Birmingham City Council

Birmingham Health and Wellbeing Board

NHS

Birmingham Justice Health Needs Assessment

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Illustrations and artwork: Laura Brodrick, Think Big Picture

Storytelling: Jordan, Leigh, Michael, and Mellissa [artwork reproduced with permission]

In Memoriam: This report is dedicated to the memory of Michael, whose sudden passing has been deeply felt by all who knew him. Michael made a valuable contribution to this Justice Health Needs Assessment through his insight, experience, and generosity, helping to strengthen the report and the work around it. He was also a much-valued member of the Birmingham's Inclusion Health Living Library, where he gave his time and perspective to support greater understanding, compassion, and change. His contribution will be remembered with gratitude and respect.

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Executive Summary

People in contact with the criminal justice system (CJS) experience poorer health outcomes than the general population and face multiple, overlapping forms of disadvantage. National evidence highlights higher levels of mental ill health, substance misuse, unmet physical health need, neurodivergence, homelessness and other complex needs among people in prison and on probation. Recent national work has also reinforced the importance of prevention, equitable access to healthcare, continuity of care, and improved partnership working across health and justice services.

This is an important public health issue for Birmingham. The city has high levels of deprivation and longstanding inequalities, both of which are closely associated with vulnerability across the life course and increased risk of contact with the criminal justice system. In Birmingham, the first-time entrant rate to the youth justice system for 10- to 17-year-olds was 132.5 per 100,000 population in 2023, equivalent to 176 children, which was similar to the England rate of 143.4 per 100,000.

Birmingham's local context makes justice health a particularly important public health priority. The city has a population exceeding 1.15 million and is England's largest local authority. It is also a young and super-diverse city, with 51% of residents under the age of 35 and minority ethnic groups representing over half of the population. These strengths sit alongside significant and longstanding inequalities, including high levels of deprivation, child poverty, housing insecurity, youth unemployment and economic inactivity. These wider determinants do not cause criminal justice contact in a simple or direct way, but they shape exposure to risk, access to support, and the ability of individuals, families and communities to recover from adversity.

The Birmingham justice health population is not confined to HMP Birmingham. HMP Birmingham is a Category B men's reception prison and forms a key part of the local secure estate, but many Birmingham residents are held in prisons outside the city, while many people in contact with the justice system are supervised in the community. As of July 2024, 2,961 Birmingham residents were incarcerated across 116 prisons in England, equivalent to an incarceration rate of 256 per 100,000 population, substantially higher than the national average of 146 per 100,000. In addition, Birmingham has four probation offices, and more than 2,800 individuals were managed by Centenary House and Perry Barr probation offices alone in 2022, the majority of whom were Birmingham residents. This means that the local justice health response must consider custody, community supervision, court pathways, release, resettlement and prevention together.

The prison population is only part of the overall justice health picture. Ministry of Justice statistics show that there were 85,372 people in prison in England and Wales as at 31 December 2024, compared with 240,497 offenders under probation supervision as at 30 September 2024. This underlines the importance of considering justice health beyond the prison estate alone, including the needs of people supervised in the community and those moving between custody and community settings.

This Justice Health Needs Assessment (JHNA) draws on a mixed-methods approach, combining quantitative data analysis from national and local sources, a rapid literature review, stakeholder engagement across health, justice, local authority and voluntary sectors, and peer-led qualitative research with people with lived experience of the criminal justice system in Birmingham. This approach ensures that statistical trends are interpreted alongside lived experience, enabling a more complete understanding of need, gaps in provision, and opportunities for prevention.

It highlights key drivers of poorer outcomes, inequalities experienced across the life course, and opportunities for prevention, earlier intervention and more joined-up support. It adopts a life-course and health inequalities approach, recognising that contact with the CJS is often associated with cumulative disadvantage and that opportunities to improve outcomes exist before, during and after contact with the justice system.

Key factors associated with increased vulnerability to CJS contact and poorer health outcomes include:

- Adverse childhood experiences
- School exclusion
- Experience of the care system
- Economic insecurity and housing insecurity
- Learning disability
- Neurodivergence
- Mental health
- Substance misuse
- Physical health needs and disability
- Veteran status
- Demographic inequalities, including those relating to age, sex, and ethnicity

Overall, the following issues have been identified as key priorities for the Birmingham system to address the needs of those at risk or in contact with the CJS:

- Governance, data and accountability remain immature and require system ownership.
- Justice health is a health inequalities emergency that starts in childhood and place.
- Neurodivergence, learning disability and suspected Foetal Alcohol Spectrum Disorder (FASD) are structurally under-recognised and physical health, disability, sensory needs and frailty are insufficiently addressed and require minimum standards.
- Gender specific health and wellbeing needs as well as unique needs of specific population groups such as older people, veterans, migrants, LGBTQ+ are not sufficiently recognised and addressed.
- Mental health, self-harm and suicide risk are pervasive.
- Housing, poverty, digital exclusion and unstable resettlement multiply health risk and drive reoffending.

Key findings from the Birmingham JHNA include:

- Birmingham has a higher imprisonment rate than the national average. As of July 2024, the rate of incarceration among Birmingham residents was 256 per 100,000 population, compared with 146 per 100,000 nationally.
- Children and young people in Birmingham are entering youth justice at concerning levels. Birmingham has one of the highest rates of first-time youth justice entrants in England and Wales, at 4 per 1,000 compared with an England and Wales average of 2.8 per 1,000.
- Local youth justice need is complex and starts early. Between October and December 2024, Birmingham Youth Justice Service worked with 568 children, including 34 children aged 10–12, showing that primary school-aged children are also at risk of criminal justice system involvement.
- Children in custody from Birmingham often have significant additional needs. Between October and December 2024, 20 children in Birmingham were subject to remand in custody. Of the eight children receiving a custodial sentence, five had some form of special educational need and five had a history of contact with mental health services.
- Serious violence and exploitation remain key local concerns. In Q3 2024, 69 children entered the Birmingham Youth Justice Service for the first time, a 20% increase compared with the same period in 2023, despite rates decreasing across England and Wales overall.
- Lived experience evidence shows high levels of unmet health need. Among the 17 participants interviewed through peer-led qualitative research, 100% had at least one mental health diagnosis, 70.6% reported a history of substance misuse, 41.2% had a diagnosis of ADHD, 33.5% reported physical health conditions, and 11.8% disclosed autism.
- Data gaps are themselves a key finding. Across the needs assessment, local data were often incomplete, inconsistently shared, or insufficiently disaggregated, limiting the ability to fully quantify need, understand inequalities and monitor outcomes across the justice, health and care system.

These findings show that justice health in Birmingham is both a health inequalities issue and a system issue. The population includes people in prison, people under probation supervision, children and young people in contact with youth justice services, people at risk of first-time entry, and people moving between custody and the community. The evidence points to the need for earlier intervention, better continuity of care, stronger data linkage, trauma-informed practice, and more coordinated pathways across health, local government, criminal justice, education, housing and the voluntary and community sector.

Through adopting a 'life-course' approach, this report considers the drivers of CJS involvement from conception to old-age in Birmingham. Early life experiences, including exposure to adversity and unmet health and developmental needs, can influence outcomes across childhood, adolescence, and adulthood, increasing vulnerability to later contact with the CJS.

The wider living environment can also influence CJS involvement with deprivation and housing insecurity being known risk factors. Birmingham has substantially higher levels of deprivation compared to the national average with youth unemployment and economic inactivity rates being particularly stark. Experience of trauma is known to be another key driving factor for CJS involvement and whilst not all individuals living in deprivation may experience trauma, where it does happen there may be less resource available for support. Trauma can result from many different interpersonal, impersonal, immediate, and long-term events but all may impact behaviour and neuro-cognitive development in children. Trauma can lead to compulsive behaviour and emotional avoidance which can increase risk of involvement with the CJS both as a perpetrator of crime but also as a victim of criminal exploitation. It is reported that up to 90% of people involved in the CJS have experience of abuse or loss of a significant family member during childhood.

Childhood experiences such as trauma and associated behavioural responses can lead to school exclusion. School exclusion can impact children immediately through lack of structure and social connection leading to risk of involvement in crime and child criminal exploitation which is of particular concern in Birmingham. Many people in contact with the CJS have experience of school exclusion with low levels of educational attainment.

Often, children who are excluded from school have additional learning needs such as neurodivergence or learning disability. It is thought that up to 50% of people in prison have neurodivergence and often, services are not designed to take their specific needs into consideration.

Many individuals within the CJS also have experience of living in the care system and military service. These experiences and identities can compound to influence behaviour during adolescence and adulthood, leading to increased risk of substance misuse and mental ill health, both of which are common amongst people in contact with the CJS. These patterns can be particularly significant for women in contact with the CJS, who often experience multiple and overlapping forms of disadvantage.

People within the CJS are more likely to have health problems like cardiovascular disease and infectious diseases like Tuberculosis, and the CJS can also contribute to health issues. Neurodivergent people, people who identify as lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ+), people with physical disability, people from minority ethnic backgrounds, and those who do not speak English as a first language are all known to experience worse outcomes in the CJS relating to health and justice. Negative experiences within the CJS can impact mental health, substance misuse, and access to healthcare services where health needs are not identified.

Finally, it is important to note the changing demographics within the CJS. In recent years, sentence lengths have increased and there are a growing number of individuals being convicted for historical sexual offences. There is an ageing population within prisons with increasing needs including physical disability and social care. Evidence also shows that people within prison can experience accelerated ageing and often have multiple long-term health conditions. There is a need for a renewed focus on health and social care within the CJS to adapt and accommodate for the increasing health needs and the ageing population.

The recommendations arising from this JHNA are structured around the main areas where system action is needed. They focus on improving governance, data and accountability; strengthening prevention and early intervention across childhood, place and community

settings; improving recognition and support for neurodivergence, learning disability, suspected FASD, disability, sensory needs and ageing; developing integrated adult and youth justice health pathways; improving continuity of care, mental health, suicide prevention and substance misuse support; and addressing the wider resettlement issues that shape health and reoffending, including housing, poverty, digital exclusion, employment and benefits advice. The recommendations are intended to support both immediate action and longer-term system change, with an emphasis on shared ownership, lived experience, prevention, equity and measurable improvement.

The JHNA makes 27 recommendations:

1. Increase awareness of Zero Suicide Alliance and expand suicide prevention training for staff, prisoners and families, including peer-support schemes (Samaritans Listener) and evaluation, with consideration of women-specific adaptation.

2. Deliver education and training on PTSD, domestic abuse, autism, ADHD to staff within the criminal justice system and other services supporting justice involved populations.

3. Provide sustainable trauma-informed, gender-responsive tailored wraparound services and interventions for groups with distinct justice health needs, including women, older and frail adults, veterans, children of prisoners, and children in care, to ensure support addresses their specific health, wellbeing, safeguarding, social needs and end of life care.

4. Promote and deliver educational, sports and arts-based programmes to support prevention, early intervention, diversion and rehabilitation of people at risk of or in contact with the criminal justice system. Evaluate and embed proven interventions into core commissioning plans and mainstream delivery.

5. Introduce a systematic Vitamin D assessment and supplementation approach across custodial and community justice settings, aligned with national guidance, with particular focus on high-risk groups (e.g. individuals who are indoors for prolonged periods, older adults, people with higher levels of skin pigmentation, and those in institutional settings).

6. Strengthen implementation of LGBTQ+ inclusive practice across custodial and community services.

7. Ensure justice and post-release pathways identify and address domestic abuse to reduce re-traumatisation and risk of harm.

8. Review time spent in cell and increase access to outdoor space, physical activity, and purposeful activity to encourage behaviour change, support health improvement, rehabilitation and future employment prospects.

9. Prioritise access to stable, safe accommodation for justice-involved women, children and young people, and people with repeat contact with the criminal justice system who have unmet housing support needs.

10. Embed employment support, literacy support, digital inclusion, and benefits advice within resettlement as core outcomes, to support stability on release and reduce the risk of poor health and reoffending.

11. Ensure access to routine screening across the CJS for both communicable and non-communicable diseases to improve access to treatment and reduce the risk of transmission.

12. Introduce reasonable adjustments and accessible information for sensory needs, emotional regulation and specific learning difficulties, also recognising the intersectionality of trauma, neurodivergence, ethnicity, language and cultural needs.

13. Strengthen cross-sector collaboration to improve identification and support for neurodivergent individuals and those with experience of trauma across education, health, justice, and other services to mitigate risks of exclusion, exploitation and/ or criminalisation.

14. Strengthen neurodivergence-informed practice across the criminal justice system by improving workforce capability and embedding reasonable adjustments for neurodivergent people and people with learning disabilities. This should include input from people with lived experience and consideration of environmental and custodial design adaptations to improve access, support, and outcomes. Consider alignment with the recommendations from the JSNA Neurodivergence Deep Dive.

15. Embed trauma-informed training and ensure robust early help in schools and community settings to provide appropriate support, address behaviour issues and mitigate risks of first time entry into the CJS. This includes scaling up school based early intervention and alternatives to school exclusion.

16. Adult justice health pathway: co-produce and implement an integrated adult justice health pathway for people in contact with the criminal justice system, providing coordinated, trauma-informed support for mental health, substance misuse, neurodivergence, physical health, disability, and wider needs linked to multiple disadvantage. The pathway should ensure dual/ multiple diagnosis, continuity of care between custody and community, include clear referral and intake processes, support multidisciplinary working across agencies, and make use of co-located or one-stop-shop community hub models where appropriate. It should be underpinned by shared outcomes, data-sharing arrangements, and joint commissioning or pooled-budget approaches where feasible to support joined-up delivery.

17. Children and Young People justice health pathway: co-produce and implement an integrated youth justice health pathway for children and young people at risk of, or in contact with, the criminal justice system, providing coordinated, trauma-informed support for mental health, substance misuse, neurodivergence, physical health, and wider needs linked to multiple disadvantage. The pathway should ensure continuity of care across education, community, health and justice settings, reduce fragmentation between services, include clear referral and intake processes, support multidisciplinary working across agencies, and make use of co-located or one-stop-shop models where appropriate. It should be underpinned by shared outcomes, data-sharing arrangements, and joint commissioning approaches where feasible to support joined-up delivery.

18. Develop system approaches to improve continuity of care for people experiencing frequent prison transfers. Ensure those undertaking the Recovery Unit programme remain in situ until completion, with an operational agreement that participants can complete the programme without transfer disrupting progress.

19. Introduce quantified continuity-of-care indicators to monitor and measure the effectiveness of health and care pathways and transitions between community and secure settings.

20. Develop secure interoperable digital health and justice records.

21. Advocate for improved granularity in coroner reporting to identify suicide deaths with recent criminal justice contact through either a Real Time Suspected Suicide Surveillance System or through Coronial Audits.

22. Agree and implement a minimum shared justice health dataset and linked dashboard across youth and adult justice pathways, using ONS Harmonised Standards where applicable, to improve the routine collection, disaggregation, linkage, and analysis of local place data on health needs, inequalities, risk factors and outcomes, with data reported separately for children and young people, and for adults.

23. Undertake further analytical research to understand the drivers of Birmingham's higher imprisonment rate compared to the national average, including age profile, migration status, education outcomes, family structure, and other social risk factors.

24. Commission a programme of research into the impacts of criminal justice system involvement and imprisonment on women across the life course, including women with and without parental responsibilities, to better understand the short, medium, and long-term health, social, economic, and family impacts, and to inform gender responsive policy, commissioning, and service design.

25. Develop and embed lived experience co-research roles.

26. Commission and undertake targeted research and evaluation to address priority evidence gaps relating to neurodivergence, disability and wider inclusion health needs among people at risk of or in contact with the criminal justice system, to inform equitable service design, workforce development and investment decisions.

27. Establish a Justice Health Partnership Board (or formal subgroup of Inclusion Health Partnership) to own delivery and report into HWBB / ICS / Reducing Reoffending governance.

Overall, the Birmingham JHNA shows that the criminal justice system cannot be viewed as a separate or isolated sector. It is part of a wider system shaped by health, social care, education, housing, policing, probation, prisons, courts, communities and wider social policy. The findings point to a clear need for shared ownership of justice health in Birmingham, supported by stronger governance, better data, integrated pathways, trauma-informed and neurodivergence-aware practice, and sustained action on the wider determinants of health. The recommendations provide a framework for partners to move from describing need to coordinated action, with the aim of reducing inequalities, improving health outcomes, strengthening prevention and supporting safer, healthier communities.

Foreword

People in contact with the criminal justice system experience some of the poorest health outcomes in our communities. Their needs are often multiple and interconnected, shaped by trauma, poverty, poor mental health, substance misuse, homelessness, exclusion and other forms of disadvantage that accumulate across the life course. These are not issues for the criminal justice system alone. They are matters of public health, prevention and health equity.

For Birmingham, this is particularly important. As a large and diverse city with high levels of deprivation and longstanding inequalities, Birmingham is significantly affected by the wider social and structural factors associated with criminal justice system contact. Improving outcomes for this population requires us to look beyond individual services or settings and to take a more joined-up view across health, local government, criminal justice agencies and the voluntary and community sector.

This Justice Health Needs Assessment provides an important overview of the health and wellbeing needs of people in contact with the criminal justice system in Birmingham. It brings together the available evidence to describe need, highlight inequalities, identify gaps in data and provision, and support a clearer understanding of where action is most needed. It also reinforces the importance of continuity of care, particularly at key points of transition and vulnerability.

The report adopts a life-course and health inequalities approach. It recognises that contact with the criminal justice system is often associated with cumulative disadvantage, and that there are opportunities for prevention, early intervention and improved support at every stage: before contact with the justice system, during imprisonment or supervision, and on release or return to the community.

This needs assessment is intended to support both strategic planning and partnership action across Birmingham. It provides a foundation for improving how we understand, commission and deliver support for people in contact with the criminal justice system, with the aim of reducing inequalities and improving health outcomes.

I welcome this report as an important contribution to Birmingham's evidence base and as a prompt for continued collective action to improve justice health across the city.

Sally Burns
Director of Public Health
Birmingham City Council
April 2026

1. Introduction

1.1 Purpose

This Justice Health Needs Assessment (JHNA) focuses on the health and wellbeing of Birmingham citizens within, or at risk of being within, the criminal justice system (CJS), through a life-course approach. It brings together data from health, social care, justice and voluntary and community sector sources in Birmingham, alongside published literature and lived experience. The aim is to provide an evidence base on the health and wellbeing needs of this population, including levels of need, inequalities, and gaps in service provision, to inform strategy, commissioning and practice across Birmingham. It may also be relevant to any professionals involved in the health, social care and criminal justice systems.

1.2 Why Focus on Justice Health?

Justice health is a term used to describe the health and wellbeing of people in contact with the CJS from the community to probation and prison settings. People in contact with the CJS endure some of the most profound health inequalities in society, with lower life expectancy and higher risk of both communicable and non-communicable disease.[1] Involvement in the CJS can have lasting impacts on the lives of the individual but also the lives of those around them, including their health and wellbeing.

Involvement in the CJS is inextricably related to health inequalities: involvement in the CJS is both a symptom of, and a contributor to worse health outcomes.[1] Many of the wider determinants of health are factors that may increase a person's likelihood for involvement in CJS including deprivation and early childhood adversity, and these factors also lead to health inequalities. Healthcare issues are also risk factors for CJS involvement; addiction and mental health issues are known drivers of CJS involvement. Therefore, addressing health issues can form an important part of CJS prevention.[2]

The 'equivalence of care' principle specifies that people involved in the CJS should receive the same level of healthcare as the general population.[3] However, the CJS population are known to endure profound health inequality, and involvement in the CJS itself risks impacting a person's health in ways that the general population will not experience, especially where continuity of care is not achieved and individuals are exposed to infectious disease outbreaks in prisons.[2] Justice health is therefore about providing equivalence of care but also providing a health promoting prevention focused environment and opportunity for individuals to access services and support to address their specific health needs.

Within this JHNA, we explore the risk factors for CJS involvement and the wider determinants of health to gain a system wide understanding of the health and care needs of people within the CJS. By considering the wider determinants of health, including how health and care inequalities may lead to CJS involvement, and how CJS involvement may impact health and care of individuals, we can build a picture of risks and protective factors to guide how services in Birmingham can best be delivered. The JHNA aims to provide evidence to policy makers and commissioners to inform the planning and implementation of services and care pathways to reduce health inequalities endured by people in the CJS, focusing on prevention across the life-course.

1.3 Scope

The report refers to 'people involved in the CJS' which includes:

- Individuals of all age-groups who have had contact with the CJS within the last 24 months
- Individuals of all age-groups who are at risk of CJS involvement
- Individuals of all age-groups who are at risk of re-entering the CJS.

The specific objectives of the JHNA were to:

- Describe the demographics of the population in contact with the CJS in Birmingham
- Describe the drivers of offending across the life course in Birmingham
- Describe the impacts of offending on health and wellbeing

- Describe the protective and risk factors associated with offending behaviours in Birmingham
- Describe the current provision of services and intervention, and how these meet the health and wellbeing needs of the CJS population in Birmingham
- Review the strategic context of the CJS in relation to health and wellbeing in Birmingham
- Provide an evidence-base for interventions or solutions that could prevent offending and associated negative impacts on health and wellbeing
- Make recommendations to address local need.

We must acknowledge the significant physical and psychological harms endured by victims of crime as a result of perpetrators' actions. A public health approach to serious violence recognises that people may be affected by violence in different ways over time, including as victims, as perpetrators, or as both; a framing reflected in the Strategic Needs Assessment and Violence Reduction Strategy for the West Midlands [4].

While this JHNA focuses on the health and wellbeing needs of people in contact with, or at risk of contact with the criminal justice system, this should not be interpreted as minimising the harms experienced by victims of crime, and families affected by offending, are critically important; however, it is beyond the scope of the JHNA to explore the needs of this population. There are also many individuals who are impacted by family members' involvement in the CJS: there are social, psychological, and financial implications for partners and children of people in the CJS. Whilst we acknowledge this briefly within the report, it is beyond the scope of this JHNA to explore the needs of this population in depth.

1.4 Methodology

This JHNA draws on multiple sources of evidence, including published literature, national and local data, stakeholder insight, and lived experience. The methodology was designed to provide both a quantitative overview of need and a qualitative understanding of the experiences, barriers and service gaps affecting people in contact with, or at risk of contact with, the criminal justice system in Birmingham.

The JHNA incorporates more than one strand of qualitative evidence. Peer-led interviews and storytelling work with people with lived experience, alongside wider stakeholder engagement, were undertaken through commissioned work led by Birmingham Voluntary Service Council (BVSC) and partners. In addition, the Public Health team undertook supplementary engagement to strengthen the local picture in specific areas, including discussions with people in custody and follow-up discussions with stakeholders. Findings from these different strands have been incorporated into the report and are identified in the text where relevant.

Where qualitative findings are presented in the report, the source of the insight is identified where this is relevant to interpretation.

1.4.1 Peer-led Qualitative Research with People with Lived Experience

Community researchers with lived experience of the CJS conducted interviews with 17 individuals in Birmingham who had either been in contact with, or were at risk of entering, the CJS. Participants reported a range of health needs, including mental ill health, substance misuse, neurodivergence, physical health conditions and learning difficulties. Offences ranged from lower-level offences, such as theft, to more serious charges.

- 100% had at least one mental health diagnosis.
- 70.6% reported a history of substance misuse.
- 41.2% had a diagnosis of ADHD.
- 33.5% reported physical health conditions (e.g., COPD, asthma, arthritis).
- 11.8% disclosed autism.
- 5% had dyslexia.

1.4.2 Storytelling and Case Studies

Four participants with lived experience of the criminal justice system took part in a two-day creative storytelling workshop. Using poetry, collage, visual mapping and dialogue, participants explored their journeys through the criminal justice and health systems. Their stories provided additional insight into the emotional and structural barriers they had experienced. Artwork developed through these sessions is included throughout the report.

1.4.3 Participatory and Inclusive Approach

Community Researchers with lived experience of the CJS were recruited from trusted VCFSE partners and were instrumental in designing and delivering elements of the qualitative research. Their involvement enhanced the quality, depth, and accessibility of the research by fostering rapport with participants and enabling respectful, peer-to-peer dialogue.

1.5 Terminology and Definitions

Term	Definition
Adultification	Certain children are perceived as being less vulnerable and more 'grown up' than other children. In some contexts, adultification may mean children are less likely to receive the support they need. Children from minoritised ethnic groups are at greater risk.[5]
Attention Deficit Hyperactivity Disorder (ADHD)	Attention deficit hyperactivity disorder (ADHD) is defined by the World Health Organization as being characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning, the level of which is outside the limits of normal variation expected for age and level of intellectual functioning. (NHS, England)[6]
Bail	Release from custody until the first court hearing. May include conditions like living at a certain address and not contacting certain individuals.[7]
Criminal Justice System (CJS)	The agencies within the CJS include the Police, the Crown Prosecution Service, the courts, the prison service, probation services, and youth justice services.
Community Offender	People who have been in contact with CJS who are serving their sentence in the community.
Community Researcher	Individuals from the community involved with the study who assist with designing, directing, and conducting research.
Community Sentence	Individuals are convicted of a crime but not sent to custody. The individual may receive conditions such as Community Payback, curfew, wearing a location tag, attending probation meetings, being banned from certain places like bars or pubs, and being told where you live.
Community Sentence Treatment	An alternative to custody for offenders with mental health conditions, substance misuse problems, or learning disabilities.
Community Payback	Completing unpaid work in a community as a condition of a sentence such as removing graffiti or clearing wasteland.
Conviction	The fact of officially being found guilty of a crime.
Ex-Military Personnel and/or Veteran	Individuals who have previously served in the armed forces and have since been discharged.

