Mental health in prisons: crisis and opportunity

Pact

Prisoners · Families · Communities
A Fresh Start Together

CENTRE FOR MENTAL HEALTH

Summary

Nine out of ten people in prison have at least one mental health, neurodevelopmental or substance use problem, and rates of severe mental illness are ten times those in the general population

Rates of self-harm in prisons are high and rising, with the highest rates in women's prisons.

Prison mental health services currently **support one person in seven in the prison population**. They provide vital care and support but are often overstretched because of high levels of need and complexity.

Involving family members in providing mental health support in prisons can be beneficial but is often limited.

Transfers from prison to hospital for urgent treatment **are still too often delayed**, sometimes by weeks and months.

Community sentences with mental health treatment can divert some people from custody. This **reduces pressure on prisons and enhances their chances of successful rehabilitation.**

We urge the Government to **invest in community-based options**, in line with the Sentencing Review and the NHS 10-year plan for healthcare in England, as an alternative to prison expansion.

Introduction

Almost thirty years ago, the only national study of its kind found that nine out of ten people in prison had at least one mental health, neurodevelopmental or substance use problem. Two-thirds had multiple mental health needs, and rates of severe mental illness were around ten times the rate in the general population (Singleton et al, 1998).

Remarkably, given these extraordinary findings, that exercise has not been repeated since. But in the meantime, the prison population has doubled, and plans are afoot to expand it once again.

This is a call to explore how the Government could use public funds differently. To investigate how the justice system could work for victims, communities, people who have committed offences, and families alike with a better understanding of mental health. To ensure investments and decisions made now make communities safer and people healthier in the long term.

In this briefing, we look at the current evidence about the mental health of people in prison and the options available to government to address people's needs more effectively.

We explore the consequences of poor mental health in prisons, the ways in which health and justice services are working hard to address them, and some of the challenges this poses.

We discuss the impact of imprisonment on people's families, including how families can often be part of the solution. And we look at ways to relieve pressure on the prison system, for example by diverting some people from prison to community where that is safe and effective.

In the light of the Sentencing Review and reforms to the Mental Health Act in progress, this is a good time to reimagine and rebuild a justice system that works for the common good of all - for victims, communities, people who suffer mental ill health, and the dedicated people who work in our struggling justice system.

We hope this briefing will prompt debate and discussion about what a mentally healthier justice system might look like.

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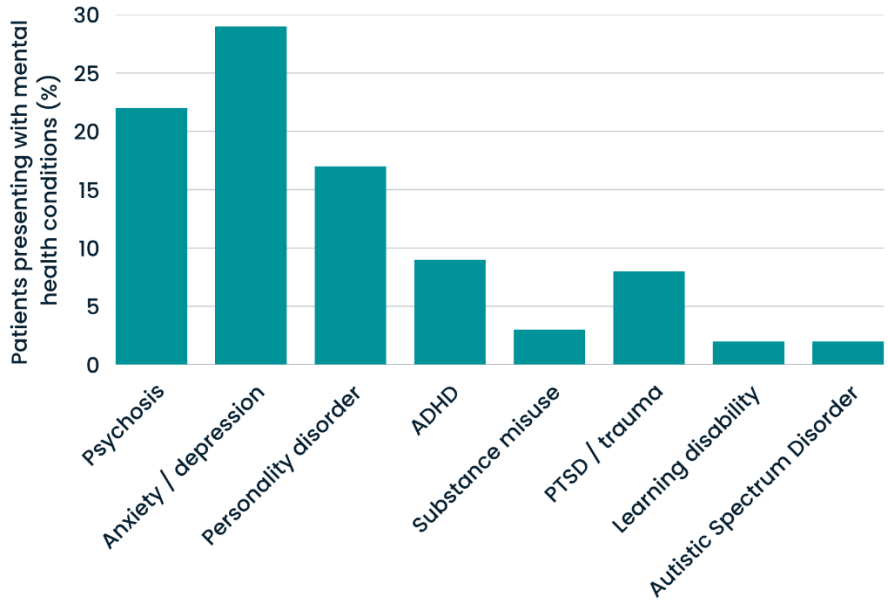
Andy Bell, CEO, Centre for Mental Health

The current state of mental health in prisons

Poor mental health is the norm, not the exception, among people in prison. HMIP's Annual Report 24/25 shows that 56% of men and 74% of women report that they have mental health problems.[1] A national survey of mental health in the prison population, carried out in 1997, found that nine out of ten prisoners have at least one mental health or substance misuse problem, and a majority have two or more diagnosable difficulties.[2] While this survey has not been updated since, there is no reason to believe that the situation has changed in the intervening decades.

