and as the Chief Medical Officer and academics from The University of Manchester have highlighted, they can be effective in reducing the burden of long-term or chronic conditions.[157]

Improve coordination and integration across health services

Healthcare in prisons is less effective and harder to access because services are fragmented and siloed. Delivering good health outcomes in custody requires coordination across the prison estate, yet this is neither routine practice nor easy to achieve. Improving healthcare in prisons not only relies on adequate resourcing, but changes to how care is planned and delivered, moving to a more integrated and holistic approach.

Dr Jane Senior noted that, in the current system, "everything becomes so bitty and it doesn't join." This creates two key problems. First, it makes accessing the right care more complicated for prisoners. Secondly, it means the care provided in one area (for example, mental health) may not be aligned with support provided in another area (alcohol and substance use treatment), which can be particularly problematic for prisoners with multiple and complex needs. As discussed throughout this briefing, while fragmented care can also be a challenge in community settings, people in prison are more likely to have overlapping health needs and are therefore also more dependent on effective, joined up support.[158]

Changes to commissioning could enable this. As Dr Senior observed, services do not tend to be commissioned on a geographical basis, which can weaken relationships with local secondary care providers, disrupt care, and diminish the trust of prisoner-patients. For example, a contracted provider may be based in one part of the country

while responsible for delivering services in a prison elsewhere, with less familiarity with local trusts, secondary services, and referral pathways. Experts at our roundtable also highlighted the value of local co-commissioning of services, which offers the dual benefits of pooled resources and smoother collaboration between services.

Another potential avenue for reducing siloing and fragmentation is the adoption of a 'no wrong door' approach – a collaborative strategy where initial contact points easily refer and connect individuals and to build inter-agency relationships.[159] As the name suggests, this means prisoners receive some form of help no matter which service they first raise concern, rather than being turned away or told to self-refer elsewhere. For instance, a prisoner with sleep problems might be screened not only for physical health issues, but also for underlying mental health needs, substance withdrawal, or trauma, with active referrals made across services.

Roundtable participants also discussed the role of families and carers in supporting prisoners – an underused asset. The SMF was told that families can play a proactive role in in identifying changes in behaviour or health that may be missed by prison staff, and involving them can have positive outcomes for prisoners' health and wellbeing.[160] While NHS England has a statutory duty to involve carers in care delivery, this is not consistently realised, while families can be locked out of the justice healthcare system and prevented from supporting their loved ones. A pilot project run by Pact in prisons across London and the South East seeks to address this gap by embedding family engagement into healthcare provision, enabling earlier dialogue, consultation, and intervention before a patient reaches crisis point.[161]

Underpinning all efforts to improve coordination is reliable information and data. Strengthening health data sharing was one key recommendation of the CMO and had previously been noted by the NAO.[162] The CMO emphasises the importance of ensuring NHS data can move seamlessly in and out of secure settings, with the full digitisation of prison health records – we were told that some prisons still use handwritten documents – standing out as a necessary and long-overdue step. Many government systems involved in prison healthcare lack interoperability and are unable to communicate with one another.

Improved information sharing would also support continuity of care during transfers within the prison estate and into probation and the community. Delays and lost records interrupt treatment, prevent completion of care, and lead to unmet need following release – undermining health outcomes and rehabilitation. NICE has outlined the need for the timely transfer of relevant medical data to the relevant parties in order to support continuity of care.[163]

Strengthen cross-departmental oversight of prison health in government

Healthcare in prisons sits at the juncture of DHSC and the MoJ, and operationally between the NHS England, HMPPS, and – particularly in England – various service providers. Neither holds sole responsibility, and weak integration between systems continues to undermine delivery. The Health and Justice Framework for Integration

acknowledges these challenges and sets out ambitions for closer working, but significant gaps remain.[164]

One opportunity to strengthen ties between the departments is through shared targets. As separate entities, involved organisations each have different priorities, which can work at cross-purposes and compromise the provision of prison health and care.[165] The Chief Medical Officer has noted persistent differences in culture between health and justice, despite evidence that good health reduces reoffending and that prison healthcare is key for overall population health.[166] They have reinforced the need for closer collaboration between clinical and professional leadership across the prison estate, echoed by the NAO which recommended joint strategic goal-setting as early as 2017.[167] Shared goals could help align prison healthcare with the DHSC's 10 Year Health Plan (prisons are not explicitly mentioned in the policy paper).[168]

Improved collaboration also depends on better information sharing. The CMO has called for stronger cross-departmental leadership on data sharing, noting the absence of a clearly designated team to lead this work.[169] They add that establishing a joint unit to oversee data interoperability would support effective prison population health surveillance, workforce planning, and service commissioning. Better data linkage would also allow prison health data to be routinely included in national health reporting.

Interview and roundtable discussions for this research further highlighted opportunities to strengthen oversight and integration. Suggested reforms included placing a statutory duty on NHS trusts to include local prison populations within their planning responsibilities and embedding prison placements within healthcare training pathways. It was also suggested that prison healthcare becomes fully incorporated into wider health system, policies, and strategies, rather than treated as a distinct or siloed service. Improved data sharing would support this integration, enabling health data from prisons to be included in national reporting – such as disease prevalence and incidence – and ensuring that prison health is recognised as part of population health, not an exception to it.

Recommendations for delivering systemic change in prison health

1. **Support effective prison healthcare through sustainable funding,** in line with increased investment across the prison estate, recognising that the delivery of healthcare in custody – including staffing – depends on a functioning prison regime, and deterioration across the estate makes additional funding urgent.
2. **Prioritise prevention and support targeted, practical interventions,** considering the conditions people face before entering custody and focusing on measures feasible in prisons, such as access to exercise and outdoor spaces.
3. **Improve coordination and integration across health services** to reduce siloing and fragmentation, which could be enabled by changes to commissioning, approaches like 'no-wrong door', and involvement of families and carers.
4. **Strengthen cross-departmental oversight of prison health in government** by improving ties between DHSC, MoJ, NHS, HMPPS, and service providers through clear accountability, shared goal-setting, and data sharing.

ENDNOTES

This briefing paper draws on research papers and journal articles to which the following University of Manchester academics have contributed: Darren M. Ashcroft, Kim Barnett, Jana Bowden, Deborah Buck, Alistair Burns, Stephen M. Campbell, Matthew J Carr, Sandra Flynn, Katrina Forsyth, Falaq Ghafur, Kerry Gutridge, Leanne Heathcote, Thomas Hewson, Saied Ibrahim, Richard N. Keers, Sarah/Sarah-Jayne Leonard, Shiyao Liu, Baber Malik, Tim Millar, Matilda Minchin, Lee Mulligan, Adam O'Neill, Maria Panagioti, Catherine A Robinson, Caroline Sanders, Jane Senior, Jenny Shaw, Joshua Southworth, Caroline Stevenson, Ellie Thompson, Verity Wainwright, Florian Walter, and Roger Webb. Special thanks are due to Katrina Forsyth for her sustained contribution to this paper.

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