Term	Definition
Focus Population	For the JHNA the focus population are those who: a) are within the CJS. b) have risk of entering the CJS for the first time. c) at risk of re-entering the CJS. d) or had past contact with the CJS.
Health Inequalities	The unfair and avoidable differences in health across the population, and between different groups within society.
Health Teams	Specialist teams that provide healthcare services to offenders in the community.
Inclusion Health	A term used to describe services for people who experience combinations of barriers to accessing healthcare.
Intervention	A programme, policy, or practice designed to have an impact on a specific problem.
Justice Health	The health and wellbeing of those in contact with the CJS. The term is also used to describe the health and wellbeing of young people receiving support from the youth justice services.
Lived Experience	Describes knowledge gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people.
Multiple Disadvantage	Describes those individuals experiencing a combination of problems such as homelessness, substance misuse, mental ill health and contact with the CJS.
MDMA (Ecstasy/ Molly)	3,4-Methylenedioxymethamphetamine (MDMA), commonly known as ecstasy (tablet form), and molly (crystal form), a Class A illegal stimulant and hallucinogen.
Neurodivergence	A noun to describe people whose brains function, learn, and process information differently from what is considered typical (neurotypical).
Offender	Describes someone who has been found guilty of a criminal offence. This is not a term preferred by the research team; however, it remains in professional use throughout the CJS and within wider society, thus, it appears in the JHNA for consistency.
Parole	Possibility of leaving prison or being released from custody before the end of the sentence, being kept under supervision. A solicitor is required to get parole.
Probation	A statutory criminal justice service that supervises offenders serving community sentences or being released from prison into the community.
Remand	Imprisonment until the trial begins.

Term	Definition
Recall	Where an individual does not meet the conditions of Parole, they may be recalled. This can be fixed-term Recall for minor issues lasting 28 days or standard Recall which can last to the end of the original sentence or until the Parole board decide they can be released.
Risk, at Risk	Pertains to behaviour or circumstances that put someone in a position where they may encounter the CJS. A person considered at risk has not been convicted of an offence but may have encountered the CJS or are in circumstances where their risk of contact with the CJS is increased.
Sentence[8]	Formal punishment to be served in response to a conviction. • Suspended: Served in the community instead of in prison. • Determinate: For a fixed length of time including time in prison and time in the community 'on license'. • Indeterminate: Does not have a fixed length of time but a minimum amount of time in prison (a tariff) has to be served before consideration of release. • Life: Lasts for life. If released from prison, a 'license' must be served in the community for life. • Whole Life Order: Release from prison will not happen, except in exceptional compassionate circumstances. • Detention and Training Order: For persons aged 12 to 17 years. Lasts between 4 months and 2 years with first half served in custody, the second half served in the community 'under supervision'.
Substance Misuse	The hazardous or harmful use of psychoactive substances, including alcohol and illicit drugs.
Summary Offence	Least serious offence that can be tried in a Magistrates Court.

1.6 The National Picture

1.6.1 Prisons

There are 123 adult male prisons across England and Wales and 12 adult female prisons categorised from A to D according to prisoner risk and security (Table 1) with potential to accommodate up to 90,239 individuals as of 2024.[8] The majority are run by HM Prison & Probation Service (an executive agency sponsored by the Ministry of Justice, MOJ) but 15 of the prisons in England and Wales are run by the private sector. There are four types of prison function[9];

1. Reception: take prisoners from local courts on remand awaiting trial or sentence.
2. Training: designed to accommodate offenders at their corresponding category (either B or C).
3. Resettlement: preparing prisoners for release with some being open allowing prisoners to leave to go to work, training, or visit family.
4. High Security: can serve all three functions but can also hold those serving long sentences or with category A requirements.

Table 1: Prison Categories in England and Wales (adult).[9]

Category	Description	Purpose
A	Highest-risk prisoners, escape made extremely difficult.	High security.
B	Prisoners for whom escape must be very difficult.	Serving local courts, training.
C	Prisoners who are unlikely to make a determined escape attempt.	Training, resettlement.
D	Lowest risk prisoners who can be reasonably trusted in open conditions.	Open prisons.

1.6.2 Mental Health Secure Units

Medium secure units are mental health facilities supporting individuals who may or may not have criminal convictions but also have mental health needs meaning they may be of significant danger to the public.[10] There are around 60 medium secure units in England and Wales. Medium secure units have strict eligibility criteria, and all referrals are screened by consultant psychiatrists and a multidisciplinary team to determine eligibility.[12] Individuals may be referred to medium secure units by clinicians in the community, from other NHS institutions, or from custody.[10]

Individuals with a criminal conviction and mental health need who present with 'grave and immediate danger' are placed in high secure mental health hospitals.[10] There are three high secure mental health hospitals in England; Broadmoor in West London, Rampton in Nottinghamshire, and Ashworth in Merseyside providing security equivalent to a category B prison.[12]

1.6.3 National Prison Population

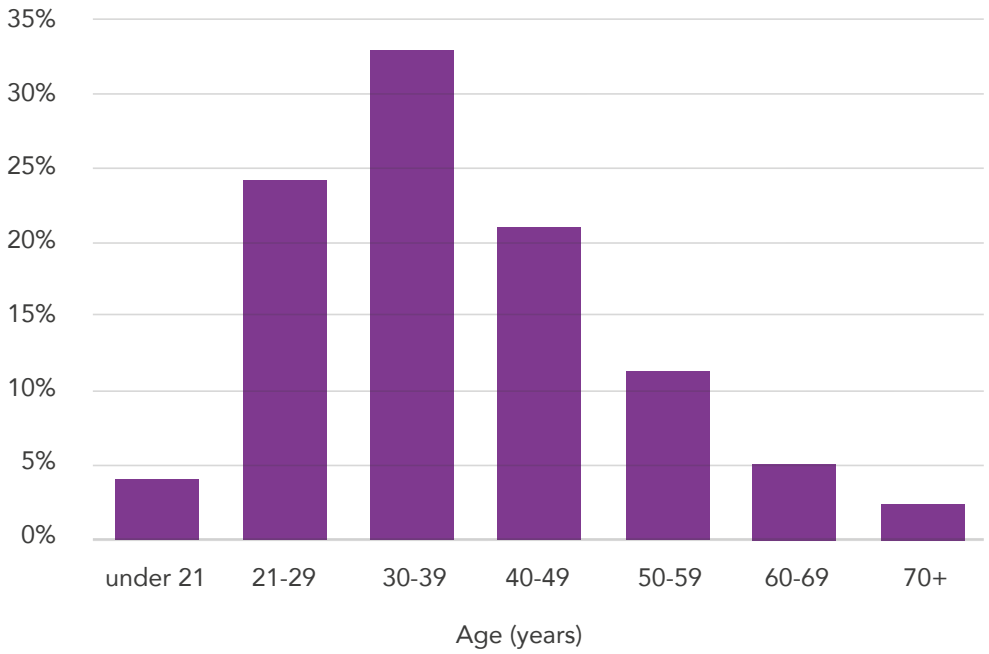
England and Wales have the highest population in prison per capita in Western Europe and a recent independent review conducted by the UK MOJ highlighted a crisis in prison capacity.[13] There are concerns that prison overcrowding is having a determinantal impact on the health and wellbeing of the individuals involved.[13] In 2025, the prison population was reported to be 87,334 which is relatively stable compared to June 2024 but is a substantial increase compared to 2005 where there were 77,300. The prison population is predicted to continue rising without intervention.[13,14] The number of individuals involved in the wider CJS is substantially larger. In England and Wales, there were reported to be 241,540 people under probation supervision in March 2025, which is 9% increase since March 2015.[14]

The reasons for the rise in the prison population are complex, but one contributing factor is the substantial rise in prisoners serving sentences of over four years in comparison to short sentences.[15] There are also higher numbers of people on remand awaiting trial or sentencing, reflecting system pressures across the CJS following the COVID 19 pandemic, including restricted prison regimes linked to staff shortages. The recall prison population is also at an all-time high, in part due to early release schemes, increased numbers of people on extended license, and removal of standard recalls for those with determinate sentences of less than 12 months.[15] In June 2025, there were 17,701 people in the reception prison population (20% of the total prison population). There were 9,957 recall prison admissions between January to March 2025 which increased by 39% compared to the same quarter in 2024.[14] The majority of recalls are reported to be due to 'non-compliance', such as failing to attend probation interviews.

1.6.4 Demographics of People in Prison in England and Wales

The majority of people in prison are male (96%, equating to over 84,000 men) with the number of women in prison remaining near constant over the last decade at around 3,500-4,000.[16] The number of young adults in prison aged 18-20 has dropped significantly over the last 20 years from 7,811 in 2005 to 3,063 in 2024, likely due to increased rates of community sentencing and a greater focus on support and rehabilitation to prevent incarceration in young people.[16] A third of the prison population (29,339 individuals) in 2024 were in the 30-39 age group but there has been a significant increase in the number of older people in prison over the last decade which has implications on health and care needs.[15]

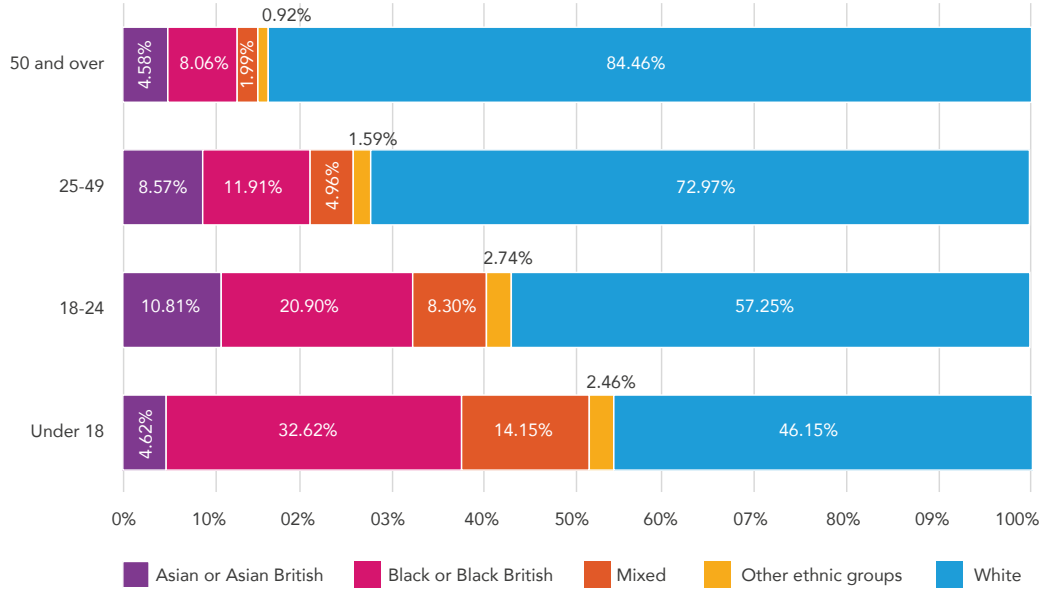
Figure 1. Prison population in England and Wales, by age group (Jan-Mar 2025).[15]



People from minority ethnic groups are over-represented within the prison population: for example, 12% of the prison population were reported to be Black ethnicity despite making up only 4% of the general population.[17] Overall, 27% of people in prison in England and Wales are reported to be from an ethnic minority group despite making up only 16% of the UK population.[17]

Figure 2 shows that ethnic minority groups are more highly represented among younger people in prison than among older age groups. Among children under 18 in custody, people from ethnic minority groups account for 53.9% of the prison population, compared with 46.2% who are White. Among young adults aged 18–24, people from ethnic minority groups account for 42.8% of the prison population, compared with 57.3% who are White. This indicates that ethnic minority representation is highest in the youngest prison age group shown in the data.

Figure 2. Percentage of prisoners (England and Wales) by ethnicity and age group (2022).[18]



1.6.5 Offence Types

In England and Wales in 2025, the most common offence types for the prison population were violence against the person (35%), sexual offences (22%), and drug offences (13%).[19] For women, theft from shops was the most common offence in 2023 accounting for 27% of indictable offences compared to 12% for men.[19]

In England and Wales in the year to July 2024, a total of 107,703 individuals entered the probation population (i.e. they were given either a community order or suspended sentence). The most common conviction within the probation population was minor criminal offence (i.e. non-motoring) but 20,933 individuals (19.4%) in the probation population were convicted of violence against the person and 16,614 individuals (15.4%) were convicted of motoring offences (Figure 3).[20]

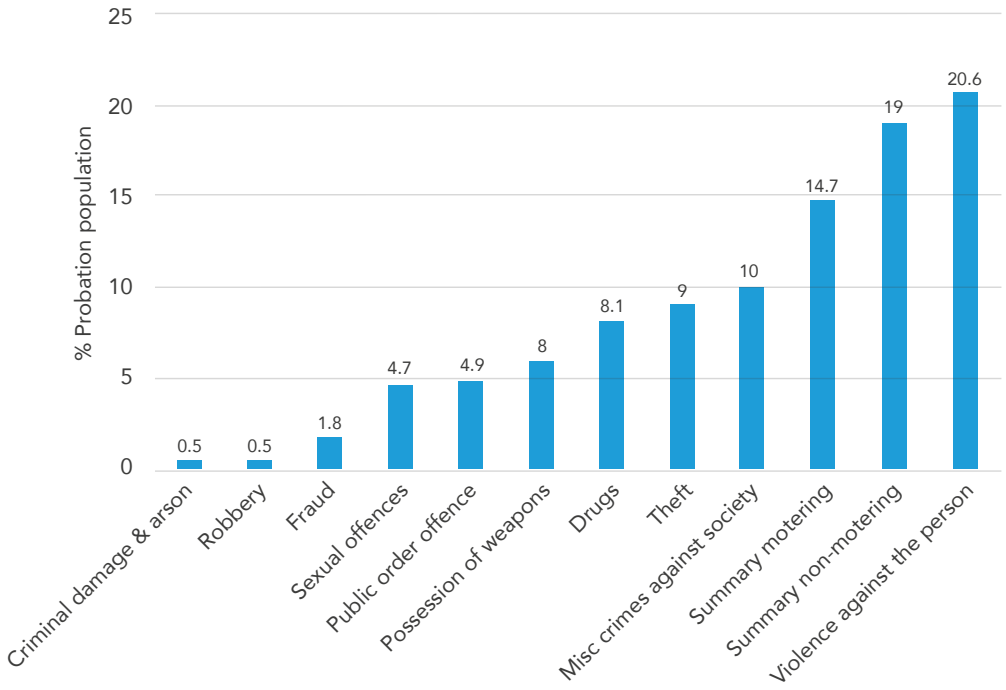
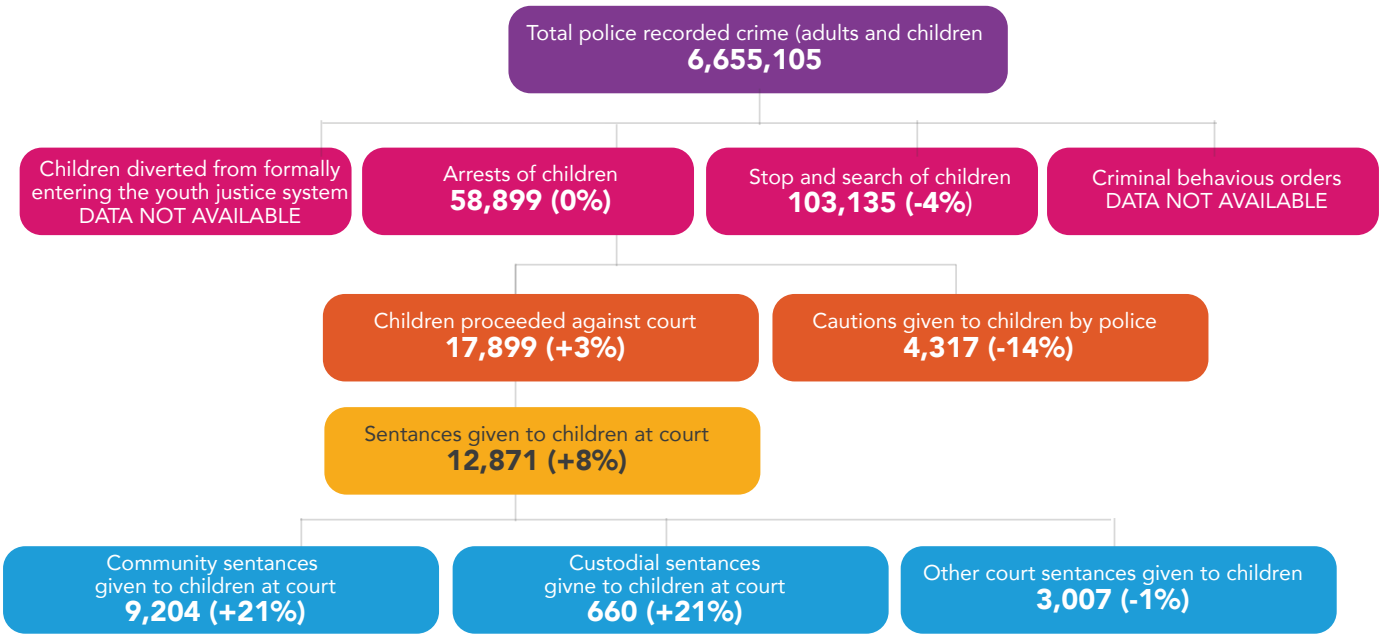


Figure 3: Percentage of the probation population by offence type (Jan-Jul 2025).[20]

1.6.6 Children and Young People

Where children and young people between the ages of 10 and 17 are involved in crime, they attend a specialist Youth Court. The Youth Court is a type of magistrates' court where there is no jury, members of the public are not allowed to attend, and the individual should be accompanied by a parent or guardian.[21] The majority of children in the CJS in England and Wales are within the probation service with most receiving community sentences. Figure 4 shows the number of children receiving each sentence type in the year ending March 2024.[22] Children from minority ethnic background are over-represented within custody making up 53% of the population in England and Wales compared to 30% of the general population aged 5-16 in the UK.[23]

Figure 4: Children within the Criminal Justice System (2023-24).



Note: Reproduced from report. Brackets indicate percentage change compared to the previous year.[22]

For children and young people receiving a custodial sentence, the Youth Custody Service (covering England and Wales) will determine placement in one of four different types of institution[25]:

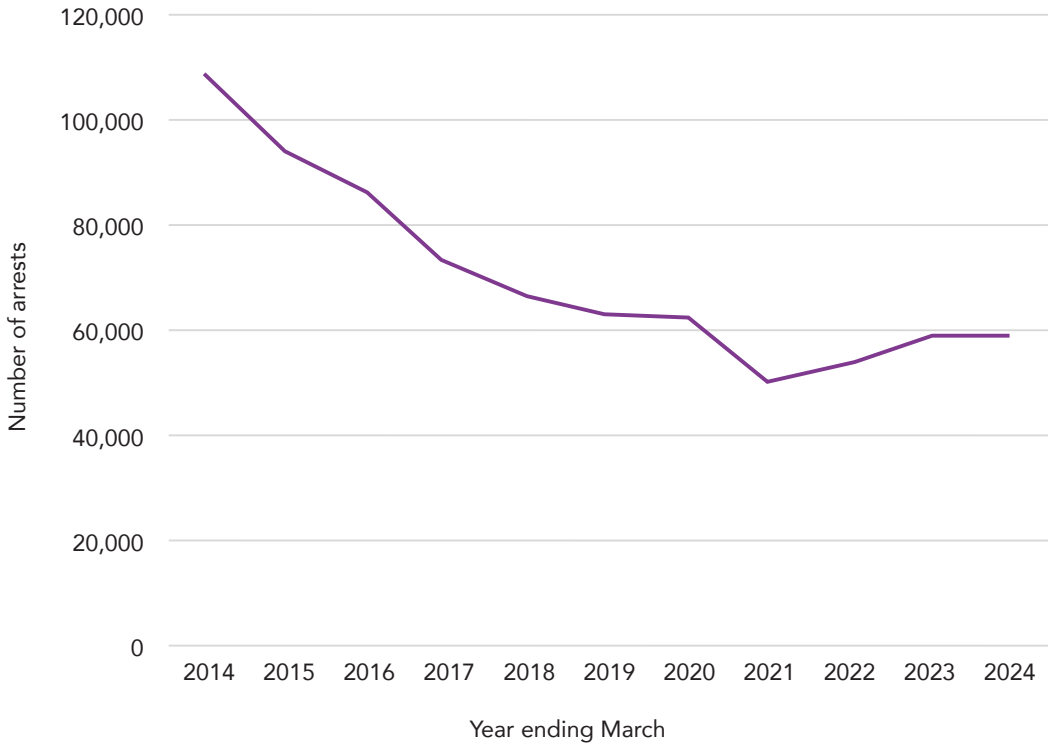
- Young Offender Institutions (YOI) (accommodate male offenders only, age 15-17 or 18-20, set up similar to adult prisons). There are 3 in England and Wales.
- Secure Training Centres (STC) take children up to age 17, accommodating children who are too vulnerable for YOI. There is one that serves both England and Wales.
- Secure Children's Homes take children age 10-17. They are developed by the Secure Accommodation Network. Children are placed by local authorities through the Secure Welfare Coordination Unit (a single point of contact for local authorities to match individual needs of children to appropriate secure care locations, funded by the department of education). Secure Children's Homes accommodate a small number of children with high staff-to-child ratios. There are currently 14 in England and Wales.[25]
- Secure schools take children aged 12-18 years. In response to the 2016 Taylor Review of the Youth Justice System, there has been a shift towards establishing Secure Schools which aim to be 'schools with security' rather than 'prisons with education'.[24,25] The first Secure School opened in Kent in 2024, centring rehabilitation of young people in custody around health and educational needs.[26]

Inspection of custody settings for young people are overseen by Ofsted, His Majesty's Inspectorate of Prisons (HMPPS), and the Care Quality Commission.[27] The MOJ is responsible for commissioning and overseeing the youth justice system (YJS) in England and Wales and day-to-day management of services is overseen by HMPPS.

In 2021, two of the UK's three STCs were deemed to have failed to meet the needs of children which led to their closure. There are longstanding concerns that many young offender facilities have been failing to meet the needs of young people: they are considered too big, too far away from children's families, and lacking in community support networks.

In April 2025, there were 495 children and young people in secure settings in England which is well below capacity of 821. The number of individuals reported within each ethnicity were 39 (7.9%) Asian, 92 (18.6%) Black, 92 (18.6%) Mixed, 22 (4.4%) Other, 211 (42.6%) White, and 13 (2.6%) Unknown. The number of young people arrested in England and Wales has been reducing year on year for the past decade (Figure 5) perhaps in part due to introduction of the Child First framework aiming to prioritise the needs and rights of children which is discussed in more detail later in this report.

Figure 5: Number of children arrested for offences in England and Wales (2014-24).[29]



1.7 National Health and Care Strategies and Guidance within the CJS

The introduction of the Health and Care Act 2012 led to the formation of the National Partnership Agreement for Health and Social Care for England between The Department of Health and Social Care (DHSC), HMPPS, the MoJ, NHS England (NHSE), and the United Kingdom Health Security Agency (UKHSA) for the commissioning and delivery of healthcare services within the CJS. The partnership published their *Improving Quality of Services for People in Prison and those Subject to Statutory Supervision by the Probation Service in the Community (2022-2025)* report. This aimed to provide guidance to reduce health inequalities of those involved in the CJS, reduce reoffending and support rehabilitation. It also highlighted the need to support continuity of care through the prison estate, pre-custody, and post-custody.[31]

In 2018, the UK Government recognised the need to improve continuity of care for those in secure settings. *The Guidance for Improving Continuity of Care between Prison and the Community (2018)* aims to improve transitions of care, encourages development of standardised referral forms, contact with community support prior to release, and strengthening of links between related services for improved service coordination.[29]

In 2022, NHS England produced the *Health and Justice Framework for Integration (2022-2025): Improving Lives – Reducing Inequality* framework. This aims to ensure that the patient voice is at the centre of service design and delivery, evidence-based treatment is provided, early and avoidable deaths are prevented, continuity of care is maintained, and services are improved through learning and technology. The framework also highlights certain groups of interest including people with neurodivergence and complex health needs, children, and people with mental health issues.[30] In 2025, the Chief Medical Officer for England published The health of people in prison, on probation and in the secure NHS estate in England. The report was developed with partners including the Department of Health and Social Care, Ministry of Justice, HM Prison and Probation Service and NHS England, and provides a recent national overview of the health needs of people in contact with prison and probation services. It highlights the importance of prevention, continuity of care, equitable access to healthcare, and coordinated action across health and justice systems.