The most common diagnoses outside London are anxiety and / or depression, personality disorder, ADHD and PTSD. In London, where the prison population is largely made up of remand and short sentences, the proportion of prisoners presenting with a main presenting problem of psychosis was significantly higher.[3]

Primary presenting problem of prisoners on a mental health caseload in England



The crisis in mental health can also be seen in the alarming increase in self-harm in the last decade. Figures have risen from 266 incidents per 1,000 prisoners in 2013/14 to 852 incidents per 1,000 prisoners in 2023/24.[4]

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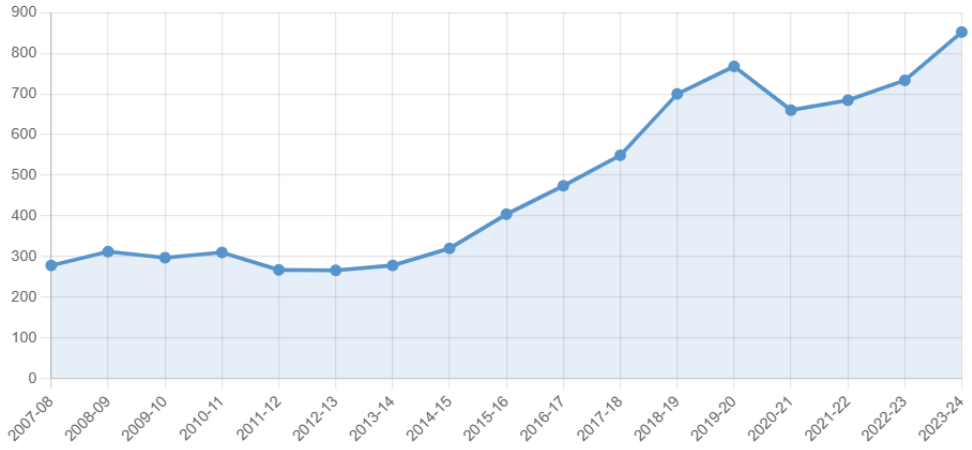
[1] HMIP Annual Report 2024/25, Prisoner Survey Responses 2025
[2] Quoted in Durcan G. (2023) Prison Mental Health Services in England; Centre for Mental Health.
[3] Ibid.
[4] Justice in Numbers GOV.UK Self Harm incidents per 1,000 prisoners; (accessed 15/04/2025)

Self-harm incidents per 1,000 prisoners



The level of incidents of self-harm in women's prisons is particularly striking. The rates of self-harm in the female estate are almost eight times higher than in the male estate and are at record levels.[5]

It is estimated that the total cost of mental ill health among people in prison is £2.1bn every year. This includes £400m from prison sentences that could be avoided linked to mental health issues.[6]

Current provision of mental health care in prisons

All prisons in England have dedicated mental health services that are commissioned by the NHS. A census of these services by Centre for Mental Health (Durcan, 2023) found that they support around 14% of prisoners nationally (the proportion in women's prisons being far higher).

These are vitally important health care services, based on the principle of equivalence between prison and the community, but with high rates of mental ill health and complexity of need in the prison population, many struggle to provide the quantity and quality of care that is required.