1.7.1 Communicable Disease

The British Association of Sexual Health and HIV produced *Standards for the Management of Sexual Health in UK Prisons (2023).* The standards aim to improve access to sexual health services and clinical assessment in prisons, improve clinical management and diagnostic capacity. The standards also focus on clinical governance, staff training, partnerships, and the need for patient and public engagement in sexual health service development in prisons.[32]

The UK Health Security Agency *Management of Tuberculosis in Secure Settings in England* 2025 report provides single combined guidance for all audiences in secure settings including residents, prison workers, and healthcare workers.[33] The guidance outlines the advised treatment regimens and governance procedures, and links to relevant resources for service providers.

1.7.2 Children and Young People

The Youth Justice Board Strategy for Delivering Positive Outcomes for Children by Reducing Offending and Creating Safer Communities (2024-2027) aims to support improvement of youth justice services in local communities, address racial disparities, and influence development of policy and practice to advance adoption of the Child First principles which emphasises strengths-based, developmentally informed and child-centred approaches. This framework is considered further later in the report.[34]

The Youth Endowment Fund Arrested Children produced *How to Keep Children Safe and Reduce Reoffending Guidance (2023).* The guidance aims to improve the support provided to arrested children, divert children with low-level offences away from the CJS, provide evidence-based support, and improve treatment and outcomes of arrested children – especially those from ethnic minority backgrounds.[35]

1.7.3 Women in the CJS

The MOJ recognise the need for specific needs of women to be addressed within services. *The Female Offender Strategy Delivery Plan (2022-2025)* aims to prevent women from entering the CJS and reoffending, for a greater proportion of women to be managed in the community rather than in short custodial sentences and improve outcomes for women in custody.[36]

NHS England have published a *National Service Specification for the Care of Women who are Pregnant or Post-natal in Detained Settings (2022)* (prisons, immigration removal centres, children and young people settings). The service specification recognises the importance of providing a consistent and equitable approach to maternity service delivery in the secure estate. The specification sets out standards required of maternity service providers, benchmarks for identifying development and improvement areas, and processes for planning, implementation, and evaluation of change.[37]

1.8 Birmingham Strategies and Guidance

The 2021 West Midland Combined Authority report *Punishing Abuse: Children in the West Midlands Criminal Justice System* highlights the extent of adversity and abuse experienced by children within the West Midlands Youth Offending system.[53] The report highlights prevalence of vulnerable children within the CJS: children with neurodivergence and traumatic brain injury, children with adverse childhood experiences, girls, children in custody, gang involved children, and migrant children. This report emphasises the need to address underlying factors that have predisposed children to involvement in the CJS which requires multi-sector involvement and sustained, coordinated action.

The Birmingham Youth Offending Services (YOS) *Strategic Youth Justice Plan: (2023-2028)* sets out the strategy for delivering services that enable children to thrive, informed by the HM Inspectorate of Probation inspection in 2022. The strategy begins by describing the children within the CJS in Birmingham incorporating the perspectives of the children themselves, their caregivers, and victims of crime. The strategy describes the governance and leadership of the YJS in Birmingham, partnership arrangements, and focuses on opportunities, challenges, strengths, and areas for development within services.[54]

The Birmingham Health and Wellbeing Strategy (2022-2030) outlines core themes to improving the city's health and wellbeing. One of the core aims within the strategy is ensuring citizens get the best start in life and there is a particular focus on reducing youth justice involvement and reducing health inequalities experienced by people involved in the CJS more widely.[55]

West Midlands Violence Reduction Partnership *West Midlands Violence Reduction Strategy (2023-2026)* focuses on the drivers of violent behaviours and development of trauma-informed approaches to reduce vulnerability and prevent harm. The strategy aims to develop community and youth led violence reduction programmes with improvements in data sharing and collaborative commissioning to support sustainability.[56]

2. The Birmingham Picture

A consistent theme across this needs assessment is the limited availability and consistency of local data across parts of the justice, health and care system. In some areas, data are incomplete, not routinely shared, not comparable across services, or do not capture important characteristics and outcomes. These gaps limit the ability to fully quantify need, understand inequalities and monitor outcomes, and should be considered a key finding of this report.

Cross-cutting gaps identified through this needs assessment include limitations in local data and intelligence, variable continuity of care between custody and community, and inconsistent visibility of need across different parts of the system.

2.1. The Secure Estate in Birmingham

HMP Birmingham is the only prison facility within Birmingham (in Winson Green). It is a Category B men's reception prison operated by HM Prison and Probation Service. At the time of inspection, 976 prisoners were held at the establishment. The inspection reported a baseline certified normal capacity of 1,099, an in-use certified normal capacity of 772, and an operational capacity of 997. The prison receives people from Crown and Magistrates courts including Birmingham and Shrewsbury and Magistrates' courts including Lichfield, Sutton Coldfield, Tamworth, Warley, Dudley, and Telford and, therefore, remains a key part of the local justice health landscape.[39]

There are no **Youth Custody facilities** within Birmingham but there is a **Youth Offending Service** run by Birmingham City Council (BCC) as part of Birmingham Children's Trust.[54]

There are **no prison facilities** for women within Birmingham. The nearest is HMP Drake Hall in Eccleshall, Staffordshire.[38]

There are **two medium secure units for men** in Birmingham who have severe mental health problems and have committed a criminal offence; the Reaside Clinic in Rubery and the Tamarind Centre in Bordesley Green.[39]

There is **one medium secure unit for women** in Birmingham called Ardenleigh in Erdington.[40]

There are 22 probation offices in the West Midlands. Birmingham has **four probation offices** located in the city centre (Centenary House), Perry Bar, Selly Oak, and Kitts Green and are responsible for supporting and supervising men and women over the age of 18 years who are in contact with the CJS in the community.[41]

2.2 The CJS Population in Birmingham

As of July 2024,
2,961 Birmingham residents
were incarcerated across
116 prisons across England

West Midlands Violence Reduction Partnership

As of 2025, there are on average
1,099 prisoners within
HMP Birmingham

HM Inspectorate of Prisons

As of 2022, there were over
2,800 individuals managed
by two of Birmingham's four
probation offices

HM Inspectorate of Prisons

With a population exceeding 1.15 million, Birmingham is England's largest local authority. Birmingham is a young city with 51% of the population under the age of 35 and was recently recognised as a 'majority minority', super-diverse city where minority ethnic groups represent over half of the population.[42] The city also has pronounced social deprivation with 44% of residents living in the top 10% most deprived areas nationally. [43] Birmingham has high rates of crime with 118.8 offences per 1,000 people compared to 87.1 per 1,000 people in England.[42]

As of July 2024, 2,961 Birmingham residents were incarcerated across 116 prisons across England. We were unable to obtain more granular data to describe the number of Birmingham residents in each prison. The rate of incarcerations in the Birmingham population is 256 per 100,000, a rate substantially higher than national average (146 per 100,000) which may, in part, be explained by the relatively young population of the city and the likelihood of being imprisoned also being higher within younger populations.[44]

In 2025, there were on average 1,099 prisoners within HMP Birmingham which is below capacity of 1450 due to wings being closed for refurbishments. Within HMP Birmingham, 30% of the population are reported to be from minority ethnic groups compared to 51% in the general Birmingham population. This figure is higher than the national average (27%) which may reflect the ethnic diversity within the city. The population within HMP Birmingham is unlikely to reflect the demography of the general population of Birmingham. Firstly, HMP Birmingham is a reception prison and therefore serves courts that extend to the rest of England and Wales. Secondly, Birmingham residents also serve time in prisons outside of HMP Birmingham where their sentencing requires a longer period in custody.

Within the West Midlands in 2022, there were over 21,000 individuals within the Probation service. Over 2,800 individuals were managed by Centenary House and Perry Barr Probation offices alone (84% of whom were Birmingham residents, and 16% being from Solihull).[46]

At HMP Birmingham, HM Inspectorate of Prisons reported that prison staffing shortages and a restricted regime meant that too many healthcare appointments could not be facilitated, highlighting how system pressures can directly affect access to care and stability for people in custody.[50]

2.3 Children and Young People in the Birmingham CJS

There are no secure children's homes in Birmingham with the nearest being Clayfields House Secure Unit in Nottingham. The only Secure Training Centre within England is Oakshill in Milton Keynes and the Young Offender Institutions in England are Feltham in West London, Wetherby in West Yorkshire, and Werrington in Stoke-on-Trent. If a young person from Birmingham goes to custody, they will be placed a significant distance from their families and social networks. In Oct-Dec 2024, 20 children in Birmingham were subject to remand in custody. Of the eight children from Birmingham receiving a custodial sentence in Oct-Dec 2024, five had some form of special educational need, and five had history of contact with mental health services.[47]

There are high rates of CJS involvement amongst children and young people in Birmingham. Birmingham has one of the highest rates of first-time youth justice entrants (4 per 1,000) in England and Wales (average 2.8 per 1,000).[47] The majority of children within the CJS in Birmingham are under the probation service in the community. Between Oct-Dec 2024, Birmingham YJS reported working with 568 children with the majority (85.9%) being male and aged between 15-17 years (76.0%).[47] There were 34 children aged between 10-12 involved in the YJS in Birmingham between Oct-Dec 2024 demonstrating that primary school-aged children are also at risk of CJS involvement. Figure 6 shows how children and young people from Black and other ethnic groups are overrepresented in the Birmingham YJS compared with the general population of 10–17-year-olds in Birmingham. Children and young people from Asian, mixed, and White ethnic groups are underrepresented in the Birmingham YJS compared to the general population in Birmingham.

Figure 6: Young people aged 10-17 years in contact with the Birmingham Youth Justice Service, by ethnicity (Oct-Dec 2024).[47]

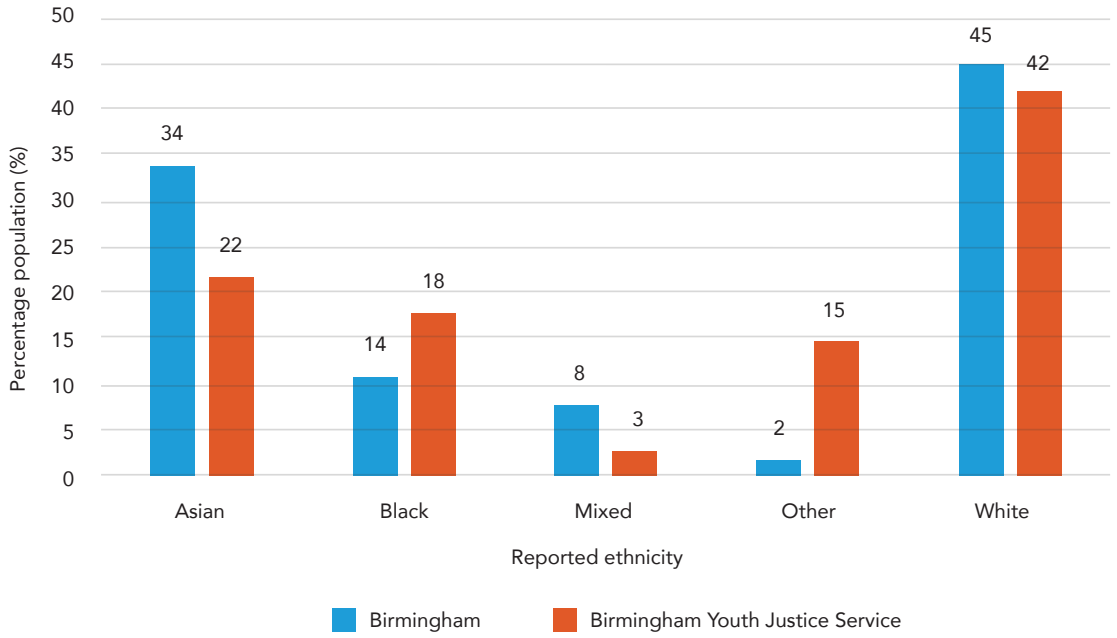
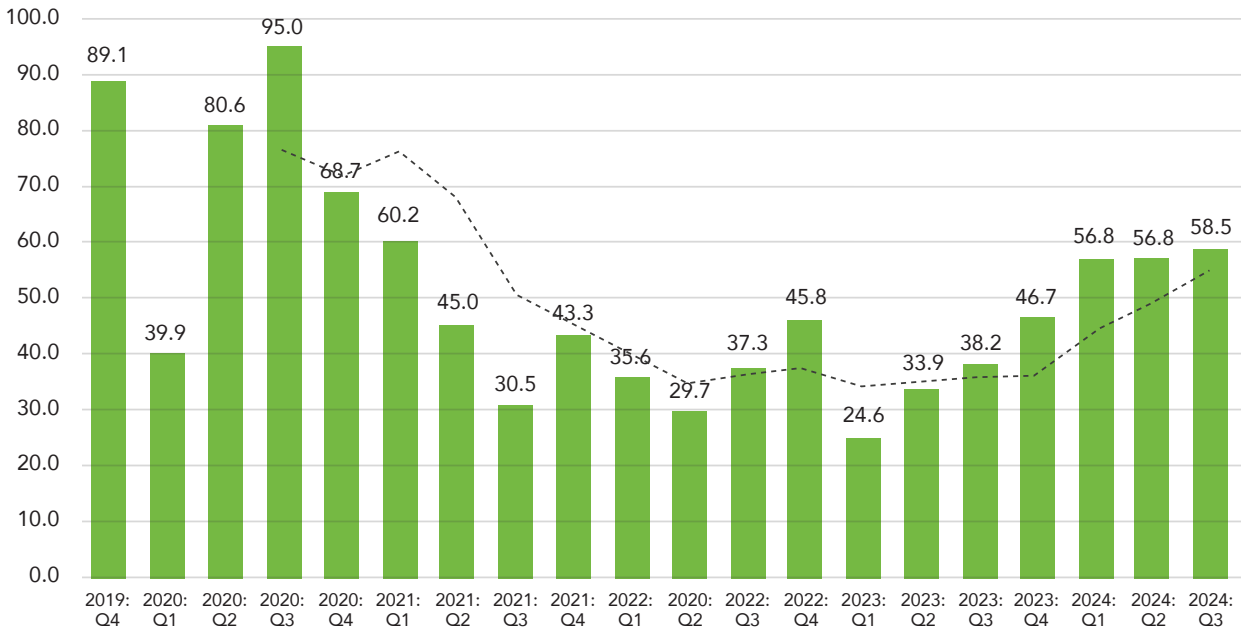


Figure 7: Rate per 100,000 of first-time entrants to the Birmingham Youth Justice Service (2019-2024).[47]



Note: dotted line shows the England average. Reproduced from report.

National data shows that arrests of children in the West Midlands increased by 19% in 2023–24, compared with increases of 1–11% in other police force areas in England. Locally, Birmingham Youth Justice Service data shows that in Q3 2024, 69 children entered the YJS for the first time in Birmingham. As shown in Figure 7, this equated to a rate of 56.5 per 100,000, representing a 20% increase compared with the same period in 2023, despite rates decreasing across England and Wales as a whole.[47]

Arrests of children fell in England between 2014-2024 (22)

London: **68% decrease**

West Midlands: **11% decrease**

All other areas of England: **32-59% decrease**

One driver of high numbers of first-time entrants of children and young people in Birmingham may be knife crime - the West Midlands had the second highest rate of knife crime in England in 2024.[45] Males aged 15-19 are most likely to be the victim and suspect of knife crime in Birmingham.

Recent measures introduced by West Midlands Police (WMP) to increase Youth Conditional Cautions in place of the Outcome 22 diversionary (which focuses on preventing reoffending through education without formal prosecution) aim to reduce knife crime rates in the region but may also be contributing to increasing numbers of convictions.[47]

Since the introduction of the WMP initiative, there has been a 15% reduction in knife crime reported by West Midlands Police in the year to March 2025 compared to the year to March 2024.[47,48] The reduction in knife crime reported in Birmingham is reflected across England and Wales - in 2024, rates of offensive weapon crime were 6% lower compared to the year previous but this still remains 20% higher than rates 10 years ago.[49]

Another key factor driving the high rates of CJS involvement of children and young people may be that Birmingham has one of the highest child poverty rates in the UK, with significant proportions of the population exposed to early disadvantage. Birmingham is the second most deprived Core City in England and eighth highest for children sentenced or cautioned.[48]

A large proportion of children involved in the CJS in Birmingham have complex needs. In a self-assessment survey conducted by the Birmingham YOS in 2023/2024, 40.9% of children and young people reported missing school, 13% reported needing help with reading, and 6% reported having thoughts about ending their own life.[51] In July-September 2024, 46% of children and young people assessed by speech and language therapy in the YOS were identified as needing follow-up.[51]

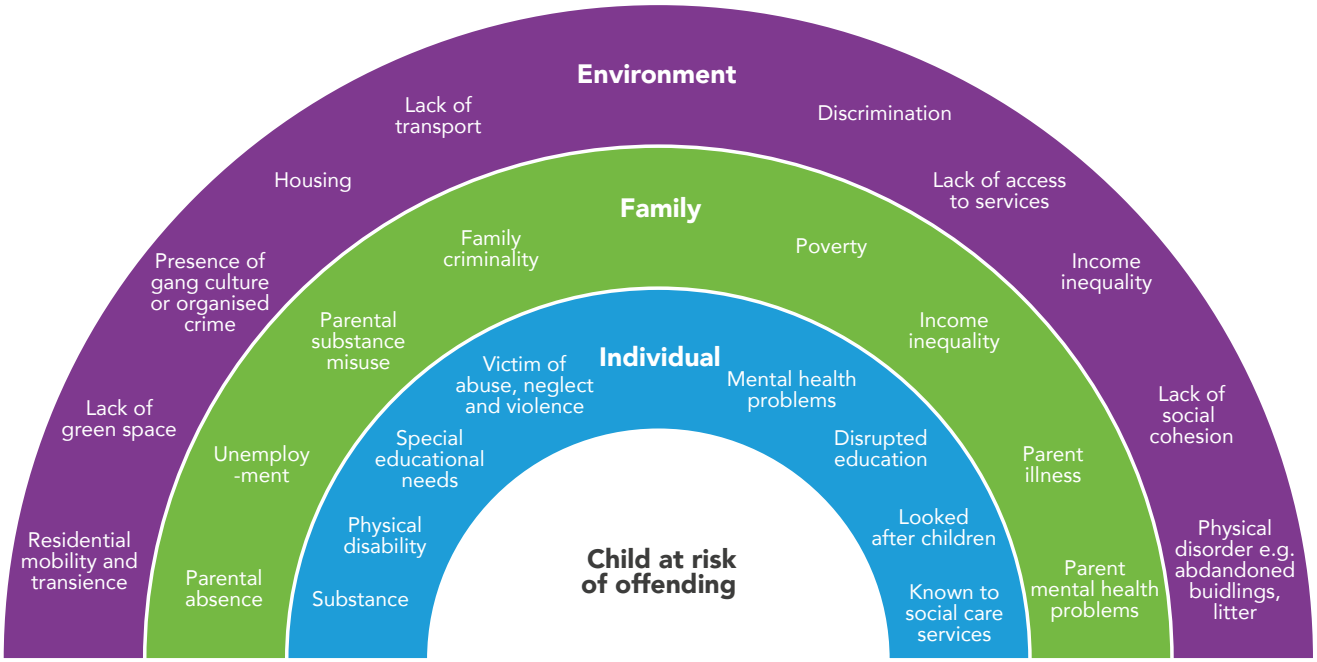
3. Drivers of Offending Across the Life Course

Risk factors associated with CJS involvement are complex and multi-faceted. In 2021, West Midlands Combined Authority published a report titled 'Punishing Abuse' which highlighted the extent of abuse, loss, trauma, and childhood adversity amongst children involved in the CJS in the West Midlands.[49]

There are factors that may directly impact a child to increase their likelihood of CJS involvement such as poverty, special educational needs, and mental health problems. There are also indirect factors that may influence a child's outcomes and CJS involvement both within the home through family influences, and outside the home relating to environmental factors.

All these risk factors are compounding; the greater number an individual experiences, the greater the risk of CJS involvement. Figure 8 shows some of the direct and indirect drivers of offending that may impact anyone, but particularly young people. Where available, the prevalence of each influencing factor within the West Midlands youth justice population is presented (data from the West Midlands Combined Authority Punishing Abuse report), alongside regional/national figures in brackets.

Figure 8: Conceptual model of drivers of offending across individual, family, and environmental domains.[53]



This conceptual figure synthesises evidence presented in the literature and regional intelligence to illustrate the multi-level drivers associated with offending behaviour among children and young people. It is not intended to represent quantitative weighting of factors.

Prevention is unlikely to succeed without considering the full context and wide-ranging contributing factors that lead to CJS involvement. Therefore, a whole system, trauma-informed, life-course approach is required to address individual, familial, and environmental risk factors. This holistic approach to CJS prevention requires 'systemic resilience'.[53] Systemic resilience is a concept that acknowledges the need for collaborative and adaptive working within and between organisations within a system to maintain essential functions even where system pressures and change occurs, see Figure 9, below.

Systemic resilience involves open and dynamic change processes involving multiple sectors, with a particular focus on diversity and participation as key parts of the process.[53] For example, studies have shown that neurodivergence is often related to school absence and CJS involvement.[63] To reduce school absence and CJS involvement, neurodivergence services will need to be strengthened with collaboration between the education sector, the NHS, and those with lived experience. Transparent, aligned data collection and sharing between organisations is needed to ensure the full picture is understood. It is also essential that whilst each sector or organisation may have different strategic aims, the shared goal is to improve people's lives, and a dynamic and open cross-sector culture is key to achieving this.

Figure 9: Sectors and agencies that are involved with the criminal justice system requiring systemic resilience to maximise opportunity for prevention.

3.1 Protective Factors

Based on the literature review, findings from lived experience and stakeholder interviews, the following protective factors have been identified.[61-63]

- Support from relatives, peers, and caring adults (including parents, primary carers, and secondary carers).
- Support for additional needs such as neurodivergence or learning disability.
- School inclusion, particularly where there are challenges at home.
- Access to safe places (within the home and outside of home).
- Sense of belonging in safe and supportive communities.
- Positive communication, problem solving, social, and emotional skills.
- Involvement in activities that encourage positive behaviours.
- Health promoting activities such as access to green spaces, culture, and the arts.

These protective factors align with wider work across Birmingham to strengthen community assets and reduce inequality. BCC has developed an Environmental Justice Index to identify and map inequalities in access to green space and environmental risk factors across the city[59], recognising the role of place-based determinants in shaping health outcomes (Sultan, 2023). This work sits alongside Birmingham's City of Nature programme, which embeds equitable access to high-quality green space within long-term city planning and public health strategy.

National public health evidence indicates that access to safe green spaces and community-based engagement initiatives are associated with improved mental wellbeing and strengthened community connectedness (NICE, 2016; Public Health England, 2020). These mechanisms, including social connectedness[60] and supportive relationships, are identified within UK public health and serious violence prevention frameworks as protective factors associated with reduced risk of youth violence and related harms.[60]

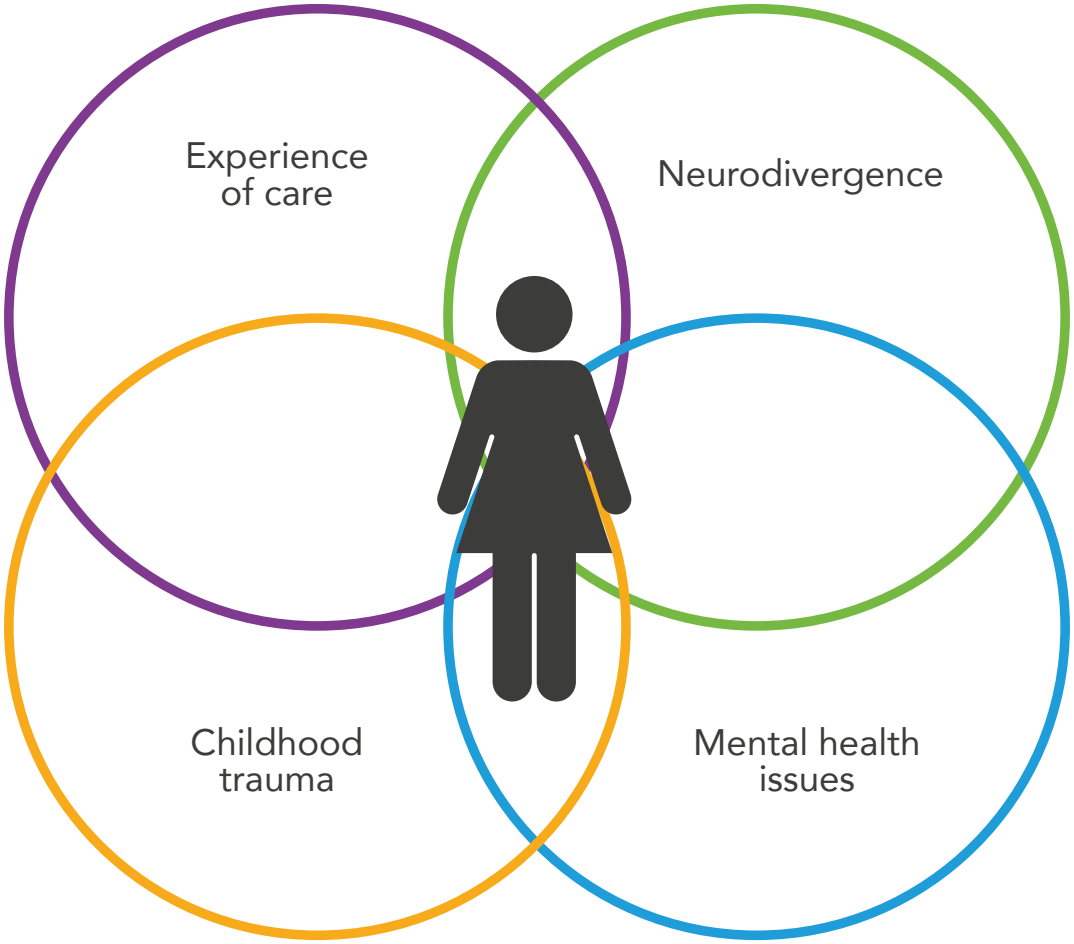
Birmingham's wider environmental, cultural and community infrastructure therefore represents an important component of the broader prevention landscape.