The HMIP Annual Report 23/24 found that there were 'worrying gaps' in mental health services, in part driven by 'high health care staff vacancy rates, coupled with chronic recruitment and retention issues' which means that 'many prisons did not have an

[5] Safety in Custody statistics, England & Wales: quarterly update to September 2024 (accessed 15/04/2025)
[6] Cardoso F., & McHayle Z. (2024) The Economic and Social Costs and Mental Ill Health; Centre for Mental Health; p40.

adequate number of clinical staff to deliver effective care …. resulting in unmet need and adverse patient outcomes for some.'[7]

The 24/25 report found that staffing difficulties leads to a 'dependence on additional agency or locum personnel to deliver critical mental health services' which mean that support has be prioritised and that
'some care was missed or delayed, particularly for patients requiring psychological interventions.'[8]

HMIP figures show that a minority of people who need support receive it. Just 39% of male prisoners and 43% of female prisoners who say they need help receive it.[9]

Many prisons acknowledge skills gaps in a range of areas. 33% said they had gaps for learning disabilities, 58% for autism, 43% for ADHD, 87% for acquired brain injury and 84% for speech, language and communication difficulties.

Mental health staffing varies by region, but even regions with the highest levels of provision had only nine nursing staff per 1,000 people in custody; two psychiatrists; seven occupational speech and language therapists; eight psychologists/therapists; five social workers and seven support workers.[10]

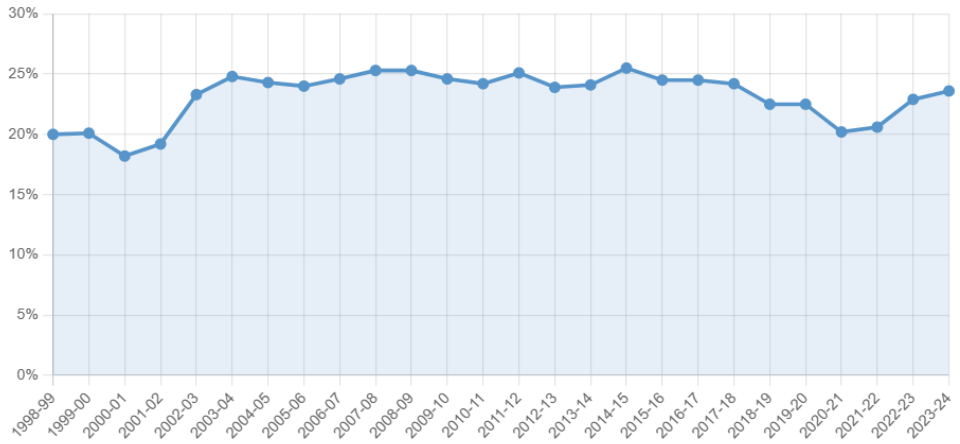
Prisoners should receive an initial health screening within their first 24 hours in prison. However, the Justice Select Committee described it as 'unacceptable' that one in 12 prisoners do not have a health screening appointment within 24 hours of arrival.

The impact of prison overcrowding and Covid-19 on mental health

Whilst the capacity crisis has hit the headlines in the last 18 months, statistics show that levels of overcrowding have remained at consistently high levels for over a decade. In 2013/14, 24.1% of prisoners were held in crowded accommodation compared to 23.6% in 2023/24.[11]

[7] HMIP Annual Report 23/24; p21; 2024
[8] HMIP Annual Report 24/25, p31, 2025
[9] HMIP Annual Report 2024/25, Prison Survey Responses (tab 15) 2025
[10] Prison Reform Trust, Bromley Briefings Prison Factfile, February 2025
[11] Percentage of prisoners held in crowded accommodation, GOV.UK (accessed 15/04/2025)

Percentage of prisoners held in crowded accommodation



However, it is clear that these consistently high levels of overcrowding have an impact not just on prisoners' mental health but also on the capacity of the system to provide patients with the care they need.

A 2018 paper published in the International Journal of Prisoner Health found that 'overcrowding is an obvious cause of and contributing factor in many of the health issues in prisons, most notably infectious diseases and mental health issues.' It concluded that 'the case of prisons in England and Wales demonstrates that overcrowding is a key factor that continues to have a wide-ranging impact on prisoner health and well-being and on their living environment.'[12]

These consistently high levels of crowding were exacerbated by the impact of lockdowns during Covid-19 when many prisoners spent up to 23 hours locked in their cells. Covid-19 restrictions persisted in prisons longer than they did in the broader community. In his Annual Report 22/23, the Chief Inspector of Prisons noted that 'Despite final COVID-19 restrictions being lifted in May 2022, we found far too many prisons continuing to operate greatly reduced regimes in the last year.'[13]

There is even evidence to suggest that the Covid-19 restrictions have had a long-lasting impact on the amount of time out of cell and prison officers' attitudes in this area. In his 23/24 Annual Report, the Chief Inspector found that 'despite some improvements from the severely impoverished regimes during the pandemic, this year many prisoners still spent far too long locked up.' Despite this, the report found that 81% of frontline staff and 79% of managers strongly or somewhat agreed that prisoners had enough time out of cells.[14]

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[12] MacDonald, M. (2018) Overcrowding and its impact on prison conditions and health; International Journal of Prisoner Health; p3.
[13] HMI Prisons (2023) Annual Report 22-23 p5
[14] HMIP Prisons (2024) Annual Report 23-24 p34

The underuse of Mental Health Treatment Requirements (MHTRs)

There are a range of requirements that may be included in a community order with the purpose of addressing offending through punitive or rehabilitative requirements. One of these is MHTRs, which provide the judiciary with the option to apply community orders as an alternative to short custodial sentences. MHTRs have been found to be effective in both improving health and reducing reoffending.[15]

Individuals may be sentenced to an MHTR if they present with a range of mental health issues, including people who present with lower-level mental health needs and could be supported in the community.

Although the use of MHTRs has risen in the last decade, just 2.2% of all community or suspended sentence orders include MHTRs.[16] There has also been a wider trend of a significant decrease in the number of people sentenced to community sentences – down from nearly 150,000 in 2012 to 74,847 in 2024.[17]

This is despite evidence that they work. People who receive MHTRs have a reoffending rate nine percentage points lower than those given short custodial sentences. Moreover, when people are given an MHTR, a wait for treatment can see an escalation of their offending behaviour.[18]

Clinks has highlighted a range of barriers to increasing the uptake of MHTRs. These include the impact of backlogs across the courts system, a fall in the number of pre-sentence reports written by probation officers and a lack of awareness among sentencers regarding the availability of MHTRs, which often results in the requirements not forming part of community sentences.[19]

The Justice Select Committee in 2021 concluded that too many people are sent to prison 'because community orders with mental health treatment requirements are unavailable in many areas', describing it as 'unacceptable that in many parts of the country and for years to come, sentencers will continue to be obliged to send offenders to prisons simply because appropriate community sentences are unavailable.'[20]

A recent example of this was included in the HMI Prisons report on HMP Styal. The report found that in the 12 months prior to the inspection, 39 women had been sent to the prison due to their acute vulnerabilities and the absence of specialised support in the

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[15] Chalam-Judge, R. & Martin, E. (2024). Evaluation report: The impact of being sentenced with a community sentence treatment requirement (CSTR) on proven reoffending; p36 Ministry of Justice.
[16] Bromley Briefings Prison Fact File February 2025; Prison Reform Trust; p67; 2025
[17] Ministry of Justice; CJS sentence types: Offenders sentenced to Community Sentence
[18] Chalam-Judge, R. & Martin, E. (2024). Evaluation report: The impact of being sentenced with a community sentence treatment requirement (CSTR) on proven reoffending; p36 Ministry of Justice.
[19] Clinks (2025); RR3 Special Interest Group on Community Provision 2024-25 Report 1
[20] Mental Health in Prison Fifth Report of Session 2021/22 (2021) House of Commons Justice Committee; p28

community. The report found that 'prison was clearly not the right place for them as options for treatment were far more limited than in a hospital, and prison officers were not equipped to provide the necessary care which required specialist health care support.'[21] The Mental Health Bill, in Parliament at the time of writing, will repeal the 1976 Bail Act provisions that allow this to happen.