4. Inclusion Health Groups and the Criminal Justice System

Within this section, we set out the health and social care needs of people involved in the CJS, focusing on distinct inclusion health groups and the drivers of CJS involvement across the life-course. Inclusion health is a term to describe populations who have multiple risk factors that may lead them to endure poor health outcomes such as poverty, trauma, and addiction. Whilst we present this section by distinct inclusion health groups, it must be acknowledged that individuals do not exist in silos.

We all have multiple identities and life experiences that shape the way we interact with the world around us and also shape the way in which the world interacts with us. This concept is termed as 'intersectionality' and whilst we present this section of the report in distinct sections, it must be interpreted with intersectionality in mind. Figure 10 shows how one individual can have multiple, intersecting risk factors that may contribute to CJS involvement.

Figure 10: Example of how an individual can have multiple intersecting risk factors, that may contribute to criminal justice system involvement.



4.1 Childhood Adversity and Trauma including Child Criminal Exploitation

Trauma can come from the actions of a stranger, someone inside or known to the family, or from an incident that the child or young person has experienced or witnessed. These traumatic experiences can impact the ways they behave, communicate, relate to other people, and perceive the world around them. Many people tell us that they find it hard to trust or feel safe around other people, or in their everyday lives. The consequences of childhood trauma can stay with a person over their lifetime.

The Childhood Trauma Recovery Network[59]

4.1.1 Childhood Trauma

Children within the CJS often endure multiple childhood adversities such as abuse, neglect, and domestic violence. There is limited data available on the prevalence of childhood adversity in justice-involved individuals in Birmingham. However, stakeholders including those working in Probation and the YJS consistently identified trauma and difficult childhoods as key drivers of later CJS contact. The Birmingham YJS reported that 38% of the children they are in contact with report having lost someone special from their lives.[46] Being children of parents in prisons may also be a risk factor for childhood adversity and later CJS involvement.[51] Birmingham's Children Heard and Seen, an organisation supporting children who have a parent in prison, reported that 40% of the children accessing support also had a parent who had experienced domestic abuse.

Trauma can result from interpersonal or impersonal, immediate or long-term, and one-off or repeated events.[68] Trauma impacts behaviour and neuro-cognitive development: it can lead to development of tension reducing behaviour such as substance misuse or self-harm, compulsive behaviour, and emotional avoidance, as well as difficulties in controlling negative emotions that can impact a person throughout their life. In turn, these behaviours can contribute to school exclusion during childhood or adolescence, increase risk of offending, and have implications for later adult functioning, including parenting difficulties. Trauma is a common factor shared by most individuals involved in the CJS – over 90% of young offenders have experienced abuse and/or loss of a significant family[69] member or friend.[70] Children who have endured childhood adversity are more likely to be a victim of violence, perpetrator of violence, and be involved in the CJS within their lifetime.[70] Additionally, there is a risk that experience of the CJS could contribute to trauma, especially during childhood.[70]

A key concern is the systemic failure to recognise and respond appropriately to trauma, particularly among children and young people. Behavioural manifestations of trauma are frequently interpreted as behaviours worth being met with discipline which can lead to school exclusion and CJS involvement. There is a distinct need to ensure that all services are aware of the influence and consequence of trauma, to ensure delivery of care that is safe, compassionate, and respectful. This is termed 'trauma-informed practice'.[69]

Childhood trauma may not only drive involvement in crime, but it may also increase risk of exploitation and radicalisation. In 2024, 20% of arrests relating to terrorism were of children under the age of 17 years.[72]

4.1.2 Child Criminal Exploitation

Child Criminal Exploitation (CCE) is a particular risk amongst children who have endured trauma. CCE is a form of modern slavery where children are recruited into organised crime, often with influence from peer pressure and group mentality. Children involved in CCE, and especially those linked to the illegal drugs trade routes known as county lines, often endure coercion, blackmail, and violence with fear used by perpetrators as a tool to incite commitment and loyalty. Data from the National Crime Agency report that the most common age for exploitation within county lines was 15-17 years, but victims can be younger than 11 where perpetrators may look to build relationships that they can exploit in future.[73] CCE is a contributor to trauma but also increases the risk of young people's involvement in the CJS - there are links between county lines and violence, substance misuse, and homicide.

Local intelligence from the Birmingham City Observatory's Serious Violence Duty profile[74] brings together public datasets and West Midlands Police information to describe the

demographic patterns of serious violence in the city, including the age and ethnicity distribution of suspects and victims within the Serious Violence Strategic Needs Assessment context. This local evidence base highlights concentrations of serious violence among younger people and across specific communities, and, while not identifying exploitation mechanisms directly, provides relevant context for understanding how vulnerability to criminal exploitation and associated harm emerges in Birmingham.

The Observatory data therefore supports the need for trauma-informed and exploitation-aware responses that are tailored to local demographic and geographic patterns of serious violence (Birmingham City Observatory, Supporting Delivery of the Serious Violence Duty in Birmingham (Serious Violence Duty Profile). It is likely that any prevalence figures for childhood trauma and CCE involvement are a substantial underestimation.

Firstly, many children who are victims of exploitation may also be exploited to commit harm – their offending is investigated but their vulnerability as a victim may go unrecognised. Secondly, many children are not aware they are victims of trauma or exploitation and do not seek support. Thirdly, there is an impact of unconscious bias by professionals such as 'adultification' of children which is a form of racial prejudice where children from minority ethnic groups are perceived to be more mature and responsible compared to children from majority ethnic groups. There is also the underestimation of risks through online forums.[5] Girls are at increased risk of abuse and sexual exploitation and there is a significant under-reporting of sexual exploitation, and boys are at higher risk of criminal exploitation.[75]

A HM Inspectorate report highlighted that to tackle CCE, it is necessary to understand the child's context including relationships and social capital. It is important that all agencies take a trauma-informed approach, treating the child as a victim not a perpetrator, exploring what may have led to the behaviour rather than focusing on the behaviour itself. The Youth Justice Board term this the 'Child First Approach' (Figure 11). It is important that professionals do not lose momentum when supporting young people with experience of CCE, they must 'stay with' the child and remain flexible even when engagement is low.[77] The Child First approach has been initiated nationally and evaluation is ongoing.[80]

Figure 11: The Youth Justice Board's Child First Approach aims to ensure that organisations and their services work for children's needs.[80]

As children

Prioritise the best interests of children and recognise their particular needs, capacities, rights and potential All work is child-focussed, developmentally informed, acknowledges structural barriers and meets responsibilities towards children.

Building pro-social identity

Promote children's individual strengths and capacities to develop their pro-social identity for sustainable desistance, leading to safer communities and fewer victims. All work is constructive and future-focussed, built on supportive relationships that empower children to fulfil their potential and make positive contributions to society.

Collaborating with children

Encourage children's active participation, engagement and wider social inclusion. All work is a meaningful colloration with children and their careers.

Diverting from stigma

Promote a childhood removed from the justice system, using pre-emptive prevention, diversion and minimal intervention. All work minimises criminogenic stigma from contact with the system.

A report published by the West Midlands Combined Authority highlighted that in 2023, 337 children were reported to be at risk of CCE in Birmingham. 63% were reported to be from minority ethnic groups and 82% were reported to have a Child Protection/Child in Needs Plan or were a Child in Care.[75]

A prevalent aspect of CCE within Birmingham is county lines.[73] County lines describes the exploitation of children and vulnerable people for transportation of drugs using the road and rail network and is a major source of CCE concern due to the coercion, intimidation, and violence involved. Around 180 of the 2,000 UK county lines (9%) originate from the West Midlands Police force area, the second highest after the Metropolitan Police Service area.[73] West Midlands Police is responsible for 4.9% of the England population.[67] Involvement in county lines often leads to abusive relationships, trauma, and CJS involvement.

The Youth Justice Board's Child First Approach has been adopted across services within Birmingham and the West Midlands. The Youth Justice Board's 2025 report 'Applying the Child First Framework in Youth Justice Settings' highlighted a best practice example project called Kitchen Table Talks (KTT) that was initiated in the West Midlands. The KTT programme involved parents of children within the CJS providing them with education and support around navigating the YJS. Evaluation demonstrated that parents' wellbeing and confidence improved and there was increased engagement in YOS. This project is one example of how taking a holistic approach through collaboration with caregivers can improve engagement and outcomes for young people in the CJS. The Child First approach has also been adopted as part of the Birmingham YOS Strategic Youth Justice Plan.[78]

4.1.3 Insights from Experience

Lived Experience of CJS in Birmingham: Many citizens described untreated trauma as the root cause of later offending and substance misuse. Stakeholders emphasised the need for early identification of trauma and responsive services across schools, GPs, and social care.

Many individuals described childhood trauma as a turning point that led to disrupted education, substance misuse, and criminal activity. Several had been excluded from school, placed in care, or had witnessed or endured domestic abuse from a young age. These individuals often lacked early support and described repeated failures of services to recognise or address their underlying trauma.

"Trauma, abuse, and family loss was the three large things. What they are exponentially, I guess, up the line leading to is a severe mental health crisis amongst our population and drug and alcohol dependency."

– Stakeholder (MoJ)

Stakeholders identified gaps in early intervention and trauma-informed care, highlighting a need for better screening, support for families, and more integrated approaches across education, health, and youth justice.

Current systems were described as reactive, fragmented, and poorly equipped to address long-term impacts of childhood adversity. By addressing root causes - such as unmet mental health needs or unstable home environments - multi-agency approaches have shown potential in reducing the number of children entering the CJS.

This section summarises findings from engagement undertaken as part of the JHNA. Engagement included peer-led interviews with 17 individuals in Birmingham with lived experience of contact with, or risk of contact with, the criminal justice system; more in-depth storytelling and narrative work with four participants; and interviews with 23 stakeholders across health, youth justice, probation and the voluntary and community sector. Participants were recruited through established local networks and partner organisations. The findings presented here are qualitative and are intended to illustrate themes, experiences, and system issues rather than provide statistically representative estimates.

4.1.4 Case Study 1: Michael's Journey

This section presents Michael's story, shared as part of the JHNA engagement process and included alongside his creative portrait and poems. Michael was a Birmingham resident with lived experience of prison and community supervision. His account offers a personal insight into how violence, housing insecurity, mental health, trauma, contact with services and involvement with the criminal justice system can intersect over time. Read together, his words, portrait and poems help ground the assessment in lived experience and show why coordinated, person-centred and trauma-informed support is needed.

"It was just violence for the sake of violence. That's all I knew."

A rough childhood with violence in the home and within the community is where Michael found his beginnings. Safety was found in gang membership and antisocial activity was the way of life. Alcohol helped to block it all out, and paired with the environment, created a cycle of anxiety and fear and more misuse. When Michael entered the prison system, he was clean and used the time to be a model prisoner, helping fellow prisoners with school work or learning English. His reputation and past life of violence kept him safe on the inside and everyone knew he wasn't interested in drug use, so dealers stayed clear of him. It was upon reintegration to society that Michael returned to violent activity and heavy alcohol misuse to cope and adjust.

"I'm more than my past behaviours.
It's not me anyone I don't carry that hate in my heart."

It wasn't until 2020 that Michael found his faith and started to put his violent past behind him. A feeling that something wasn't right with the world drew him to the Old and New Testament where he adopted the tenants of turning the other cheek and helping his fellow men. Working with a psychologist, Michael was diagnosed with ADHD, which helped explain many of his childhood behaviours and how he was treated by others. Michael is also known to inflict self-harm when emotionally dysregulated and us under the care of a mental health support team for the issue.

Four decades of alcohol misuse has also caused several health issues including Wernicke-Korsakoff syndrome and Wernicke encephalopathy, a type of alcohol related dementia and swelling of the brain that is reversible if caught early, chronic pancreatitis, kidney problems, and shakes. Michael also suffered from several concussions due to his past violent lifestyle that also impact his cognition and functioning. The health issues paired with past bouts of homelessness has Michael viewed as a complex case within services.

I am a client of Housing First and have been for a number of years now.

Bock in 2019, I was working through a very chaotic and difficult time in my life. I was repeatedly getting into trouble with the law and creating a stressful and dangerous environment. Life was becoming more and more challenging for everyone around me. I was out of control and perhaps subconsciously wanting to go back to prison, as my life had spiralled into an existence of alcohol fuelled violence and madness.

Finding a place of my own seemed like on unrealistic expectation. A fantasy that only other people lived due to my almost constant interactions with the police and violent clashes with neighbours of my mother's. I was advised by the police to speak with SHELTER a homeless charity.

"I'm lying in this hospital bed twisting and retching.
I wish I was dead.

The Pain in my back and ribs is hard to fathom
It's hard to understand unless you have had 'em

These nurses with swabs trying to stick up my nose..."

"Days go by and I'm feeling well I finally have been pulled from this hell

Time to go home now

I hope I make it this time

Sometimes it's hard to know how,
The sober ladder to climb.."

"Crushed beneath the bones of my idleness?

These bones? listless? lackadaisical?

Yes! great energy abounds me not, as doth it abound the slothenly not.

And as to the moniker "lazy" I retort.";

I am in quite a stable place at the moment and have been alcohol free for some time.
I could not have done this on my own.

Without the help of everyone I have worked with from housing first, I can honestly say I would be dead or serving a lengthy sentence in prison. I am eternally grateful to all of them.

I currently attend a church and have regular contact CL, who help people with drug and alcohol issues

If my chaos of a life can become so full of hope, then with the help that everyone from housing first can offer, there is hope for the many people who are in need, desperate need, of the same kind I help and support I have received.

Thank you so much to housing first.

You have made such a wonderful difference and improvement to my life. Godbless you all.

"…The last night is here after all these years.

At last, I can release some of my tears.

I'm happy to go home but a little apprehensive.

I sit by myself, reflective and pensive.

Has this prison has become more a sanctuary?

I must put on a new man, the old man to bury.

I leave the gates and enter a new world.

The carpet of my future at last unfurled."

"…We start to achieve things working together. I finally see an improvement in the weather.

Volunteering on weekdays To give something back. Making new friends and acquaintances, my life finally on track.

This is cause for celebration I think. How much fun can I have if I don't have a drink?

Maybe just one then, I wont have another. If I can't have a bit of fun in life, then why bother…"

"…The Dichotomous thinker and

The Tautologous drinker,

were sitting in a boat.

The Dichotomous Thinker thought the

boat was a sinker,

but he also thought it would float.

Then The Tautologous Drinker took a

drink from his cup,

from the vessel he was holding he drank.

And as the boat started sinking he

just carried on drinking

And his drinking continued till it sank."

4.2 School Exclusions

Research consistently shows that educational exclusion is strongly associated with future offending. Being out of school means children have a lack of structure and are vulnerable to exploitation from organised crime groups and gangs that may provide them with a sense of belonging and inclusion.[80]

The school-to-prison pipeline refers to the pattern by which exclusionary school practices, such as suspension and permanent exclusion, increase the likelihood of young people entering the CJS.[80]

There are multiple risk factors for school exclusion and children with special educational needs (SEN) - children with learning disability, learning difficulty, or neurodivergence - are particularly affected. Children with SEN account for 44% of all permanent exclusions and 82% of permanent exclusions in primary schools.[81] People from minority ethnic backgrounds are also more likely to be excluded from school, as are those who have care experience or have endured trauma.[71,73]

4.2.1 School Exclusion, Inequality and Pathways to Justice Involvement

Exclusion from school is recognised within national evidence as a marker of increased vulnerability to later adverse outcomes, including youth justice contact. While exclusion does not directly cause offending, longitudinal studies[82] indicate that pupils who experience suspension or permanent exclusion are more likely to experience disrupted educational attachment, reduced attainment, and subsequent involvement with statutory services.

To examine local patterns, three-year averaged suspension and permanent exclusion rates (academic years 2021/22–2023/24) were analysed using Department for Education (DfE) published data.

Ethnicity

Using White pupils as the reference group, marked disparities are observed in Birmingham.

The three-year averaged permanent exclusion rate for White pupils was 0.0602. Rates were higher for:

- Black pupils: 0.0933 (Rate Ratio [RR] = 1.55) Mixed ethnicity pupils: 0.0853 (RR = 1.42)
- Asian pupils had lower exclusion rates (0.0212; RR = 0.35).

Suspension rates showed a similar pattern. The three-year averaged suspension rate for White pupils was 3.15. Rates were:

- Black pupils: 3.78 (rate ratio = 1.20)
- Mixed ethnicity pupils: 3.96 (rate ratio = 1.26)
- Asian pupils: 1.26 (rate ratio = 0.40)

These disparities are consistent across the three-year period.

Socioeconomic Disadvantage (Free School Meals)

Socioeconomic inequality demonstrates a stronger gradient.

FSM-eligible pupils had a permanent exclusion rate of 0.0818 compared to 0.0188 among non-eligible pupils (RR = 4.35).

Suspension rates were 4.06 compared to 1.40 (RR = 2.91).

Special Educational Needs

The largest disparities were observed among pupils with identified special educational needs.

Compared to pupils with no identified SEN:

- Pupils receiving SEN Support had a permanent exclusion rate of 0.1459 (RR = 6.29).
- Pupils with an Education, Health and Care (EHC) Plan had a rate of 0.0976 (RR = 4.20).

Suspension rates were similarly elevated (RR ≈ 3.46 for both SEN Support and EHC Plan).

The magnitude and consistency of these rate differentials indicate sustained structural disproportionality in exclusion outcomes across ethnicity, deprivation and SEN in Birmingham.

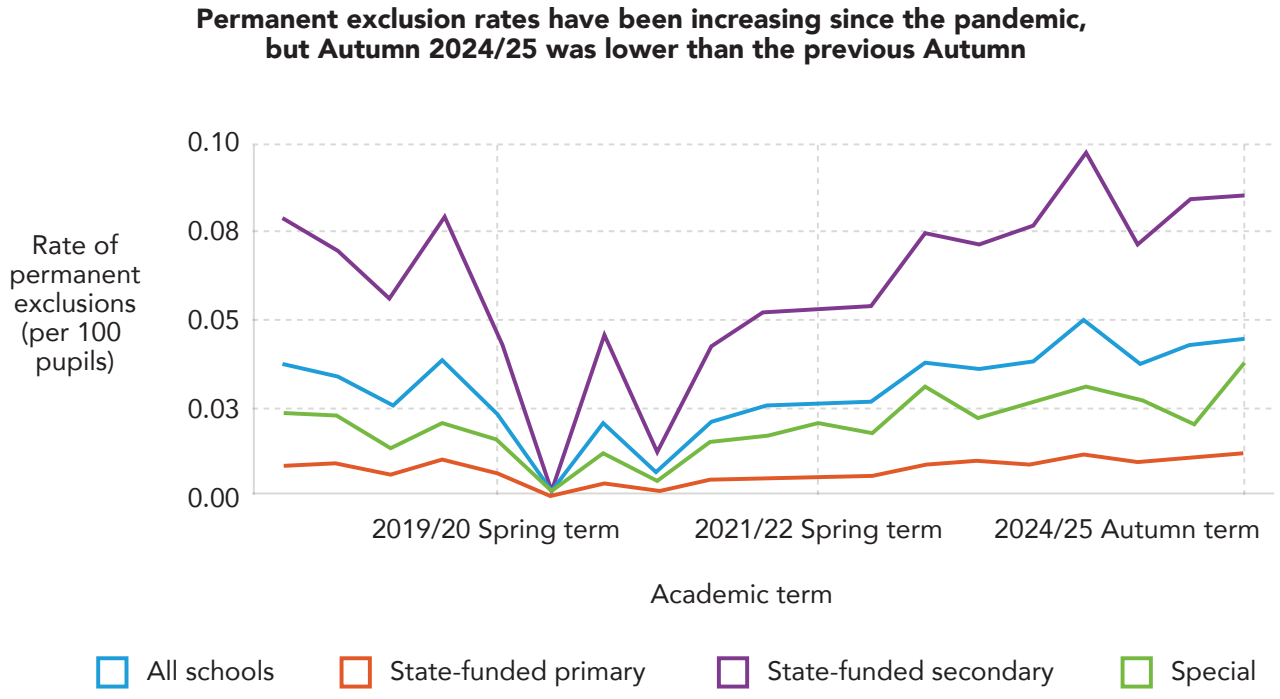
While exclusion should not be interpreted as a causal pathway to criminal justice involvement, it functions as an upstream risk indicator within a public health framework. The pronounced gradients observed for SEN and socioeconomic disadvantage suggest that unmet additional need and structural inequality represent significant prevention opportunities within Birmingham's serious violence and justice prevention agenda.

Relative risks presented here are descriptive rate ratios calculated using published DfE three-year averaged rates. Formal confidence intervals are not reported due to absence of underlying denominator data within the published dataset.

Figure 12 shows permanent school exclusion rates in England 2019-2025. The graph shows a sharp dip in 2020 due to the Covid-19 pandemic before a sharp rise in exclusions after lockdown lifted which exceeded rates pre-pandemic. Exclusions in England have reduced between 2023-2025 but still remain higher than rates prior to the 2020 Covid-19 pandemic (Figure 12).[83]

Figure 12 presents national trends in permanent exclusion rates by school type from 2018/19 to 2024/25 (autumn term). The term-level presentation reflect the format used in official Department for Education statistics.

Figure 12: Permanent school exclusion rates, by school type in England (2019-25).[83]



Footnotes
1. For 2019/2 and 2020/21, while suspensions and permanent exclusions were possible throghout the academic year, pandemic restrictions will have had an impact on the numbers presented and caution should be taken when comparing across years.

Source: School census

While term level fluctuations are visible, the overall trend demonstrates a marked reduction during the COVID-19 period, followed by a sustained post-pandemic increase, particularly within state funded secondary schools. Rates in 2024/25 autumn term, (provisional) remain elevated compared to pre-pandemic levels, despite being marginally lower than the previous autumn term. For clarity, three-year average rates are presented elsewhere in this section to support interpretation of sustained trends.