More recently, the Independent Sentencing Review also recommended greater investment in Community Sentence Treatment Requirements (of which MHTRs is one) to increase accessibility for offenders with substance misuse or mental health issues. David Gauke noted that 'increased investment in treatment providers would help to better manage offenders with alcohol or drug misuse and/or mental health issues in the community.'[22]

The crucial role of families and carers

It has long been recognised that families and carers have a crucial role in caring for loved-ones who suffer from ill health. Families bring with them a wealth of experience and knowledge - they know what 'well' looks like and understand the subtle signs that someone is struggling.

Family and carer involvement is a principle enshrined in the Mental Health Bill 2025, with a pledge that 'greater involvement of patients, families and carers will improve treatment while protecting patients, staff and the wider public'.[23]

Despite this, NHS England has acknowledged that more needs to be done to involve families and carers in their loved-ones' mental health care in prison. In a foreword to a toolkit for carer support in secure mental health services, Dr Neil Churchill, the then Director for Participation and Experience at NHS England, wrote that 'Many forensic carers report not feeling valued, not being given information and not being involved or listened to by professionals.'[24]

Research by Pact shows that greater family involvement in prison health care would benefit all actors in the process - prisoners, families, the criminal justice system and the NHS. However, Pact's 'Nobody's Listening' report concludes that families and significant others are too often locked out of a system that doesn't value their role as carers.[25]

Pact delivers its Listen to Families project, delivered under contract to NHSE in prisons in London and the South East, and has spoken to more than 1500 families, summarising their views and experiences in its 1500 Voices report [26]. The project has also co-created with families, the NHS and health care providers a Carers' Charter which sets out nine

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[21] Report on an unannounced inspection of HMP/YOI Styal (2025); HMI Prisons p17.
[22] Independent Sentencing Review: Final report and proposals for reform (2025); GOV.UK
[23] GOV.UK; Better care for mental health patients under major reforms (2024)
[24] NHS England (2018); Carer support and involvement in secure mental health services – a toolkit; p3.
[25] Prison Advice and Care Trust (2023); Nobody's Listening – what families say about prison healthcare.
[26] Pact (2025); 1500 Voices: What it's like to support your loved-one in prison with health issues

ways in which providers pledge to involve families and carers proactively in the loved-ones' health care.[27]

The impact on families' mental health should also be considered in the debate. Research from Pact shows that 83% of prisoners' family members said that their mental health had deteriorated as a result of their loved-ones' imprisonment.

This is connected to a range of factors including worsening finances, losing relationships with friends and family, and the stigma and perceived shame of having a loved-one in prison.[28]

The Mental Health Bill will strengthen the rights of families and carers through changes to the nominated person role and require clinicians to consult with others close to the patient as they make decisions around their care where appropriate or where the patient wishes. [29]

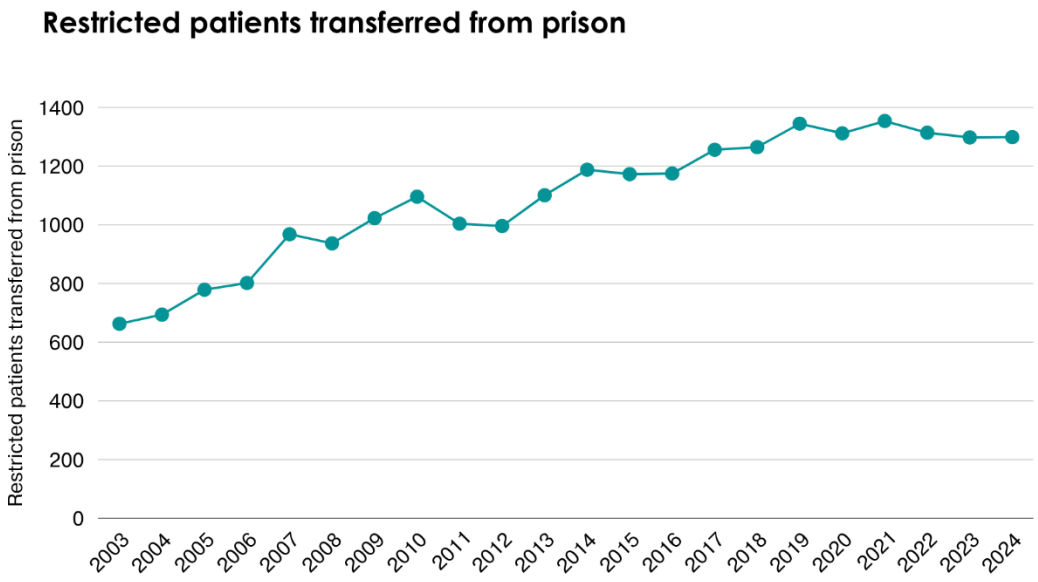
The Government and the NHS must ensure that prisoners' families and carers are given the same rights as those in the community and that the barriers preventing greater family involvement in prison health care are removed as far as possible.

Transfer from prison to secure hospital accommodation

There has been a 49% increase in the number of 'restricted patients' since 2003, rising from 3,118 to 4,644. Restricted patients are defined as 'mentally disordered offenders who are detained in hospital for treatment and who are subject to special controls by the Justice Secretary due to the level of risk they pose'.[30]

In 2024, 1,299 restricted patients were transferred from prison, a figure which has nearly doubled in the last 20 years from 663 in 2003.[31]

[27] NHSE (2024); The Family and Carers' Charter for Health and Justice
[28] Pact (2023); Serving a hidden sentence – the financial and emotional impact of a loved-one's imprisonment
[29] GOV.UK (2024); Better care for mental health patients under major reforms
[30] GOV.UK; Working with Restricted Patients
[31] Restricted Patient statistics 2024 (2025) Table 4: Restricted patients detained in hospital in England and Wales by admission category; Ministry of Justice.



Patients in the midst of a mental health crisis should be transferred within 28 days. However, HMIP has found that just 15% of patients are transferred within this timeframe and that the average wait is 85 days from the point it was identified that the patient's mental health needs could not be treated in prison.[32]

The HMIP findings are backed up by a report by the Independent Monitoring Boards which found that prisons too often use Segregation Units as 'holding bays' and as a way of managing and caring for prisoners with severe mental health needs.

In these situations, prison officers effectively take on a carer role for prisoners. A relatively small number of severely ill prisoners take up a disproportionate amount of time for prison staff who do their best to step into a role for which they are ill-equipped and untrained. Elisabeth Davies from the Independent Monitoring Boards describes the 'compassion and understanding' shown by prison staff who were simply 'having to fill the gaps created by a broken system'.[33]

There is a welcome pledge in the Mental Health Bill to speed up transfers from prison to hospital by limiting the time it can take to transfer prisoners who need treatment in a mental health hospital to a maximum of 28 days. This is a vital step that will require systemic change to remove blockages in secure mental health services, for example by investing in step-down community support (including appropriate housing and forensic community mental health care) for people who no longer need to be in hospital, and to ensure that accountability for completing transfers in a timely way is clear.

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[32] HMI Prisons; The long wait: A thematic review of delays in the transfer of mentally unwell prisoners (2024)
[33] Independent Monitoring Boards (2024); Segregation of men with mental health needs – a thematic monitoring report

Case study – Alison

I had no knowledge of the justice system before my son got involved with it. When he was found guilty it felt as though the world around me had collapsed.

The day after my son was sentenced, our GP wrote to the prison about my son's psychosis, setting out the medication that he needed.

Despite this my son wasn't allowed his anti-psychotic medication because it hadn't been prescribed by a prison doctor. He wasn't seen by the prison psychiatrist for over a month, at which point he was incorrectly diagnosed with depression.

Six weeks into his sentence, he was moved over 200 miles away. When I got to see him again, it was heartbreaking – he was dirty, smelly, had lost a huge amount of weight and told me that he was planning to take his own life.

I was at my wits end about him not getting the right care and medication. When I spoke to the prison their attitude seemed to be that I was the problem. They said that he was fine until I got involved.