Nationally, **52.5%** of young adults who received custodial sentence had been persistently absent from school, in contrast to only **10.9%** of individuals with no criminal convictions.[73]

The Youth Endowment Fund have produced a report of interventions to prevent school exclusions, describing both universal, school-wide interventions and more individualised, targeted interventions.[85]

Studies have shown that preventative, whole-school approaches are most effective at reducing school exclusions.[86] Given the known short-term and long-term impacts on children's wellbeing and future life outcomes, school exclusions should only occur when there is a serious breach of a school's behaviour policy (such as violence or possession of drugs) or if the education or welfare of other pupils and staff is at risk.[87]

4.2.6 The Birmingham Context

Table 2 shows that in 2022-23, pupil absence in Birmingham was higher (8.0%) than England (7.4%), and permanent exclusions in Birmingham also exceeded national rates (0.14% v 0.11%). Furthermore, 8.0% of Birmingham's 16–17-year-olds were not in education, employment or training (NEET), which is significantly higher than the national average (5.2%).[77] In 2024, there were 194 pupils who were permanently excluded from secondary school which is substantially higher than the mean for England (27) and the mean for the West Midlands (85).[84]

Table 2: Pupil absence, permanent exclusions, and 16–17-year-olds not in education, employment or training in birmingham compared to the core cities and England in 2022/23.[84]

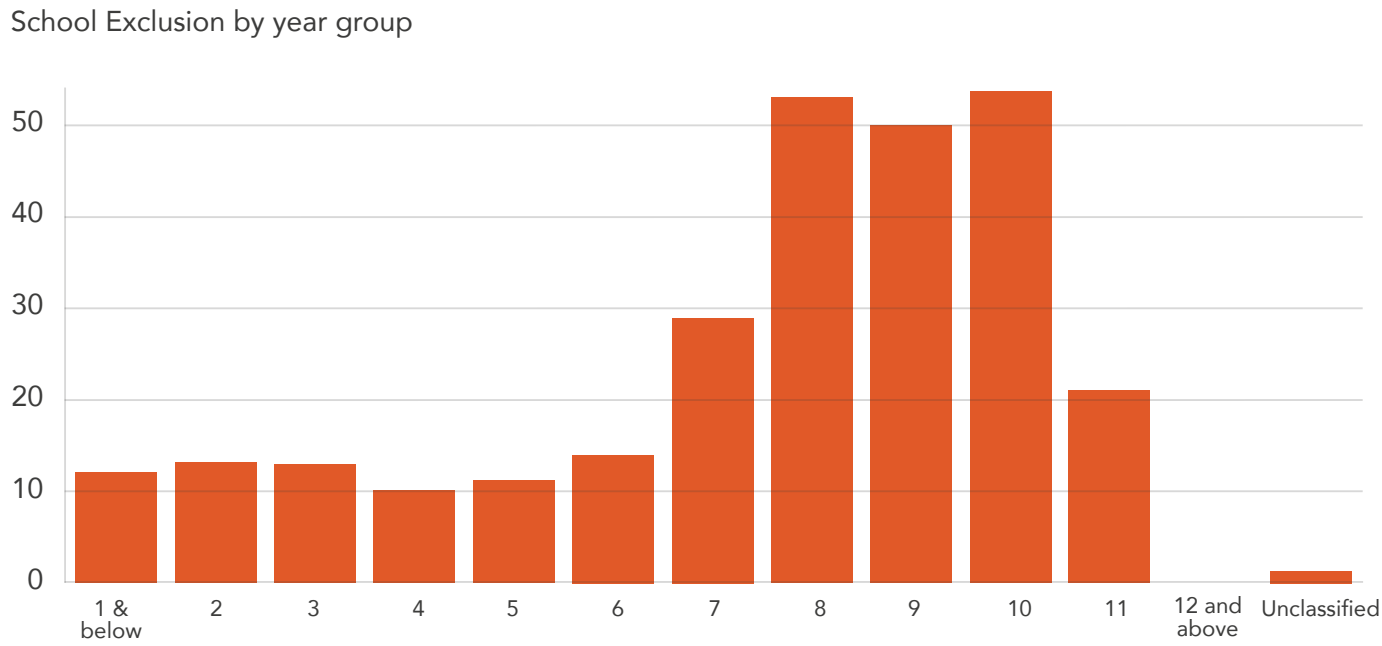
Risk Factor	Date	Birmingham	Bristol	Leeds	Liverpool	Manchester	Nottingham	England
Pupil absence (% of school sessions missed	2022/23	8.0%	8.6%	7.6%	8.2%	7.5%	8.0%	7.4%
Permanent exclusions (% of pupils	2022/23	0.14	0.06	0.01	0.20	0.11	0.20	0.11
16-17-year-olds not in education, employment or training (NEET) or activity unknown	2022/23	8.0%	5.0%	9.2%	8.5%	5.6%	5.1%	5.2%

Key: Red – worst 95%; Yellow – similar to England; Green – better 95%

Between Oct-Dec 2024, the Birmingham YJS worked with 568 children, of whom 61.1% had either current or historical permanent or fixed-term school exclusions. Many of these young people were placed in Pupil Referral Units (PRUs) which provide support for children and young people who face challenges in traditional education settings.[88] There is also a link between household income, school exclusion, and CJS involvement: in 2022/23, 73% of school pupils in Birmingham who were excluded were eligible for free school meals compared to 37.3% of the general Birmingham population.[91]

Whilst there are school exclusions that occur in Birmingham in primary school-aged children, there appears to be a step increase in years 7 and 8, which is then maintained in years 9 and 10 (Figure 13). This may suggest that prevention should be targeted at the transition to secondary school, providing support to at-risk children before incidence increases.

Figure 13: Number of children experiencing school exclusion in Birmingham by year group.



In collaboration with the University of Birmingham, BCC have produced a series of short videos, providing advice to parents and carers whose children are enduring permanent or short-term exclusion.[80] The videos give explanations for key terminology, parental/carer rights, key dates, and the review process.

The Birmingham YJS has also begun to implement ethnicity reporting within their Virtual School Register to improve monitoring of school exclusions by ethnicity. There is currently no data relating to neurodivergence amongst children excluded from school and involved with the Birmingham YJS.[81]

Birmingham YJS also provides support to schools to explore alternatives to permanent exclusion and encourage restorative practice, mentoring, and anger management initiatives such as art therapy and martial arts.[81]

4.2.7 Insights From Experience

Stakeholders and community emphasised the link between early school exclusion, poor educational outcomes, and justice involvement. Children with unmet special educational needs, especially those with neurodivergence, were highlighted as particularly vulnerable to exclusion and later involvement in the CJS. The data underlines the need for early identification and inclusive educational practices.

"You've got kids who've moved between ten different carers, kicked out of school three times, and no one really notices until they've done something serious."

– Stakeholder (Youth Justice)

4.3 Looked After Children

60% of children in Young Offender Institutions have experience of care.

By age 24, 52% of people with care experience will have recieved a criminal conviction compared to 13% of those without care backgrounds.[82]

The number of children in care has been increasing across England and Wales over recent years.[95] Children who have been in care are significantly overrepresented in the YJS. Nationally, while fewer than 1% of all children have experienced care, nearly half of children in secure training centres (46%) and over 60% of those in young offender institutions have care experience.[90] By age 24, more than half (52%) of care-experienced children will have received a criminal conviction, compared to 13% of those without care backgrounds.[95] These figures highlight the structural vulnerability of this group and the need for sustained intervention across systems.

There is a strong association between care experience and early school exclusion, undiagnosed or unsupported special educational needs and disabilities (SEND), and mental health issues. National data shows that 92% of children with care experience who received a custodial sentence by age 24 had been identified as having SEND.[81] This group were also more likely to have been excluded or suspended from school, with 1 in 5 (18%) having previously been excluded and 4 in 5 (81%) suspended.[81] Girls with care experience also face elevated risks of teenage pregnancy and self-harm. The transition from being in care to adulthood often occurring at age 18, is a particularly high-risk period for CJS involvement.

Young people may lose access to trusted professionals and support structures at a time when they are least equipped to live independently. Without sustained care and planning, these transitions often result in homelessness, mental health crises, and contact with the CJS.[96]

The Risk of Serious Harm Guidance explicitly acknowledges that children transitioning out of care face heightened risks of exploitation, homelessness, poor health, and criminal justice involvement.[97] Without structured, trauma-informed transition planning, these vulnerabilities are likely to persist and escalate

4.3.1 The Birmingham Context

Birmingham YJS data indicates that 14.3% of children supported by the service in 2022/23 had care experience, and 18.6% were subject to Child in Need Plans. Additionally, of those young adults who received custodial sentences, 17.6% had been in care and 41.7% had previously been recognised as children in need.[95]

Within Birmingham, there are 2,300 looked after children which is a rate that is similar to the England average and is lowest of all the core cities in England (Table 3).[77] However, 50% of the youth justice population in the West Midlands has experience of care compared to 14.3% in Birmingham.[95]

Table 3: Number and rate of looked after children in Birmingham compared to England and the Core Cities.[77]

Risk Factor	Date	Birmingham	Bristol	Leeds	Liverpool	Manchester	Nottingham	England
Looked after children (number & rate per 10,000)	2024	2300 (79)	768 (84)	1549 (89)	1490 (155)	1303 (100)	674 (100)	83630 (70)

4.3.2 Insights From Experience

Stakeholders described multiple underlying drivers that place looked after children at greater risk of entering the CJS. These include early exposure to neglect or abuse which can impact childhood brain development, frequent placement moves, instability in education, exposure to criminal exploitation, and lack of access to consistent, trauma-informed support.

Lived experience participants and professionals emphasised that early adversity and systemic neglect can lay the foundation for poor outcomes later in life. Many care-experienced children face disrupted relationships, low educational attainment, and exclusion from mainstream services. The lack of coordinated support during transitions, particularly from care to adulthood, was cited as a key failing.

Local professionals reported that the shift from youth to adult services can be particularly problematic, especially for those with neurodivergence or mental health issues, because support pathways often change or disappear entirely once a young person reaches 18 years of age.

One stakeholder noted:

> *"Young people come out of care, or they're just transitioning out of youth justice, and there's a cliff edge. Adult services are harder to access, and they're not tailored to this age group."*
>
> – Stakeholder (VCFSE)

Stakeholders stressed that improved data sharing, earlier intervention, and relational support models could prevent many of these outcomes.

The following case study is drawn from qualitative engagement undertaken as part of this needs assessment and illustrates themes raised through lived experience work.

4.3.3 Case Study 2: Melissa's Journey

Melissa always knew she was adopted at 18 months old, and this was a huge part of her life. She describes feeling different from her family, her friends, and peers at school despite belonging to a loving and supportive family.

Melissa has a history of toxic and co-dependant relationships that revolve around drug use. She ran away from home a lot and reports having behavioural problems.

Melissa has been in and out of recovery for about 4.5 years. She entered her first dry house when her son was 12 months old, lasting a week before relapse.

She was transferred to an HMO that was unsafe and rife with drug misuse. During this time, Melissa worked with several drug agencies and support organisations but consistently relapsed-the longest relapse lasting about three years. Melissa believes she just wasn't ready to change at the time and acknowledges that relapse was a major part of her journey due to her youth and unsupported mental health needs. A younger Melissa was drawn to the perceived excitement of drug use; however, she quickly experienced drug-induced psychosis, and the experience ceased to be fun.

"A bad day in recovery for me is nothing compared to a bad day using"

Melissa currently lives in an HMO, but it's run well and the woman she lives with isn't a substance misuser. Supports such as Foundations for Change and her sponsor in the 12-Step Programme were cited as instrumental to her success.

Melissa believes her biological mother may have some type of substance misuse or mental health issues because three children (Melissa and two siblings) were removed from the home and adopted out. Melissa claims she would have likely become an addict even if her adoption was kept secret, feeling naturally wired for that type of coping mechanism. Work has started to identify and deal with the underlying issues of her substance misuse and she's currently undergoing screening for ADHD. Melissa stated her childhood issues with emotional dysregulation, impulse control, and destructive behaviour could be explained by the undiagnosed condition.

"If you've got an addiction, don't give up. Keep trying. If I'd given up, God knows where I'd be today"

4.4 Economic Insecurity and Housing Insecurity

National data consistently demonstrates the strong association between socio-economic deprivation and imprisonment, with the most deprived communities enduring the highest rates of CJS involvement.[98] Individuals in contact with the CJS frequently face multiple economic disadvantages including long-term unemployment, low levels of educational attainment, and insecure income. These factors can create significant barriers to rehabilitation and reintegration, increasing the likelihood of reoffending and worsening health inequalities. The process of imprisonment also risks worsening financial instability, impacting not only the individual but also their family network.[99]

Housing insecurity is another significant driver and consequence of involvement with the CJS. Up to 15% of people in prison have endured homelessness compared to 3.5% in the general population.[102] The lack of a secure home impedes recovery from addiction, management of mental health conditions, and reintegration into society. 80.6% of prison leavers in England were released into settled accommodation in 2025, and those without a fixed address were found to have almost double the proven reoffending rate compared to those with stable housing.[101,102] Homelessness is also linked to a higher risk of physical illness, injury, and mortality, as well as poorer access to healthcare services.[104] Children growing up with housing insecurity are likely to experience disrupted education, especially when living in temporary accommodation which can impact educational outcomes and social connectedness.

4.4.1 The Birmingham Context

Birmingham has significantly higher levels of deprivation than national averages, with 44% of its population living in areas ranked within the most deprived 10% in England (Figure 14).[48] This structural disadvantage is particularly apparent among justice-involved populations, who often endure intersecting barriers across income, housing, education, and employment.

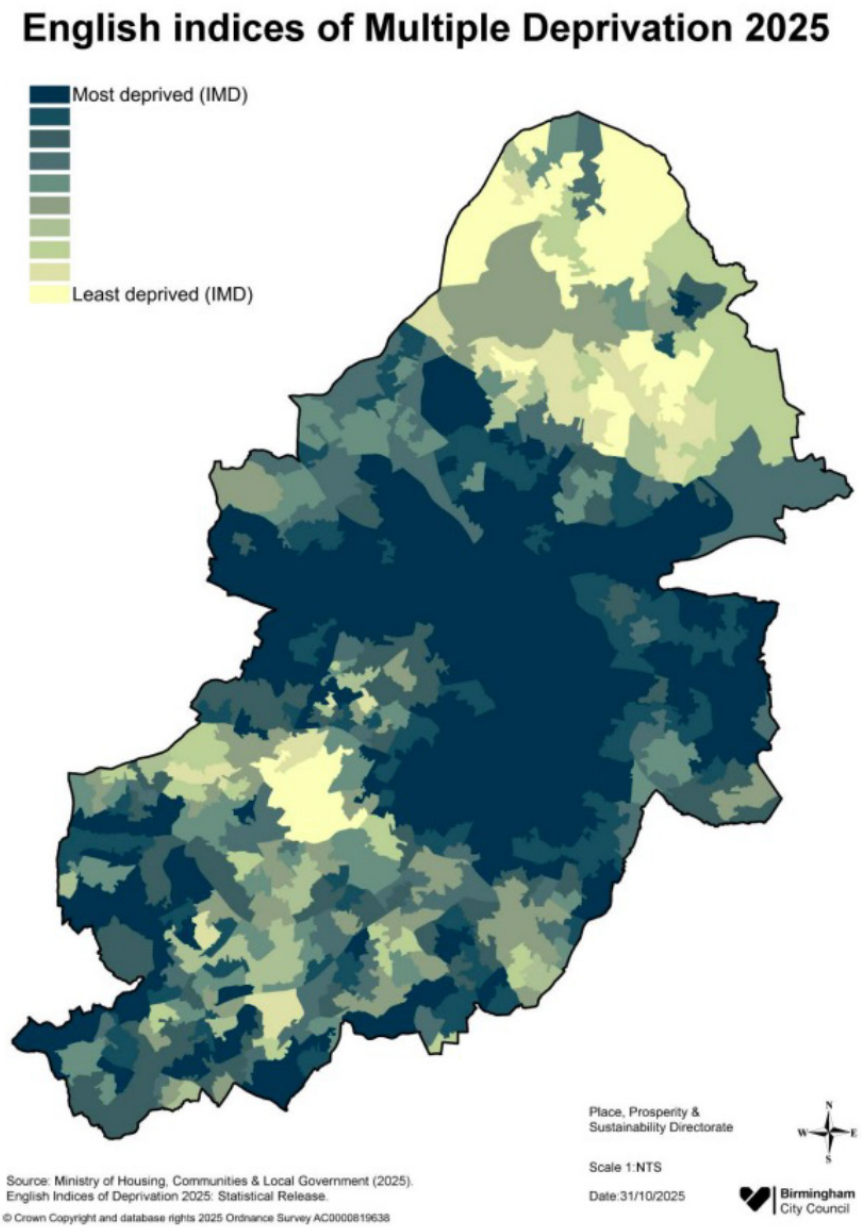


Figure 14: Map of Birmingham highlighting the reported index of Multiple Deprivation scores across different areas of Birmingham.

Within Birmingham, the risk of economic exclusion is particularly stark for young people. Birmingham has higher rates of youth unemployment and economic inactivity than both regional and national averages. As of 2024:

- 6.4% of 16–17-year-olds in Birmingham were not in education, employment, or training (NEET), similar to the West Midlands average (6.2%) but higher compared to the England average of 4.6%.[103]
- 8 of Birmingham's 10 constituencies had higher rates of unemployment compared to the England average. The average rate of unemployment in Birmingham in June 2025 was 7.8% compared to 5.9% in the West Midlands and 4.7% across England.[105]
- In August 2025, 13.0% of households in Birmingham were claiming housing benefits compared to 6.7% in the West Midlands and 5.1% across all local authorities in England.[92]

These indicators are especially relevant when considering the youth justice population. Economic exclusion, particularly when combined with school exclusion, trauma, and mental health needs, increases the risk of offending and limits opportunities for rehabilitation.

To provide an insight into the distribution of prison leavers by geography in Birmingham, Change Grow Live (CGL) provided data to show where their substance misuse clients were released to after leaving prison (Figure 15). It must be acknowledged that this map represents accommodation after release from prison (including supported accommodation) rather than where people are originally from or choose to live. However, the map shows that there are more prison releases to areas in central and eastern parts of the city in comparison to northern, southern, and western areas of the city, which loosely aligns with the map of IMD in Birmingham. More in-depth data around where people within the CJS are from within Birmingham were not available.

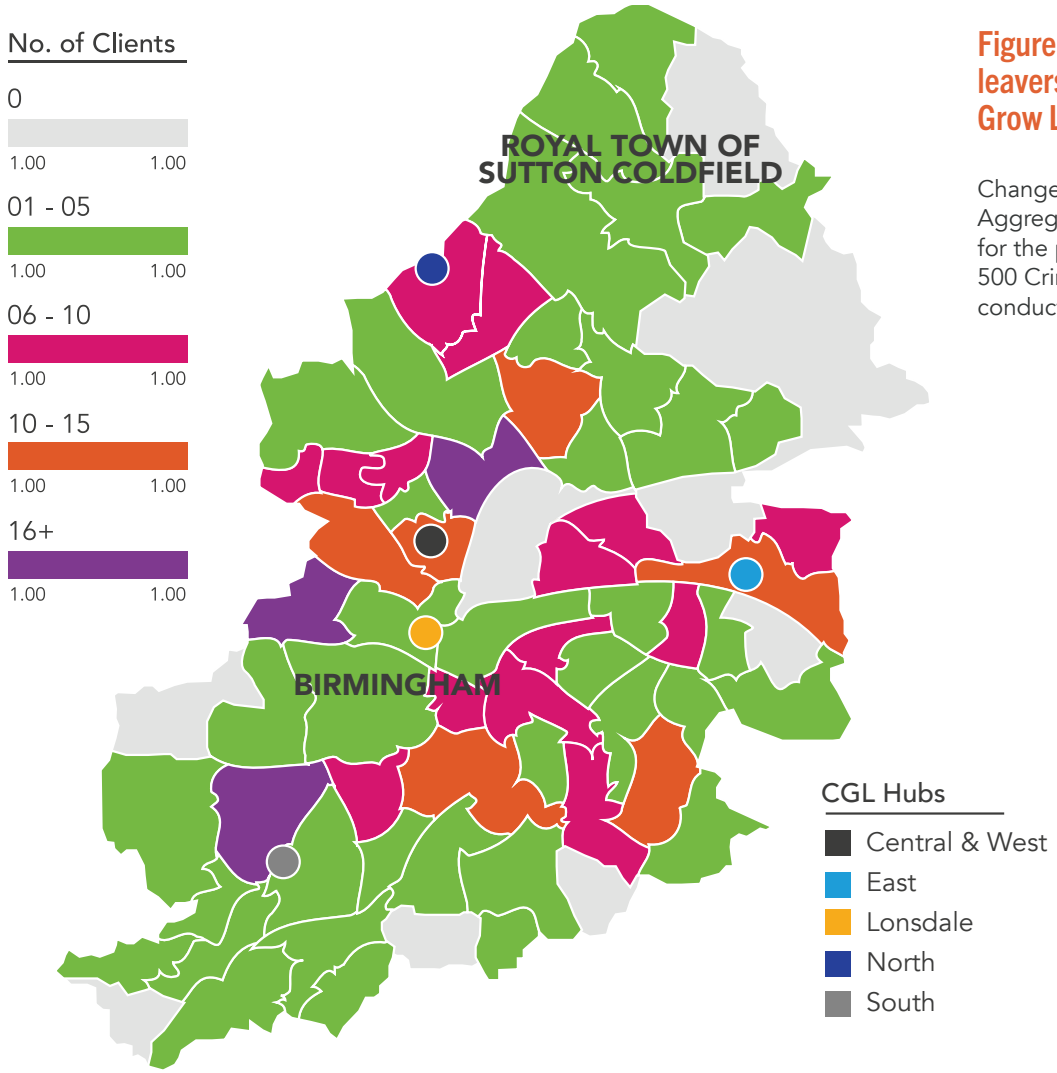


Figure 15. Map of prison leavers supported by Change Grow Live in Birmingham.

Change Grow Live (CGL) (2024). Aggregated data supplied by CGL for the purposes of this JNHA from 500 Criminal Justice assessments conducted by CGL during 2024

Table 4 shows fuel poverty and homelessness rates in Birmingham compared to the Core Cities and England. Birmingham has higher rates of fuel poverty (24%) compared to the England average (13.1%). The temporary housing rate (10.7%) is over double the England average (4.6%) and the Birmingham homelessness rate (15.9%) is also higher than the national average (13.4%). Birmingham also has a higher average number of rough sleepers per month (83) compared to the West Midlands (38) and England (26) averages.[106]

Table 4: Comparison of economic and housing risk factor prevalence in Birmingham to the Core Cities and England.[77]

Risk Factor	Date	Birmingham	Bristol	Leeds	Liverpool	Manchester	Nottingham	England
Fuel poverty (%)	2022	24.0%	13.8%	16.0%	17.2%	16.7%	19.3%	13.1%
Homelessness: households in temporary accommodation (rate per 1,000)	2023/24	10.7	7.0	0.6	3.5	no data	5.6	4.6
Homelessness (rate per 1,000)	2023/24	15.9	15.2	15.7	7.0	26.6	20.7	13.4

Red – greater than the England average, Yellow – similar to the England average, Green – lower than the England average

Birmingham has significant housing needs and there are strategies to determine priority. For example, people in the CJS are classed as the second most-urgent priority group after children and young people.[106] The 2022 Birmingham Supported Housing Strategy highlighted how 805 (9.5%) people awaiting supported accommodation in Birmingham had experience of the CJS.[106] These figures highlight how many people in contact with the CJS in Birmingham have housing needs, and a significant number may also require additional care, support, or supervision within their living situation which are all required to be arranged prior to release from custody. In 2026, BCC Public Health will be undertaking a supported housing needs assessment to explore this further.

Of people leaving prison in 2025, 85.8% were in settled accommodation (long-term accommodation intended for those experiencing or at risk of homelessness) after 3 months in the West Midlands compared to 80.6% in England on average.[104] It is worth noting that these figures may include individuals who have moved to the West Midlands specifically for supported accommodation. This is improved from 2024 figures (although direct comparison should be made cautiously due to missing cases from 2024) where 73.5% of prison leavers were in settled accommodation at 3 months post-release. A third (33.8%) of 500 prison leavers in contact with CGL in Birmingham in 2024 were living in unstable accommodation – 10.0% in hostels, 7.4% rough sleeping, 7.8% sofa-surfing, 8.6% with friends and family short-term. A further 27.8% were living in 'supported accommodation' with 'no home of their own' Change Grow Live (CGL) (2024). Aggregated data supplied by CGL for the purposes of this JNHA from 500 Criminal Justice assessments conducted by CGL during 2024. This data highlights how national reports and local experience may not always align.

4.4.2 Insights From Experience

Professionals and people with lived experience echoed the concerns around economic and housing instability. Stakeholders described how poverty limits access to healthcare, creates competing priorities (e.g. between attending appointments and meeting basic needs), and increases the likelihood of engaging in survival behaviours that lead to criminalisation. The cost-of-living crisis was cited as a major current challenge, exacerbating financial instability among people leaving prison or managing community sentences.

If you haven't got food or heating or housing, healthcare becomes a luxury. People are making choices between survival and their wellbeing every day."

– Stakeholder (VCFSE)

"People are sanctioned or lose benefits. That can push them to reoffend. Not because they want to, but because they have no other option."

– Stakeholder (Probation)

Individuals on release from custody frequently report difficulties accessing employment due to criminal records, gaps in CVs, and stigma. This was particularly acute for those with poor literacy, digital exclusion, or a lack of recent work experience. Several professionals noted the importance of employment as a stabilising factor but recognised that the current system does not adequately support justice-involved individuals into sustainable, meaningful work.

The Housing First model, which prioritises immediate access to secure accommodation alongside flexible, wraparound support, was positively referenced by several stakeholders. In Birmingham, stakeholders identified Housing First provision delivered through Cranstoun as a promising approach; however, they also highlighted that limited funding and availability restrict access for many individuals who could benefit.

"It was designed purposefully to almost be a bit of an antidote to the existing homeless pathway, which, for a lot of people, gets people off the streets and keeps them off the streets once they're picked up, which is fantastic. There's a nucleus, if you like, a group of individuals with entrenched rough sleeping backgrounds for whom that pathway just isn't working for them. It's that cohort that I think have responded actually really positively to Housing First because what Housing First did as a concept was, as the name suggests, it put housing first."

– Stakeholder (VCFSE)

Stakeholders and lived experience participants consistently described a revolving door between homelessness and custody. Individuals frequently return to prison because it offers shelter, meals, and a perceived sense of safety that they cannot find in the community.

"I've had people go to me, 'I committed an offence because I know what it's like in prison. I get my own sweet accommodation, three meals a day. It's the outside that scares me."

– Stakeholder (VCFSE)

Barriers to accessing stable housing were often compounded by stigma, complex application processes, and a lack of coordinated support across services. Several participants noted that homelessness prevented them from registering with a GP or accessing mental health support, perpetuating cycles of ill health and exclusion.

> *"People haven't got appropriate accommodation… then they're homeless, they can't get a job, they can't get support for their mental health because they can't register with a GP. Then, that becomes a rolling cycle."*
>
> – Stakeholder (NHS)

Others highlighted how release into inappropriate or unsafe housing undermined recovery efforts, especially for those with mental health needs or substance misuse issues. Yet, pressures on housing availability mean that housing providers are unable to consider the quality of the housing, their priority is finding somewhere to place people. The trauma of homelessness was often layered on top of existing disadvantage, contributing to poor outcomes across multiple domains.

Finally, stakeholders discussed how policies within the system increase likelihood of homelessness. For example, if an individual is awaiting trial in custody the housing association can hold their accommodation for a maximum of three months. Some may be awaiting trial for longer than three months meaning they lose their housing only to find that they are not convicted and are released from court with nowhere to go.

4.5 Learning Disabilities

A learning disability is defined as 'a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood'.[108] Learning disability is distinct from learning difficulty. A learning disability will affect all aspects of a person's life whereas a learning difficulty relates to specific issues in processing certain types of information and does not impact overall intelligence.[108] Learning disability exists on a spectrum and has many causes including genetic abnormality, neurodevelopmental disorder, exposure to toxins during pregnancy, premature birth, birth complications, and illness in early childhood.[112]

People with learning disabilities are overrepresented within the CJS. It is estimated that up to 7% of people in prison have a learning disability compared to 2% in the general population in England.[111] Within prison, people with learning disability are more likely to endure inequalities. Despite The Humans Rights Act (1998), The Equality Act (2010), and The Health and Care Act (2022) all outlining the right for people with learning disability to be treated with dignity and respect in all aspects of society, they are five times more likely to endure control and restraint, and three times more likely to endure segregation compared to other people within prisons.[111]

People with learning disabilities are...

5 times more likely to be **controlled and restrained**

3 times more likely to be put into **segregation**

...compared to other people within prisons.[93]

There are some processes in place to screen people within the CJS for learning disability. For example, all children and young people entering custody should be screened using the Comprehensive Health Assessment Tool (CHAT) which is a general health screening tool but also involves assessment of speech, language, and communication needs.[208] Needs may also be identified during engagement with education within custody but this is subjective and many individuals may remain undiagnosed.

There are guidelines for developing services for individuals with learning disability who exhibit behaviour that challenges by the National Institute for Health and Care Excellence (NICE) including person centred care, housing, and staff skills which may all have relevance to the CJS setting.[113] Easy-read guides have been produced by organisations such as the Prisons Trust to explain processes and available services within custody.

4.5.1 The Birmingham Context

There is limited data to demonstrate the prevalence of learning disability amongst the Birmingham CJS population. NHS Quality Outcomes Framework data suggests that the general population in Birmingham has a higher percentage prevalence of people with learning disability (0.69%) in comparison to England (0.55%).[120] However, under-diagnosis and under-reporting likely mean that this prevalence is underestimated. The high prevalence of learning disability within Birmingham compared to England may also be reflected within the Birmingham CJS population.

In 2024, BCC published the Learning Disabilities Deep Dive (BCC LD DD) which presents a comprehensive picture of the learning disability needs within Birmingham including specific recommendations for the CJS setting. The BCC LD DD recommended that a learning disability and autism healthcare champion are appointed to prisons and probation. The aim of the role would be to improve accessibility of services for people with learning disability including accessible communication, introducing and promoting adaptive offending behaviour programmes whilst also keeping a register of people in the CJS who have learning disabilities to allow prevalence estimates and monitoring of outcomes.[120] As of 2025, HMP Birmingham has a neurodiversity support manager, but supporting individuals with learning disability is beyond the scope of their role.

The BCC LD DD also highlighted a small number of services within Birmingham to support individuals with learning disabilities who also have contact, or are at risk of having contact, with the CJS. There is a Criminal Justice Liaison and Diversion Team within Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) who work in police custody suites, the Birmingham Magistrates Court, and the community.[118]

The BCC LD DD also recommended roll-out of Oliver McGowan training to all professionals working with people in the CJS.[120]

4.5.2 Insights From Experience

Discussions with stakeholders at HMP Birmingham found that staff suspect that many people within the prison may have some sort of learning disability, but most remain undiagnosed. Many may have missed opportunity for diagnosis due to exclusion from school. Staff also mentioned how there was funding to deliver training relating to learning disability within the prison but constraints on induction have meant that this section of training has been removed.

4.6 Neurodivergence

Neurodivergence refers to a variation in neurological development and functioning and includes conditions such as autism spectrum disorder (ASD), ADHD, dyslexia, dyscalculia, and dyspraxia.[64] Neurodivergent individuals may experience difficulties with language and speech, motor skills, behaviour such as impulsivity, memory, learning and other neurological functions. It is common for people to have more than one different type of neurodivergence; for example, autism and ADHD commonly co-occur which can lead to difficulties in diagnosis and diagnostic overshadowing, where symptoms are attributed to an existing neurodivergence diagnosis without full investigation and diagnosis of additional traits.[109]

Identifying the prevalence of neurodivergent people is complex due to lack of awareness and overlap between conditions.[64] Diagnosis most often occurs within school, but those who are excluded will be less likely to receive a formal diagnosis. Many individuals within the CJS have experienced school exclusion meaning many may remain undiagnosed. Despite this, neurodivergent people are overrepresented within the CJS and where possible, it would be beneficial for previous neurodivergence diagnoses to be highlighted when encountering the CJS to prevent the need for re-screening. A report by the Criminal Justice Joint Inspection estimates that up to 50% of individuals within the CJS are expected to have a form of neurodivergence.[122] Among young people in secure training centres, ADHD prevalence has been estimated to be as high as 74.2%.[124]

Table 5 shows the percentage prevalence of neurodivergence within the general population compared to those within the CJS. The data show that there is a greater prevalence of autism (>3 times higher), ADHD (>6 times higher) and dyslexia (5 times higher) amongst the prison population compared to the general population.[123] Amongst the Youth Justice population, prevalence of ADHD and dyslexia is even higher.

There are limited data around neurodivergence prevalence between men and women. Neurodivergence amongst women has historically been underdiagnosed compared to men in the general population, often due to masking at school and differences in presentation between females and males with neurodivergence.

Table 5: Estimated prevalence of neurodivergence in the general population, prison population and youth justice population.[122] [124]

	General Population	Prison Population	Youth Justice
Autism	1-2%	5-7%	Not available
ADHD	4%	25%	30%
Dyslexia	10%	~50%	31-56%
Dyspraxia	5%	Not available	Not available
Dyscalculia	6%	Not available	Not available

Many people enter the CJS without a formal diagnosis of neurodivergence, and lack of screening means that appropriate interventions or adjustments cannot be made. Screening tools for neurodivergence are available but it is often up to practitioners to identify needs of those with neurodivergence leading to variability in completion.[127] Availability of diagnostic assessments is limited, and where assessment services do exist, they are often overwhelmed with long waiting lists. Young people in particular report not being taken seriously when disclosing neurodivergence, and decisions around access to appropriate adults in custody are frequently made based on informal judgement rather than structured assessment.

Neurodivergent people often report poorer experiences of the CJS. This includes difficulties processing verbal information, heightened anxiety in overstimulating environments, and challenges navigating unfamiliar or high-pressure situations. Such difficulties are particularly acute during arrest, interviews, and time spent in custody. Custodial environments, often noisy, brightly lit, and highly regulated, can be especially challenging for individuals with sensory sensitivities or difficulties with emotional regulation. People with dyslexia may struggle to read information and people with dyscalculia may struggle with clocks and numbers. Studies have shown that neurodivergent people often report challenges to accessing the support they need whilst in the CJS, leading to feelings of distress and isolation.[64] This may be a reflection of the relative lack of recognition and understanding amongst staff about the needs of people with neurodivergence.

The HM Inspectorate of Prisons review of Neurodiversity in Prisons in 2021 highlighted the significant need for improved support for neurodivergent individuals within the CJS. The action plan led to the national roll-out of Neurodiversity Support Managers (NSM).[124] Four years on from the initial HM Inspectorate of Prisons neurodiversity review, there are now 105 NSMs in post with their role being to raise awareness of neurodivergence in prison, support staff with strategies, and act as a link between prison, education and healthcare.[124] A progress update for the MoJ Neurodivergence Action Plan was published in 2023 which highlighted improvements in service design and delivery but continued need for improved screening and consistency in services across the CJS.[125]

Resources produced by associated organisations such as The Prisons Reform Trust include an easy-read guide providing information around the CJS processes, what to expect within prison, and how to access support for those who might have additional learning needs.[125] However, there is limited availability of these resources in different languages meaning those who speak English as a second language or cannot speak English may still experience difficulties.

Overall, research suggests that services should deliver in response to individual need rather than in response to a diagnosis. This way, those who have not yet received a formal diagnosis of neurodivergence can still receive the support they require within the CJS, and the diverse needs of neurodivergent people can be met.

4.6.1 Foetal Alcohol Spectrum Disorder (FASD)

Foetal Alcohol Spectrum Disorder (FASD) is a neurodevelopmental disorder caused by alcohol exposure during pregnancy.[114] People affected by FASD often experience vulnerability in understanding, decision-making, and social skills and rates of FASD amongst those within the CJS are thought to be high.[115] A minority (5-10%) may have physical features of FASD but most are considered to have a hidden disability because many individuals will have age-appropriate physical development, language, and reading ability. Due to the variability of presentation in people with FASD, it can remain undiagnosed throughout childhood, with prevalence likely grossly underestimated. Prevalence is reported to be between 3-17% of children in the UK.[97] Individuals with FASD often require more frequent interaction with healthcare and are reported to be over 19 times more likely to have involvement with the CJS compared to individuals without FASD.[116] The Birmingham City Observatory highlights that the rates of alcohol-related-deaths are higher in Birmingham than the England average.[44] Whilst this is not evidence to demonstrate the prevalence of alcohol exposure during pregnancy and FASD in Birmingham, it tells us that within Birmingham, more people are drinking alcohol to excess than in England as a whole. This could suggest that prevalence of FASD in Birmingham may be higher than the national estimate. Overall, the CJS population within Birmingham may have higher levels of need relating to learning disability than other areas of England but exact figures to quantify this need is not currently possible.

4.6.2 The Birmingham Context

The Centre for Mental Health conducted a survey across prisons in England, which found that 20.9% of people in prison in the Midlands had one or more neurodivergence needs.[126] In response to the Neurodiversity in Prisons review, there is now a full-time NSM within HMP Birmingham whose role is to identify and support those with neurodivergence needs. This is improving diagnosis rates and also is leading to improved reporting and data collection practices relating to neurodivergence needs within the prison. There is also a paid Neurodivergence Representative role within HMP Birmingham where an individual within the prison is trained to complete a neurodiversity screening questionnaire with peers. The role provides opportunity for skills development for the individual and also provides wider benefits, including increased awareness about neurodivergence within the wings of the services and additional support for prisoners with neurodivergence.

However, there are limited data availability from youth justice, probation, or prison services to capture prevalence of neurodivergence within the Birmingham CJS in the community.

There is also limited provision for neurodiversity screening within probation and the YJS. This means that when neurodivergence needs are suspected, CJS services must refer to associated NHS services, which may have waiting lists of several years. Staff at Birmingham YJS described how they are working in partnership with Birmingham Community Health Care Trust, referring individuals for Speech and Language Therapy, paediatrics, and neurodivergence assessments, but due to long waiting lists, they report that there is significant unmet need. Professionals within YJS described how there is a need to strengthen the relationship between the YJS and health partners. They highlighted the need for a neurodivergence specialist within the YJS to help support young people in navigating the service, but also to improve diagnosis and referral rates.

Birmingham and Solihull Mental Health NHS Foundation Trust host 'Reach Out' - the West Midlands Provider Collaborative for adult secure mental health services and learning disability and autism services. In 2024, Reach Out conducted a project to explore pathways for people with learning disability and autism within court, custody, and community CJS settings.

The project recommended the need for a specialist learning disability and autism team to support CJS services alongside improved availability of easy-read documents and structured staff training. The report proposed several pathways to better support individuals with learning disability and autism navigating the CJS at different ages and in different settings.[127]

4.6.3 Insights From Experience

Neurodivergence emerged as a prominent theme across both stakeholder interviews, and peer-led lived experience accounts. Several participants reported late diagnoses (often during or after CJS involvement), contributing to longstanding misunderstanding and mismanagement of behaviour:

> *"People with neurodiverse needs (so autism, ADHD), make up a big number of the people that come through the CJS, and there just isn't a pathway set up for them."*
>
> – Stakeholder (NHS)

And

> *"They said I've had ADHD from way back from when I was 10, and I started erupting at age of 14. Why was I not screened for certain mental health illnesses from then? Why did it take until I was 30, and me getting into prison how many times in 10 years? And how much money did that cost the government, me going to prison so many times?"*
>
> – Person with Lived Experience (LE)

Over a third (n=6) of the interviewees with lived experience of involvement in the CJS had a diagnosed neurodiversity, with ADHD most prevalent. They reflected that earlier screening and support may have prevented criminalisation. They called for neurodivergence to be better understood by both health and justice professionals, noting that current systems often pathologize or punish behaviours that stem from unmet neurodivergent needs. In custodial settings, interviewees described environments that exacerbated sensory and behavioural challenges, increasing the risk of isolation, restraint, or disciplinary action.

> *"The doctors don't have any understanding of autism or ADHD, so they've given me antidepressants when I need ADHD medication, and it just brushes over the problem. In terms of actually being able to get appointments for things I've been referred for, the wait times are nearly six months to a year. By that time, half of the problems have either got worse or I just don't feel physically able to go for the appointment anyway. If I do get to an appointment, I often find that I'm medically gaslit, so the doctor or the specialist will minimize whatever problem that I'm telling them that I'm struggling with. I just generally feel like they want to get me out of the place, they don't actually want to help me."*
>
> – Person with LE

Service users and professionals alike raised concerns about the absence of local diagnostic services or accessible support pathways post-identification. The lack of available support often leaves individuals without reasonable adjustments in probation, court, or custodial environments. Professionals highlighted a gap in training and understanding among frontline CJS staff regarding the presentation and impact of neurodivergent conditions, and also an imbalance in the support available between custodial and community settings.

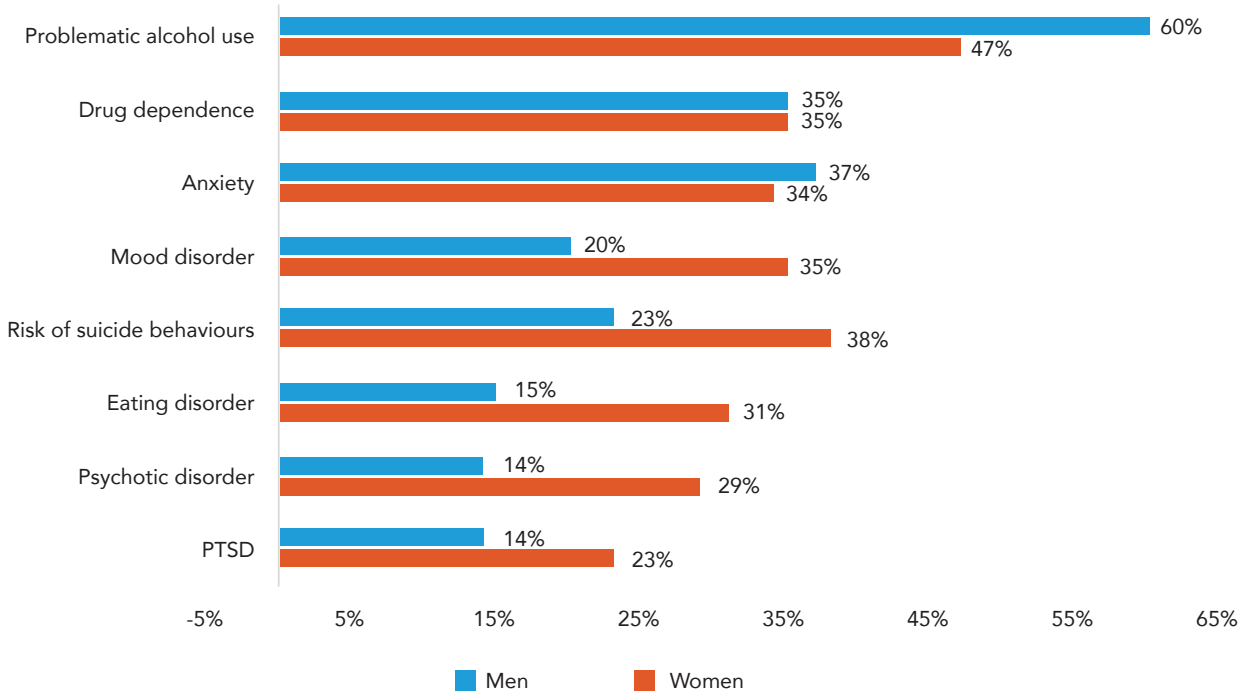
4.7 Mental Health, Self-harm, Suicidal Ideation

Up to 90% of people in the CJS (both adults and children) are reported to have at least one mental health condition compared to 20% in the general population.[22,126] Individuals in contact with the CJS are more likely to experience common mental health conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD), as well as more severe mental illnesses including schizophrenia and bipolar disorder. Mental health needs are often longstanding, complex and exacerbated by social disadvantage, trauma and lack of access to appropriate services. Limited access to timely care, compounded by stigma and systemic exclusion, increases the likelihood of CJS involvement for individuals with mental illness.

In the year ending March 2025, there were 77,898 self-harm incidents in prisons in England and Wales, the highest level recorded to date.

In the year ending March 2025, there were 77,898 recorded self-harm incidents in prisons in England and Wales, the highest annual total since reporting began.[128] This represents a continued upward trend in prison self-harm incidents. During the same period there were 86 deaths by suicide from March 2024-2025.[128] Figure 16 demonstrates the estimated prevalence of mental health-related clinical syndromes in the prison population in the UK between men and women. This shows that mood disorders, eating disorders, psychosis, risk of suicide, and PTSD are more common in female compared to male prison populations, whilst addiction, and anxiety are more common in male prison populations than female prison populations.

Figure 16: The estimated prevalence of clinical syndromes in the prison population.[135]



National evidence demonstrates a high prevalence of clinical mental health syndromes among people in prison custody. A UK meta-analysis identified substantially higher rates of mood disorders, PTSD, substance misuse, and risk of suicidal behaviours among both men and women in prison compared to the general population.[135]

Being in prison can also contribute to mental health problems, especially where pre-existing trauma is compounded by adverse experiences within prison.[136] Stressors within prison can lead to anxiety, feelings of hopelessness, and suicidality which can all influence behaviour.[136] For example, prisons with lack of time outside of cells and limited opportunity for work or recreation have been shown to have increased rates of violence – behaviours that may be driven by feelings of hopelessness and anxiety. A HM Inspectorate of Prisons (HMIP) report highlighted that within reception (remand) prisons, 50% of people reported spending over 22 hours a day within their cells which can have detrimental impacts on mental health and wellbeing.[138]

National policy and inspection standards emphasise the importance of purposeful activity, time out of cell, and access to rehabilitative services as protective factors for wellbeing in custody. HMIP expectations state that prisoners should have access to sufficient time unlocked, meaningful activity, and opportunities for physical exercise and social interaction, recognising the impact of isolation and inactivity on mental health and behaviour. Evidence from inspection reports and independent reviews has shown that restricted regimes, reduced time out of cell, and limited access to purposeful activity can adversely affect mental wellbeing and increase risk of self-harm and behavioural deterioration.

The Prison Reform Trust[129] has similarly highlighted that extended periods confined to cells, particularly where regime restrictions are imposed due to staffing pressures or safety concerns, can disrupt protective routines and exacerbate anxiety, hopelessness and distress. This underscores the importance of maintaining access to outdoor exercise, structured activity, and consistent support as part of a whole-prison approach to suicide prevention and mental health promotion.

The Zero Suicide Alliance has produced training for people within the prison environment, or who know people with recent contact with prisons, to gain skills in leading conversations around suicide and recognising when someone might be at risk.[112] The training acknowledges the specific considerations relating to the prison environment and provides information about organisations that provide support for people at risk of suicide.

4.7.1 The Birmingham Context

Upon arrival at HMP Birmingham:

54% of people report feeling depressed

23% report feeling suicidal

37% report other mental health problems.[107]

In the HMP Birmingham Prisoner Survey 2023, two thirds of prisoners (66%) reported a mental health problem, which is similar to the national average (67%). Upon arrival at HMP Birmingham, 54% reported feeling depressed, 23% suicidal and 37% reported other mental health problems.[143] As of February 2023, around 120 prisoners at HMP Birmingham were being referred for mental health assessment each month.[134]

There were 481 incidents of self-harm reported in HMP Birmingham over a 12-month period ending February 2023.[199] In the Prisoner Survey, 23% of prisoners reported feeling suicidal. There were 51 suicides recorded in the city of Birmingham between 2017 and 2021 and 16% of those were in contact with the CJS.[143] Although additional data was included in the coroner's report (such as sex, age, employment status, access to primary care, social factors, and crisis triggers), this was aggregated for all suicides in Birmingham, so no further data could be extracted from the coroner's report that related specifically to those in contact with the CJS.

Within HMP Birmingham, mental health and psychological therapy services are provided seven days a week with patients able to refer themselves.[126] Referrals are reviewed by nurses within 48 hours if urgent, and within five days if routine, in line with national guidance. There are five visiting consultant psychiatrists who review patients across the prison and on the

inpatient ward. Within HMP Birmingham there is a Samaritans Listener scheme where people in prison are trained to provide confidential emotional support to their peers, and some are also mental health first aid trained and are given the role of 'Wellbeing Navigator'. The 2025 unannounced inspection of HMP Birmingham also reported improvements in mental health awareness training amongst staff.[58] However, there were improvements to be made in adhering to transfer guidelines when completing transfers of people under the Mental Health Act with some individuals with mental health needs being placed within standard wings meaning they could not receive the support and treatment they required. There were also concerns raised around the limited time spent out of cells and the impact this may have on the wellbeing of prisoners.[58]

Creative health principles are also being used within Birmingham as a way of exploring and improving wellbeing in custody. Part of a wider programme in four prisons, Ikon Gallery has a collaboration with HMP Birmingham delivering facilitated art sessions through an artist residency. Ikon has established an art studio inside the prison which is used for weekly workshops facilitated by interdisciplinary artist and doctoral researcher Niki Gandy who works with film, photography and ambient light. At HMP Birmingham, Gandy's research considers the effects of her chosen medium (light) on prisoners' health, principally vitamin D deficiency and circadian rhythm disruption.

The programme is supported by an evaluation framework measuring wellbeing outcomes using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) before and after participation in art sessions. Evaluation will be undertaken by a Public Health officer based at Ikon Gallery.[133]

The Birmingham YJS reported that 36.5% of children and young people (age 11 to 25) with a completed assessment had an identified mental health need, compared to 20.3% children and young people (aged 8 to 16) in the general population.[90] Historically, mental health and wellbeing indicators were not monitored within the YJS but from 2025, there are 10 new key performance indicators, including one focused on mental health and emotional wellbeing.

4.7.2 Insights From Experience

Citizens with lived experience (LE) of the CJS described long-standing struggles with mental health, including hospitalisation under the Mental Health Act, suicide attempts, and feelings of being "dismissed" or misunderstood by services. For women in particular, trauma and mental health needs were frequently described as both a driver and consequence of justice involvement. Professionals emphasised the impact of domestic abuse, sexual violence, and coercive control, often unaddressed prior to arrest.

The lack of continuity of care following arrest or release from prison was repeatedly raised as a critical gap, with many individuals left without a GP, repeat prescriptions, or referrals.

Individuals described the compounding nature of trauma, mental illness, and system contact:

> *"I've got general anxiety disorder, panic disorder, complex PTSD. Then on top of that… they think I've got bipolar type II. But nothing gets followed up. You get a label and that's it."*
>
> – Person with LE

> *"I cracked three discs in my back… I self medicated with drugs for years. I got sectioned a couple of times, but I never followed up with appointments. No one checked in."*
>
> – Person with LE

Others highlighted how poor mental health contributed to a cycle of substance misuse, offending, and repeat imprisonment:

Stakeholders spoke of a fragmented system with high thresholds and limited flexibility:

"We're often just waiting for someone to hit crisis point before anything can happen. And by then they've been arrested, lost their tenancy, lost contact with their worker."

– Stakeholder (NHS)

Stakeholders called for greater integration between mental health, substance misuse and CJS services, and a move toward trauma-informed approaches that recognise the long-term effects of unresolved trauma. It was also highlighted that there could be a benefit to forming a link with the Birmingham Dual Diagnosis Steering Group.

Staff within HMP Birmingham recalled how pressures within community mental health settings are reflected within the prison. Where acute mental health beds are at capacity, staff at the prison notice that there are increasing numbers of people arriving at HMP Birmingham with an acute mental health need. This highlights how prisons are not closed entities; they reflect the wider societal context and challenges experienced by community services are often also experienced within the prison setting.

4.8 Substance Misuse and Addiction

Substance misuse and addiction are common health needs within the CJS population. Prevalence of addiction and substance misuse within the CJS is likely underestimated, especially within custody - many cases may go unreported due to stigma, fear of reporting and reluctance to highlight unauthorised ingress into prisons.

Approximately **30.8%** of people in prison have a problem with gambling.[191]

42% of people in prison report a problem with alcohol.[116]

56% of people in prison are being treated for a drug problem.[116]

Addiction and substance misuse are both drivers and consequences of CJS involvement. Individuals in contact with the CJS are more likely than the general population to experience addiction and substance misuse, with some being involved in the CJS as a result of their addiction or substance misuse behaviours.