It was nine months before he was finally transferred to a secure hospital in the community, which was a completely different experience. They actually focused on him as a person, rather than just treating him as a number.

They asked about his childhood, and his previous problems. He got to do cookery, gardening, work in the café.

Most importantly, they wanted me – his mother – to get involved in that whole process and to share my insight. They saw me as part of the solution, rather than part of the problem.

We've got him well now. He's got a girlfriend, a daughter, his own flat. But there's not a day goes past when I don't think about what could have happened if he'd been stuck in that prison for longer. I'm not sure he'd still be with us.

The risks of expanding the prison estate

There is also a good deal of discomfort across the Criminal Justice Sector around the expected increases in the prison population, which is projected to rise to between 95,700 and 105,200 by March 2029, with a central estimate of 100,800. The central estimate would be a 15% increase on today's prison population which already stands at near record levels.[34]

In its 10-year prison capacity strategy published in December 2024, the Government set out its plans to build 14,000 new prison places by 2031. The document estimates that the programmes will cost between £9.4 billion and £10.1 billion, compared to an original estimate of £5.2 billion at the time of the 2021 Spending Review.[35]

We recommend that the Government invest an element of this funding in community-based mental health interventions for people in the criminal justice system. This would include taking steps to expand MHTR provision; to improve step-down services for people who are ready to leave secure hospital; and to ensure prisoners who have received mental health support inside are provided with continuity of care when they leave. These measures will both improve outcomes in the criminal justice system and enable the Government to achieve its legislative ambition to speed up transfers from prison to hospital.

It is also vital that any changes to the prison estate are designed to bring about a trauma-informed environment in every establishment. Putting safety and wellbeing at the heart of the prison system will benefit staff and prisoners, and their families.

Conclusion

Poor mental health is endemic in prisons. Prisons, by their nature, are not mentally healthy environments. Many people who go to prison already have very poor mental health. And a stay in prison is likely to make it worse. This is harmful to them and their families and does little to help them to rehabilitate.

There is much positive intent. NHS England's Health and Justice Pathway sets out a clear strategy to inform the development of health and justice services in England.

The recent Spending Review clearly prioritised health, with a 3% average annual real-terms growth rate over the SR period. How much of the NHS's projected £200 billion budget within this period will go to historically underfunded mental health services remains to be seen. The Ministry of Justice also fared better than expected, receiving a real-terms 1.8% increase. However, a significant proportion of this funding (£7bn) will go towards the construction of 14,000 new prison places.

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[34] GOV.UK; Prison population projections: 2024 to 2029 (2024)
[35] Ministry of Justice (2024) Ten-year prison capacity strategy

We believe that a cost-neutral transfer of funding from the prisons building programme to community-based health interventions would bring a number of benefits:

- Expand the capacity for the provision of Mental Health Treatment Requirements as part of Community Orders. This is in line with the recently published Sentencing Review and the Government's stated aim to deal with more offenders in the community, thereby relieving pressure on overcrowded prisons.

- Remove blockages in the system that currently hamper prisons' ability to transfer patients to hospital for urgent treatment within the 28-day period. Improving step-down services for people who no longer need to be in hospital would help to free up capacity and ensure seriously unwell people get the care they need.

- Expand the role of families and carers in supporting prison and health care staff to care for mentally unwell patients. This is in line with the Mental Health Bill's aspiration to strengthen the rights of families and carers and to require clinicians to consult with others close to the patient.

This approach also aligns with the NHS 10-year Health Plan for England, which seeks to treat more patients in the community, as well as a shift from 'sickness to prevention'.

Pact and Centre for Mental Health have a shared commitment to take this work forward. We hope that this paper will generate further opportunities for collaboration and help to make the case for more community-based interventions. We would welcome the opportunity to:

- Discuss this issue further with officials from the MoJ, DHSC and other relevant departments and organisations.
- Work with Health & Justice commissioners and providers to identify ways in which community-based health interventions can be enhanced and family/carers can be brought more proactively into the process.
- Instigate vital research, innovation and evaluation into how to build a mentally healthier and safer justice system that works for everyone.