Around two-thirds of people entering prison have a substance misuse need.[22] Opiates are the main driver of substance misuse amongst adults in treatment in prisons and accounted for 23/38 (61%) deaths whilst in treatment in 2023-2024.[137] Drugs enter prisons through gates or over walls increasingly by drones, coordinated by organised crime gangs who view the prison system as a lucrative market.[138] A review by the HM Chief Inspector of Prisons for England and Wales found that 39% of men in prison reported it to be easy to obtain illicit drugs, 11% reported to have developed substance misuse behaviour whilst in prison, and 30% tested positive in random drugs tests.[138] Violence within prisons has been increasing over recent years and often results from the illicit drugs market.[139] Once released, individuals may reoffend in an attempt to fund their addiction. Synthetic opiates are presenting additional challenge to the health and care system as well as the CJS. From June 2023-May 2024, there were 179 drug related deaths reported across the UK associated with synthetic opioids (nitazenes) (21 in the West Midlands).[118] There are rapid developments in novel illicit substances meaning that monitoring can be challenging due to development of technology for testing lagging behind drug development. Many substances being used in prisons may be undetectable.[141]

Women in the CJS are at particular risk, with many reporting that substance misuse developed as a coping mechanism in response to trauma, coercive relationships, or sexual exploitation. Aside from ensuring strong leadership and security within prisons, reducing demand for drugs is key to addressing the issue: illicit drug demand is lower in prisons with robust support services and provision of purposeful activity.[139]

Table 6: Adults in treatment, by substance group and setting in England.[137]

Setting	Opiate	Non-opiate only	Non-opiate and alcohol	Alcohol only
Prisons	23,246 (47.6%)	10,151 (20.8%)	9,879 (20.2%)	5,572 (11.4%)
Immigration removal centres	235 (75.8%)	22 (7.1%)	27 (8.7%)	26 (8.4%)
Young offender institutions	105 (14.5%)	374 (51.7%)	212 (29.3%)	32 (4.4%)

Data from the OHID alcohol and drug treatment in secure settings 2023-2024 report. Opiates: mainly heroin. Non-opiates: cannabis, crack, ecstasy.

Table 65 shows adults in treatment by substance group and secure setting in England. It highlights that people in prison treatment are most commonly recorded as receiving support for opiate use, followed by non-opiate and alcohol use, and non-opiate use only.

The Public Health Outcomes Framework indicator C20 tracks continuity of care for substance misuse treatment following release from prison[142], measuring the proportion of adults who are successfully engaged in community-based treatment within three weeks of release.

It shows improvements over recent years with 53% of adults successfully starting community treatment within three weeks of release in 2023-2024 (up from 43% in 2022-2023)[137], likely due to improved pathways between prison and community.[137] Continuity of care is essential to break the cycle between substance use, homelessness, and reoffending with home naloxone kits provided to prison leavers being a key intervention known to improve outcomes.[149] Investing in substance misuse treatment not only benefits individuals but also yields significant societal returns: the UKHSA estimates that for every £1 spent on drug treatment, £2.50 is saved in social and health costs.

Take-home naloxone is a key part of continuity of care for opiate users as recommended by the Drug Misuse and Dependence guidelines.

A House of Commons Report highlighted that between September 2021 and December 2023, there were 137 deaths within 14 days after release from prison across, 83 (61%) of which were drug related with 20 happening on the first day after release. Only 50% of the people who died soon after release from prison had been offered a naloxone kit.[141]

West Midlands continuity of care best practice example

In 2021, Change, Grow, Live (CGL) received a Universal Grant to introduce long-acting opioid therapy as continuity of care (CoC) for prison leavers with substance misuse needs. As part of this grant, local grassroots organisations Emerging Futures and Kikit were commissioned to provide support to people in prison and prison leavers or (also known as 'through the gate' support). Emerging Futures were able to implement a national model into HMP Birmingham rapidly with positive outcomes quickly being apparent. In 2022 and in response to the success of the Universal Grant prison leavers work, CGL applied for a specialist prison leavers team providing prison leads with a specific focus on CoC. Following implementation of the CoC leads, there were further increases in the number of prison leavers accessing treatment. The CoC team leaders built successful partnerships with multiple agencies including prisons and probation with regular meetings to prevent duplication and ensure engagement post-release. In 2024, it was noted that CoC rates were plateauing which prompted monthly data sharing between prison and community, including data cleaning and de-duplication. The data sharing practice has become commonplace between CGL and all local prison estates. In October 2025, the CoC prison lead role was discontinued and prison teams have become dispersed across the service which may impact CoC outcomes. However, in late 2025, a new Criminal Justice Partnership Lead was appointed to CGL and it is hoped that this role may support continued improvements in CoC outcomes in the West Midlands.

Whilst illicit drugs may be the most commonly thought of addiction within the CJS, there are many individuals who may also experience addiction to gambling, nicotine, and alcohol.

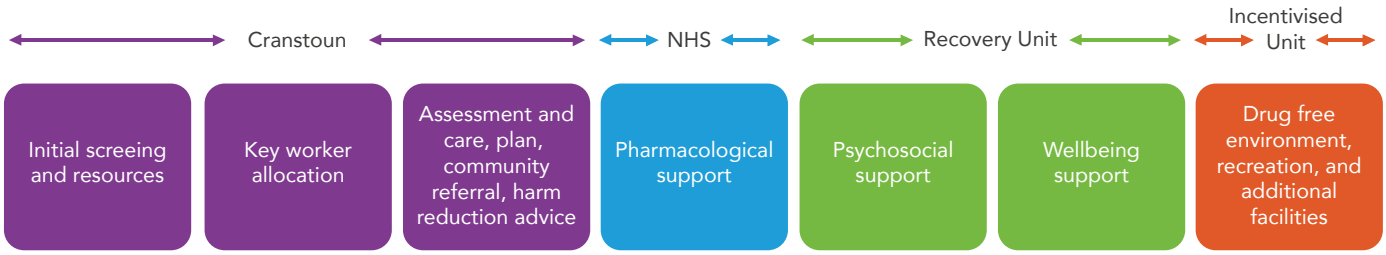
4.8.1 The Birmingham Context

HMP Birmingham reported that 381 prisoners (39.6%) were receiving support for substance misuse and 165 (34.0%) of children and young people in Birmingham YJS had an assessed substance misuse need in 2023.[90] In the 2025 unannounced inspection of HMP Birmingham, 42% of individuals reported that it was easy to get drugs compared to 22% in 2023,[58]. Over a year from 2024-25, 38% of random drug tests in HMP Birmingham came back positive[58]. Between 2023-25, there were five deaths at HMP Birmingham attributed to illicit drugs[17]. Steps have been taken to reduce ingress of illicit drugs into prison including more netting to prevent drone deliveries, grilles on windows, and enhanced search procedures[58].

Among individuals released from prison in Birmingham, 38% were reported to have both substance misuse and mental health concerns (dual diagnosis).[146] Cannabis, heroin, crack cocaine and alcohol were perceived to be the most common substances by staff although exact figures are challenging to estimate due to under-reporting perhaps secondary to stigma and fear of repercussions. Professionals highlighted that rates of non-prescribed benzodiazepine and fentanyl use are increasing, particularly among younger cohorts and those with overlapping mental health needs. Across Birmingham, 55% of individuals accessing drug treatment services are referred through the CJS, indicating the potential for integrated approaches to address substance misuse effectively.[147]

Within HMP Birmingham, a variety of addiction, drug, and alcohol support services are delivered by the social justice charity Cranstoun[148], NHS clinical staff, mutual aid such as Alcoholics Anonymous, the National Drug and Alcohol Group funded Recovery Unit, and the Incentivised Unit for well-behaved prisoners. Figure 17 shows the different types of support available from each provider. The recovery and incentivised units have strict eligibility criteria being limited to those who show active interest in seeking drug recovery and do not display poor behaviour. Eligible individuals can self-refer or may be identified by clinical staff, Cranstoun key workers, or recovery unit officers attending 'code-blue' calls where a prisoner is found to be experiencing a drug overdose within prison. Once within the recovery unit, prisoners are not permitted to leave the unit for three months to prevent any exposure to illicit substances.

Figure 17: A schematic to show the different service providers and the drug and alcohol support they provide within HMP Birmingham.



Strengths of the HMP Birmingham Recovery Unit

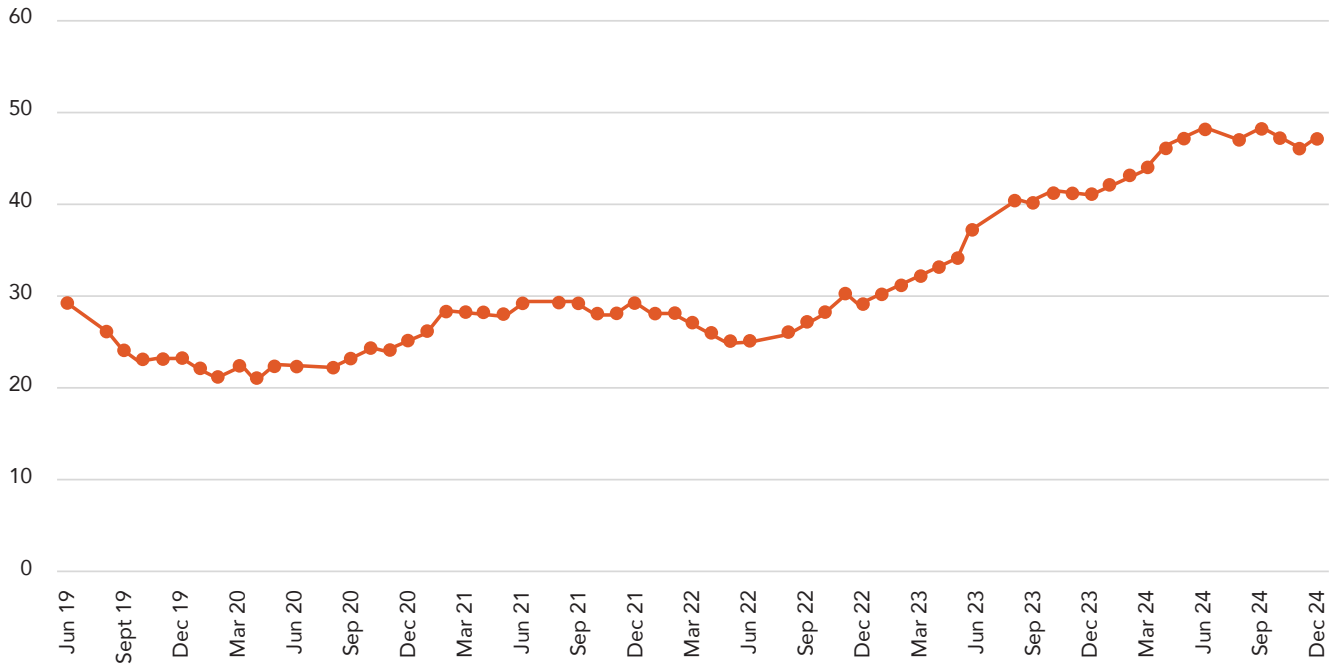
- Wide variety of activities available including art, yoga, fitness, psychosocial group work, peer support, cookery.
- Guaranteed drug-free environment providing opportunity for recovery.
- Good behaviour is incentivised.

Limitations of the HMP Birmingham Recovery Unit

- Movement restriction from the recovery unit to other areas such as the education centre and work settings may be deterring engagement.
- HMP Birmingham is a reception prison (taking individuals from the courts prior to receiving their sentence) meaning many people enrolled on the programme do not remain within the unit for the full three months and are transferred before the intervention is complete. If there is a medical reason for avoiding transfer from HMP Birmingham, medical staff can place individuals on 'medical hold' which can allow them to complete treatment programmes but this is not always completed for individuals on the recovery unit.
- Eligibility for the recovery unit programme can mean it is challenging to fill spaces and often has 'lodgers' – individuals hosted by the Recovery Unit despite being ineligible to receive the support offered. According to staff within the unit, on average, 12 of the total 47 places (34%) within the recovery unit at HMP Birmingham are filled with individuals who are not enrolled on the recovery unit programme.
- Available activities are limited to those with substance misuse needs leading to inequality in opportunity within the prison.

Within Birmingham, 47% of prison leavers received continuity of care in December 2024.[137] This is lower than the national average of 53% and there is still work to be done, but it is a substantial improvement on historical figures that have been as low as 21%.[22] Cranstoun play a role in continuity of care offering services across the whole phase of a crime being committed, from pre-arrest drug diversion courses, education around drug awareness, treatment for those with dependency, and support within West Midlands police custody suites.[106]

Figure 18: Percentage of Prison Leavers Receiving Continuity of Care by month in Birmingham[125]



In 2025, BCC Public Health produced a comprehensive report into 'Dual Diagnosis' focusing on co-occurrence of a mental health disorder and a substance misuse disorder.[122] It highlighted the lack of data for individuals with dual diagnosis and contact with the CJS, meaning that the scale of need in Birmingham is likely underestimated.

> *"They gave me meds inside, but no script when I left. I was chasing it round town, ended up using again."*
>
> – Person with LE

4.8.2 Insights From Experience

Citizens with lived experience described long histories of substance misuse, often beginning in adolescence or linked to bereavement, injury, or trauma. For some, substance misuse developed during periods of homelessness or imprisonment.

> *"When I came out, I had nowhere to go and nothing to stop me. I went back to the same people, same places. I was clean inside, but outside's where it gets hard."*
>
> – Person with LE

Professionals in HMP Birmingham spoke of the relationship between drug and alcohol supply and rates of violence. They also spoke of an increasing trend of medical emergencies involving unknown substances. One member of staff spoke of an individual who was found to be unconscious and vomiting. Naloxone was administered to no effect, and the individual was rushed to hospital. They said how unknown substances are becoming more prevalent and their side-effects are challenging to manage with the current provision of healthcare services commissioned. They also noted how the people who suffer side-effects are often the most vulnerable individuals and staff perceive that there is a culture where vulnerable individuals are used as 'guinea pigs' to trial novel substances prior to entry into the illicit drugs market.

Alcohol was highlighted as a particular issue within the prison system. Professionals within the prison perceived there to be frequent alcohol consumption and alcohol production that varied depending on drug availability – where drug availability was low, more alcohol production was conducted. However, other professionals working at a more strategic level felt that within prison, alcohol intake may be low but issues more commonly arise upon release where it is abundantly available. Professionals expressed concern that individuals with history of alcohol addiction may not be provided with support upon release from prison which may risk relapse. This points to a stronger need for pathways into ongoing alcohol treatment and recovery support in the community, with better continuity of care between prison and community services.

Professionals also spoke of fragmented care and poor integration between criminal justice, substance misuse and mental health services.

> *"You can't treat one without the o ther. But the system still splits them, mental health here, addiction there. People just fall through the middle."*
>
> – Stakeholder
> (Drug and Alcohol Provider)

There was a strong call for more flexible, person-centred approaches, including peer support, women-only provision, and trauma-informed services that recognise substance misuse as a health need, not a behavioural failing.

It was noted that many people within HMP Birmingham are regular users of nicotine vapes with use prevalent within cells and communal spaces. Staff commented on how the devices were pervasive and confiscation was avoided as it risked provoking unrest.

Finally, within probation, professionals spoke of the impact of shifting treatment patterns towards longer-acting alternatives. Whilst this means the individuals are required to attend healthcare appointments less frequently, professionals highlighted concern that they may then lose out on the 'hidden services' that occur as part of medication collection (e.g. ad-hoc check-ins, and signposting to available services).

4.8.3 Case Study 3: Jordan's Journey

At the time Jordan started experimenting with drugs and alcohol, his mental health conditions were undiagnosed, and he found that substances helped him cope. He started drinking at sixteen, and by seventeen he had added cannabis and "Molly" to the mix. By twenty, cocaine became the drug of choice. He moved to Holland to live with his stepfather at age twenty-two and lived a fast lifestyle fuelled by cannabis, cocaine, and alcohol misuse.

At twenty-five, he experienced his first episode of cannabis-induced psychosis. Over this time, Jordan always wanted to stop using and feels he was not a good person to those who mattered most. He was isolated and hid his drug use from family and friends. His relationships suffered, as did his employment. Jordan began stealing from his stepfather to fund his habits.

"My reality didn't match the fantasy of my life in my head."

Jordan entered his first dry house in Holland, but the language barriers prevented the healing process. He relapsed and was asked to leave the dry house. He moved back to England and found it quite difficult, a "culture shock". He tried working, but it was not good for his recovery journey, so he went on benefits and started volunteering and assisting in the community.

He found engaging with services stressful due to his low self-esteem, fully believing he was not worth their time and resources. It was this low confidence and emotional dysregulation that led him back to substances and a lifestyle he no longer enjoyed, and he saw how substances were getting in the way of what he was trying to achieve with his life.

4.9 Women in the CJS

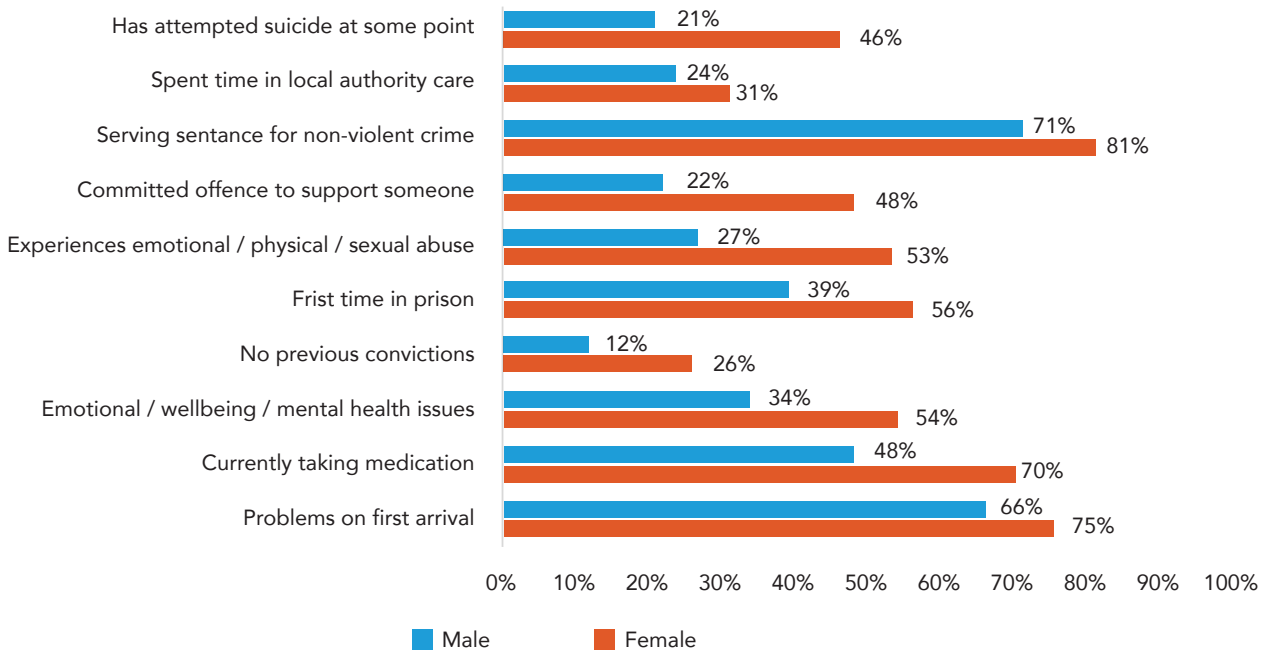
Women account for only 4% of criminal convictions in the UK but this means that often, less emphasis is placed on ensuring services and custodial facilities meet women's needs.[150] In recent years, there has been an increasing emphasis on the need for gender-specific assessment and service delivery to safeguard the health of women in the CJS and reduce risk of reoffending.[152]

Women in contact with the CJS often present with distinct and complex health and social needs, with the HM Inspectorate of Prisons survey reporting high level of self-declared physical disability, drug and alcohol issues, experience of domestic abuse, money worries, and housing worries compared to men.[138] It is reported that over 50% of women in prison have experienced sexual, emotional, or physical abuse as a child and 70% have substance misuse needs.[153] Women are also more likely to receive short sentences compared to men; in 2023, the average custodial sentence length for female offenders was 12.2 months compared 21.8 months for male offenders and on average and commit less serious offences than men; of females convicted in 2023, 13% were for indictable offences, in comparison to 24% of male convictions, meaning that most women in the CJS are under the probation service.[150]

Women in contact with the CJS consistently present with higher levels of prior adversity and complex health need than men. National evidence highlights marked gender differences in exposure to trauma, mental ill-health, and social disadvantage among people in prison.

As illustrated in Figure 19, women in prison report substantially higher levels of prior adversity compared to men. Nearly half report having attempted suicide at some point (46% compared to 21% of men), and over half report experiences of abuse (53% vs 27%). Women are also more likely to report emotional or mental health issues (54% vs 34%) and to be taking medication on entry to custody (70% vs 48%). These patterns reinforce longstanding evidence, including the Corston Review, that women in custody frequently present with trauma related and co-morbid needs.

Figure 19: Vulnerability indicators among adult women and men in prison (England and Wales).[100]



Source: Revolving Doors Agency (2017), Rebalancing Act [100]

Beyond prior adversity, women in prison also face significant gaps in access to appropriate healthcare, particularly in relation to mental health, reproductive health, and support for experiences of abuse. Mental health issues are more prevalent amongst women in the CJS. In 2023-2024, the number of females who self-harmed per 1,000 prisoners was 341 compared to 146 males.[150] Studies have also shown that women in custody are disproportionately affected by gastrointestinal diseases, injuries, reproductive health issues, and cancer compared to women in the general population.[153]

Health inequalities experienced by women in the CJS are not confined to disease – by the nature of being mothers and experiencing menstruation and pregnancy, women have significant additional health needs compared to men in the CJS. It is estimated that 100 babies are born to women in prisons in England and Wales each year, accommodated within one of the six mother and baby units available in female prisons.[37] A report by the MoJ highlighted that of mothers in custody, 60% were living with their children before going to prison compared to 45% of men who have children.[36] Data suggests that incarceration impacts not only the women themselves, but also their wider family networks in ways that differ from men.[153]

There are also links between the CJS and sex work which has several driving factors: firstly, there have been measures to try and pressure exit from sex-work including criminal orders and imprisonment which have increased numbers of sex workers in the CJS, and secondly, women involved in sex work often have substance misuse needs which may mean involvement with the CJS. In some cases, receiving a criminal record may lead women to sex work due to need for alternative employment which may then increase risk of re-offending.[155] Sex workers are a population within the CJS who experience specific and significant health and wellbeing needs but there are limited data available within HMPPS.[156]

In 2023, Intensive Supervision Court (ISC) pilot schemes were launched aiming to reduce the number of offenders with complex needs receiving short custodial sentences. The scheme adopts a multi-agency approach with regular review meetings, supervision from the Probation Service, and access to mental health, education, employment and housing support as well as specialist drug and alcohol treatment. There are specific pathways designed for women with Birmingham Magistrates Court hosting the women's ISC pilot.[157]

4.9.1 The Birmingham Context

Whilst there are no female prison facilities within Birmingham, there are many women in contact with the CJS in the community, and many women from Birmingham who are placed in prison facilities across England.

The nearest female prison to Birmingham is Drake Hall in Staffordshire which may contribute to challenges in ensuring children retain contact with their mothers whilst in prison.[37]

There is one medium secure unit for women in Erdington.

The women involved in the CJS in Birmingham have complex health needs. In the 2024 ISC evaluation, 75% of women sentenced through Birmingham women's ISC were reported as having a drug misuse need compared to only 34% of people with a suspended sentence and 65% of the ISC population as a whole.[157]

Anawim

Anawim is a centre for women in Birmingham with a dedicated CJS service supporting hundreds of women each year. Anawim provide early intervention, community order courses, employability courses, resettlement, and prison in-reach to support smooth transitions from prison and into the community. They also work alongside the probation service, providing support for mental health, addiction, trauma, domestic violence, and accommodation needs.[158] Anawim are responsible for providing the 'New Chance' programme in Birmingham which offers multi-agency support to women who have committed a low-level offence with a focus on addressing immediate issues such as substance misuse, homelessness, and debt which are all key drivers of CJS involvement for women.[133] An evaluation by the University of Birmingham in 2020 found that the New Chance programme led to a 16% reduction in reoffending compared to those who did not receive support from the programme.[158]

Table 7: services provided by Anawim in Birmingham and the number of women supported by each in 2024-2025.[158]

Service	Number of women supported (2024-25)	Description
Early Intervention	628	Addressing underlying reasons for offence including health and justice vulnerability service
Prison in-reach	30	Ensuring smooth transition from prison to community including a domestic violence course, transport and clothing support
Community connections	451	Partnership of women's centres connecting women in prisons with community support services
Probation and commissioned rehabilitative services	171	Working alongside probation to reduce reoffending through support for addiction, domestic violence, trauma, mental health and accommodation needs
Resettlement	77	Breaking the cycle of reoffending through long-term support and specialised assistance

4.9.2 Insights From Experience

Local stakeholders consistently raised concerns about the lack of tailored services for women in contact with the justice system. Interviewees noted that women face different pathways into offending, often linked to domestic abuse, coercive relationships, poverty, and caring responsibilities. The limited availability of gender-specific services in Birmingham was described as a significant barrier to engagement and rehabilitation.

> *"There's still a tendency to treat women in the system the same as men but their needs are different. We need more services that are actually designed around women's experiences."*
>
> – Stakeholder (VCFSE)

> *"The services that do exist for women are patchy and often oversubscribed. We need more continuity of care, especially around mental health and housing."*
>
> – Stakeholder (VCFSE)

In addition to poor mental health support, stakeholders highlighted gaps in support for women experiencing reproductive and sexual health issues, with services often being inaccessible or lacking appropriate sensitivity. These unmet needs were often compounded by housing instability, poverty, and caregiving responsibilities.

Several interviewees described positive experiences with trauma-informed, women-only provision but noted that such services were scarce and underfunded. Holistic models that recognised the impact of trauma, motherhood, and gender-based violence were cited as particularly effective but difficult to scale within current funding structures.

> *"Many women in prison have experienced domestic abuse. It's often a background issue that's never really addressed. And when they leave, they go right back to the same situation."*
>
> – Stakeholder (NHS)

4.10 Sexuality and gender identity

People within the CJS who identify as lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ+) face distinct and often heightened health inequalities[162]. In the 2024 offender equalities annual report, of those who declared sexual orientation, 97% stated they were heterosexual. There were 295 transgender people reported in prisons in England and Wales with 77% identifying as transgender female, and 83% being hosted in the male prison estate.[162]

LGBTQ+ individuals in prisons are more likely to experience prisoner-on-prisoner violence and abuse. Many people in prison do not disclose their sexual orientation or gender identity for fear of abuse. The setup of the prison estate also provides a challenging environment for those who identify as LGBTQ+: due to space constraints within prisons, disciplinary and protective segregation are often in the same physical spaces. If those who identify as LGBTQ+ require protective measures, they may be confined to a segregation unit leading to social isolation.[162]

Research also consistently highlights a higher prevalence of mental health issues, substance misuse, and experiences of violence and discrimination among people who identify as LGBTQ+ in custody or under community supervision. Trans individuals, in particular, report significantly higher levels of psychological distress, self-harm, and suicide risk when compared to the general prison population.[163]

National data disaggregated by sexual orientation and gender identity is limited within the CJS for several reasons: firstly, the culture of collecting data around sexual orientation and gender identity is relatively recent, secondly, there may be reluctance amongst the CJS community to disclose sexual orientation or gender identity due to fears of discrimination or safety issues, and thirdly, there may be governance structures in place limiting collection due to the sensitive nature of the data. However, the need for more granular data regarding these personal characteristics must be balanced against privacy risk.

A limited evidence base suggests that LGBTQ+ individuals may experience bullying, harassment, and isolation in custodial environments. For example, trans prisoners are frequently housed in facilities that do not align with their gender identity, increasing risks to both physical and mental health issues. National guidance, including the Equalities Act 2010 and the Ministry of Justice's care and management protocols for transgender prisoners, seek to ensure non-discriminatory and safe treatment. However, implementation varies widely across institutions. National calls have been made for better screening processes, inclusive policies, and the provision of culturally competent, trauma-informed care tailored to LGBTQ+ individuals.[162,164]

4.10.1 The Birmingham Context

The available data on LGBTQ+ individuals in contact with the CJS in Birmingham is limited. Very few services within the Birmingham CJS systematically record sexual orientation or gender identity, reflecting wider complexity around collecting this sensitive data. However, the lack of data means that it is challenging to estimate the needs of individuals who identify as LGBTQ+ within the CJS and any health inequalities or risks they may experience may be unaddressed.

4.10.2 Insights From Experience

Some stakeholder interviews and lived experience accounts did raise concerns about how people of different sexual orientations and gender identities are treated in justice and health settings. There were references to a lack of awareness among professionals and missed opportunities for support, particularly where gender identity or sexuality intersected with other vulnerabilities such as mental health issues or housing instability.

One participant highlighted concerns about inappropriate placement and lack of recognition of gender identity in custodial settings, suggesting that current systems are ill-equipped to provide the necessary support:

> *"There's no real safeguarding in place for someone who's trans in prison. It's a constant state of fear or isolation. People often hide their identity just to stay safe."*
>
> – Stakeholder (VCFSE)

Although the volume of direct evidence is low, the experiences described are consistent with wider national patterns and reinforce the need for improved inclusivity and safeguarding practices. Services in Birmingham appear to lack consistent protocols for recording and responding to the health and wellbeing needs of LGBTQ+ individuals, particularly those at the intersection of justice involvement and other forms of disadvantage.

4.11 Ethnicity and Language

Across England and Wales, people from minority ethnic groups are consistently overrepresented in the CJS. While approximately 18% of the general population identify as being from a minority ethnic group, they account for 27% of the prison population in England and Wales.[23] This overrepresentation is most pronounced among younger age groups, with ethnic diversity highest among the under-35 population. However, studies have demonstrated that ethnicity is not associated with any form of crime – being from an ethnic minority background is not a risk factor for involvement in crime. It is perhaps more helpful to view involvement in crime as a complex interplay between many environmental and personal factors. For example, the overrepresentation of individuals from minority ethnic backgrounds within the CJS can in part be attributed to police having greater presence within areas with higher populations of people from minority ethnic backgrounds.[165]

The Prison Reform Trust's report highlights how people in prison who are from an ethnic minority background experience differential experiences in comparison to people from a White ethnic background. The report discusses how 8% report experiencing discrimination as a result of their ethnicity, and 1/3 of people in prison report that their ethnicity directly impacted their rehabilitation and resettlement planning despite staff not considering there to be any issue.[22] Men from an ethnic minority background are more likely to report being recently restrained or placed in segregation. One report exploring mental health services in prisons found that whilst 92% of all male and female prisoners received first-day screening, a smaller proportion of people from minority ethnic groups received a follow-up health assessment (65%) compared to their White counterparts (73%).[126] This demographic was also least likely to have mental health and neurodevelopmental conditions identified during reception and screening on arrival in prison, meaning they are less likely to receive adequate treatment and support for any underlying conditions.

Distinct inequalities are also experienced by those who do not speak English as a first language. The scale of language needs within the CJS is challenging to estimate as these data are not routinely collected, and proxy measures such as data relating to 'foreign nationals' are insufficient to demonstrate the need given that many foreign nationals have proficient English language ability whilst some British citizens may speak English as a second language.[166] However, it is clear that a limited ability to communicate means that needs may go unnoticed and health outcomes might be implicated. The 2024/25 HM Chief Inspector of Prisons for England and Wales Annual Report highlighted that often, communication with prisoners who do not speak English is limited as telephone interpreters are seldom used.[138]

4.11.1 The Birmingham Context

The city of Birmingham's population is among the youngest and most ethnically diverse in the country, with 57% of residents reported to be from a minority ethnic group.[42] This demographic profile is reflected in local CJS data, which shows high rates of contact with people from minority ethnic backgrounds. Data regarding language needs are not routinely collected within the CJS in Birmingham meaning it is not possible to estimate the extent of the need and the variable outcomes this population may experience in comparison to the English-speaking population. Within HMP Birmingham, the kiosks used to connect with services have a limited number of languages available meaning some individuals may struggle to access services and resources where their language is not available.

These access barriers must be understood within the broader context of structural inequality in Birmingham. The city has some of the highest levels of deprivation in England, with many neighbourhoods ranking within the most deprived deciles nationally according to the Index of Multiple Deprivation (IMD). Educational attainment and employment opportunities are unevenly distributed, and individuals from minority ethnic communities are disproportionately represented in areas of socioeconomic disadvantage.

The interaction between deprivation, limited educational opportunity, language barriers and contact with the criminal justice system increases the likelihood of unmet health need. Without systematic collection of ethnicity and language data within custody healthcare services, it is difficult to assess whether these structural inequalities are being mitigated or compounded within the prison setting.

Analysis of ethnicity in healthcare contacts within HMP Birmingham is currently being sought to enable a fuller assessment of differential access, unmet need, and outcomes across ethnic groups.

Birmingham's demographic profile must be understood within the context of structural inequalities. The city has higher levels of deprivation than the England average, with marked variation in educational attainment, employment, housing stability, and income across neighbourhoods. These wider determinants of health are closely associated with increased exposure to adverse childhood experiences, poorer mental health outcomes, substance misuse risk, and greater likelihood of contact with the criminal justice system. Individuals from minority ethnic communities in Birmingham are disproportionately represented in areas of higher deprivation, which compounds vulnerability through intersecting social and economic disadvantage. Taken together, this suggests that the over-representation of minority ethnic groups within the CJS locally is not solely demographic reflection but is likely influenced by structural inequalities that increase both exposure to risk and barriers to timely support.[17]

4.11.2 Insights From Experience

Stakeholders and people with lived experience spoke about the additional layers of stigma, fear and discrimination faced by individuals from minority ethnic groups. Some participants described negative interactions with statutory services that led to mistrust or disengagement. Others highlighted how cultural stigma or language barriers prevented people from seeking support, particularly for mental health, trauma or substance misuse needs.

> *"It's not just about being in the system – it's about not being understood when you're there. There are real cultural barriers that don't get recognised."*
>
> – Stakeholder (VCFSE)

One stakeholder from HMP Birmingham spoke of the difficulties experienced by people who speak languages other than English: they mentioned an experience with an individual within the prison who was unable to communicate with staff due to unavailability of an interpreter for the dialect they spoke. Staff discussed how challenging it was for the person to understand the grounds for their arrest and navigate the CJS when they could not communicate. There was strong support for the expansion of community-based, culturally appropriate services, particularly those led by local VCFSE organisations with trusted relationships. However, limited capacity and short-term funding often constrain their reach.

4.12 Physical Disability

It is estimated that 11% of the prison population in England and Wales have a physical disability with an additional 8% having both a mental health issue and a physical disability.[168] People who have a disability and are in custody are more likely to have substance misuse needs, have experienced abuse as a child, and experienced homelessness prior to being in custody.[168] As the prison population increases in age, so will the number of people with disability, increasing demand for accessible facilities within the prison estate.

In 2025, the UK Government called for all new prisons to be fully compliant with the Equalities Act 2010 including increased numbers of low mobility cells and all cells being accessible by lifts. There was also a call to improve provision for adaptations to existing facilities (e.g. grab rails) to accommodate for mobility needs on a case-by-case basis.[169]

4.12.1 The Birmingham Context

There were limited data available on the physical health needs of people in contact with the CJS in Birmingham. Where data were collected and shared, it was reported at an aggregated level of physical health need rather than by specific condition. Co-morbidity data were not available specifically for Birmingham. A survey of 87 people in 2023 found that on arrival at HMP Birmingham, 47% had a disability, of which only 11% reported getting the support they required.[143] The HMP Birmingham survey did not specify the type of disability people were reporting which means that

it is not clear how many individuals have mobility impairment compared to other types of disability.

Birmingham YJS reported that 13.4% of children in contact with the service (n=291) in 2022-2023 had an assessed physical health need but again, no data are available to indicate which physical health needs individuals are experiencing are available. No data was available in the most recent performance reports.[94] Understanding the physical health needs of individuals in contact with the CJS is critical to allow for provision of appropriate support. For example, if a physical disability is not accounted for within license conditions, individuals with mobility impairment may be unable to comply and may be more likely to breach their conditions. This could exacerbate inequalities experienced by this population. It is essential that there are robust reporting practices relating to mobility needs not only within healthcare records, but also within prison records.

4.12.2 Insights From Experience

Prison officers at HMP Birmingham spoke about the challenges of meeting the needs of people with physical disability within their facilities. They spoke of the limited availability of cells with wheelchair accessibility, especially in wings with Victorian architecture. They also mentioned how sometimes, individuals are placed on the medical wing to accommodate for their accessibility needs until a more appropriate setting becomes available, in turn causing issues where people with medical needs are admitted.

4.13 Older Adults in Prisons

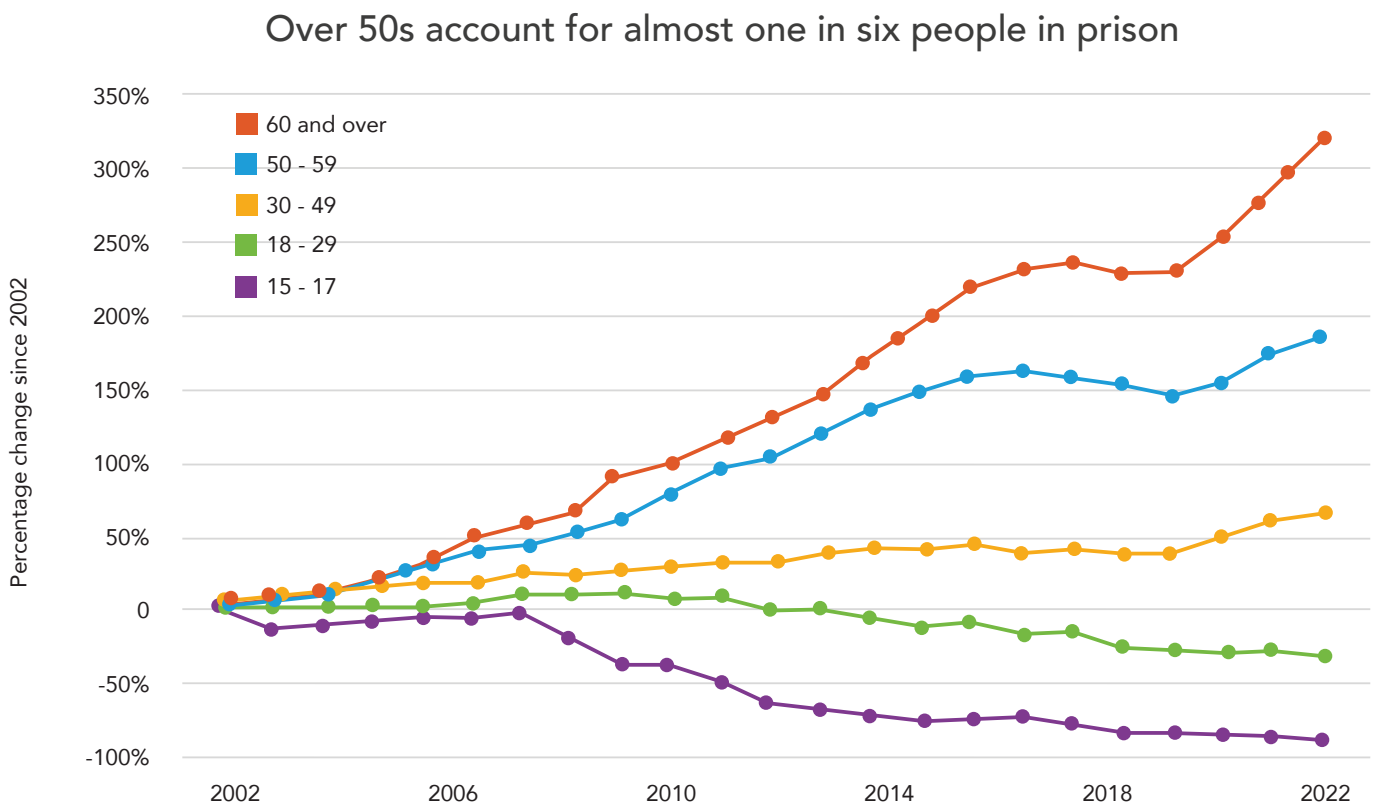
The fastest growing population within prisons are older adults, primarily being driven by an increase in the number of older adults sentenced later in life for historical sexual offences.[171] The length of sentences has also increased which means that more people are ageing in prison for longer.[172] As of March 2024, 17% of the prison population in England and Wales were aged 50 years or older.[172] There is evidence to suggest that people within the CJS experience accelerated ageing: the CJS environment and predetermined factors such as substance misuse behaviours amongst the prison population contributes to biological ageing.[173]

People in prisons present with higher rates of geriatric conditions like mobility and hearing impairment, and have lower life expectancy.[172] One study reported that the morbidity experienced by people in prison by age 59 was comparable to those aged 75 years in the general population in the US.174 A report by the Nuffield Trust also found that of male prisoners aged 50 years or older experiencing an emergency admission to hospital in 2018-20, 44% were assessed as having intermediate or high-risk frailty.[175]

The higher burden of disease amongst older adults in prisons means they are disproportionately impacted by any issues that arise in prison healthcare. The UK prison estate has a high number of Victorian era facilities that were not designed under modern accessibility requirements and meeting reasonable adjustments can be challenging.[171] There is also a significant need for social care within prisons to account for the ageing population and since 2015, this has been the responsibility of local authorities. The Prison Reform Trust produced a report highlighting the specific challenges, barriers, and needs of older adults in prisons with a strong focus on the lived experience perspective.[172] The report outlines the social isolation, sedentary lifestyle, and lack of purposeful activity within prisons and their impact on onset of frailty and worsened health outcomes. The early onset of frailty coupled with the ageing prison population is leading to increasing need for end-of-life care within prisons and methods for considering early release on compassionate grounds for those with palliative diagnoses.

Figure 20 illustrates the percentage change in the prison population in England and Wales by age group since 2002. The figure highlights substantial divergence in population trends across age cohorts over time, with particularly pronounced growth among older age groups. These shifts have important implications for health need, service configuration, and prison estate design, given the higher prevalence of long-term conditions, disability, and frailty among older people in custody.

Figure 20: The percentage change of populations within prison in England and Wales in each age category over time.[20]



Source: Ministry of Justice (2024). Offender management statistics quarterly: January to March 2024.

As shown in Figure 20, the prison population aged 50–59 and 60 and over has increased markedly since 2002, with growth accelerating from around 2020 onwards. In contrast, the population aged under 30 has declined over the same period, with the steepest reductions observed among those aged 15–17 and 18–29.

The growth in the over-50s prison population is substantially larger than that observed in other age groups and has continued despite overall fluctuations in the total prison population. This pattern indicates a structural ageing of the prison population rather than a short-term demographic fluctuation.

4.13.1 The Birmingham Context

HMP Birmingham has a wing for those with physical disabilities and older adults are eligible. However, with increasing numbers of older adults, there are pressures to ensure appropriate accommodation and often, facilities are at capacity meaning others with needs are placed within facilities that do not meet their health or care needs. There are increasing requirements for hospital beds to be available within prison where individuals require them but facilities within the wings are not always able to accommodate this. The ageing prison population is reflected within the HMP Birmingham population with increasing numbers of individuals being transferred from nursing homes to serve sentences for historic crimes.

4.13.2 Insights From Experience

Stakeholders in Birmingham raised concerns about the lack of routine screening or care planning for age-related conditions, including frailty, chronic disease management, and end-of-life care within the CJS. Although older age in custody is formally recognised (with some services designating over-50s as 'older prisoners'), the system remains poorly equipped to support their needs in practice.

> *"In HMPPS, over 50s are considered old. We see 10 years sooner onset of any diseases compared to the general population. They are ageing a lot sooner."*
>
> – Stakeholder (MoJ)

There was particular concern about older adults with complex needs, including neurodegenerative conditions such as dementia, who may become increasingly vulnerable within both custody and community settings. They mentioned how there had been an increase in older adults being convicted later in life for previous sex offences and the tension this brings when there are no appropriate facilities available to accommodate for their health and care needs.

4.13.3 Ageing, Frailty and Neurodegenerative Conditions in Prison

People in prison experience earlier onset of age-related morbidity compared to the general population. Within HMPPS, individuals aged 50 and over are often considered "older prisoners" due to accelerated ageing associated with cumulative disadvantage, substance use, trauma, and long-term health inequalities.

There was particular concern raised regarding older adults with complex health needs, including neurodegenerative conditions such as dementia. Evidence indicates that prevalence of cognitive impairment and dementia is higher in prison populations than in age-matched community populations, though accurate estimates are limited due to underdiagnosis and lack of routine screening. Individuals with dementia in custody may experience heightened vulnerability, particularly where prison environments are not designed to accommodate cognitive decline.

Stakeholders highlighted challenges in identifying and managing dementia within custodial settings, including limited specialist provision, environmental constraints, and difficulties ensuring continuity of care on release.

4.13.4 Sentencing Patterns and Later-Life Convictions

Separately, stakeholders noted an increase in some older adults entering custody later in life, including for historic offences. This presents additional complexity where individuals may enter prison with pre-existing frailty, chronic disease, or cognitive impairment.

The co-occurrence of ageing-related morbidity and custodial entry at later stages of life has implications for prison healthcare, risk management, safeguarding, and release planning. These issues require careful system-level consideration but should not be interpreted as causally related.

Interviewees also noted that older individuals may be discharged without glasses, dentures, or support with ongoing care needs, which can impede reintegration and heighten the risk of neglect or decline.

> *"People are released without glasses, dentures, or follow-up appointments. For older people, this can be devastating - it's not just health, it's dignity."*
>
> – Stakeholder (NHS)

Stakeholders also reflected on the role of age as a hidden factor in compounding disadvantage. Older individuals may face greater stigma, longer histories of system involvement, and reduced social networks, which together create high levels of isolation and unmet need.

4.14 Veterans

Military veterans represent a distinct inclusion health population whose experiences prior to, during and after service may influence health, wellbeing and contact with the CJS.

National data suggest that veterans account for approximately 3% of the prison population in England and Wales, compared with around 4% of the general population aged 16 and over.[177]

This indicates that veterans are not over-represented within the prison population at a national level. However, veterans in custody tend to be older than the general prison population and may present with complex and cumulative health needs.

Survey data indicate that, in 2022, 12.0% of UK veterans who reported witnessing or taking part in operations against enemy forces reported having been convicted of a criminal offence at some point in their lifetime, compared with 7.8% of veterans who had not undertaken such operational roles. These figures relate to lifetime conviction and do not indicate when the offence occurred relative to military service or operational deployment.[176]

There are limited contemporary data on veteran representation within probation services. Earlier estimates (2010) suggested a prevalence of approximately 3.4% though routine identification of veteran status across justice settings remains inconsistent.[180]

Veterans often present with complex health needs which may be linked to their childhood experiences, military experiences and difficulties in reintegrating into civilian life. Studies have found that veterans involved with CJS tend to be older and employed but susceptible to homelessness and unstable living arrangements.[179] They were most likely to engage in violent and motoring offences and present with excessive and hazardous drinking patterns, substance misuse, and complex mental health needs (ADHD, psychosis, PTSD, and mood disorders).178 Female veterans are reported to have a particularly high prevalence of adverse childhood experiences including physical and emotional abuse, which are closely associated with mental health issues like PTSD.[180]

National policy recognises the need for tailored support for veterans, including the Armed Forces Covenant and the "Veteran Friendly" GP accreditation scheme, which encourage identification and better service access for former service personnel.[181,182] There is also a need for organisations and their staff to understand the distinct mental health needs of veterans, with services available for support early on to prevent mental health crises.

4.14.1 The Birmingham Context

Data on veterans in contact with the CJS in Birmingham is limited. Change Grow Live reported that 3.6% of its service users were veterans whilst HMP Birmingham found that 6% of the prison population had served in the armed forces, higher than the national prevalence of 3%.[185]

Stakeholders reported that veterans accessing local services often present with a combination of mental health needs, substance misuse, and housing instability. Despite this, there was no available data locally on the specific health needs or outcomes of justice-involved veterans, which points to a gap in local monitoring and provision.

The Birmingham JSNA Veterans Deep Dive highlighted barriers to accessing appropriate mental health support, inconsistencies in recognition of PTSD and other service-related conditions, and lack of coordination between military services and civilian providers. Recommendations included a need for improved data collection that specifically includes data around past service involvement and associated demographic information within CJS services, proactive identification of veterans with mental health needs and early sign-posting to available services, and more trauma-informed and veteran-specific pathways in health, housing, employment, and CJS services.[186]

4.14.2 Insights From Experience

While veterans were not a major focus of stakeholder or lived experience interviews, some participants referenced the intersection between military service, trauma, and later CJS involvement. In particular, the loss of identity and structure post-service, combined with undiagnosed or untreated mental health issues, was cited as a significant issue for this group.

> *"Veterans often fall through the cracks. Their needs are very specific PTSD, isolation, not trusting services and those aren't always recognised by mainstream support systems."*
>
> – Stakeholder (VCFSE)

National guidance emphasises the importance of systematic identification of veterans across public services, including the routine use of the question "Have you ever served in the Armed Forces or Reserves?" to improve recognition and appropriate referral.[186] Improved recording of veteran status alongside protected characteristics (e.g. age, gender, disability and ethnicity) enables better understanding of intersectional need and targeted support.

Evidence from national reviews highlights that earlier identification of veterans within health, housing and CJS pathways supports more timely access to specialist mental health and welfare provision, reducing the risk of crisis escalation.

Several stakeholders called for better identification of veterans within the CJS and more culturally competent care that reflects their unique experiences.

4.14.3 Case Study 3: Leigh's Journey

"The Army teaches you to hate the world and mistrust everyone. That's why I didn't seek support [...] Support in the community is grim."

Leigh's frustration with treatment and recovery flows through his journey as he highlights the problems, issues and barrier faced by those with substance misuse conditions. He describes the drug agencies as a "waste of space", consistently prescribing methadone, which replaces one addiction with another. In Leigh's experience, people are not supported to get clean in prison.

Instead, they are maintained on methadone until release. He stated that addicts generally use methadone as a "hold-over" for days they have no money and cannot get their drug of choice. He believes support for beating the addiction within the community is grim, especially when one is assigned to an HMO where drug use and violence is often rife, and the standard of housing low.

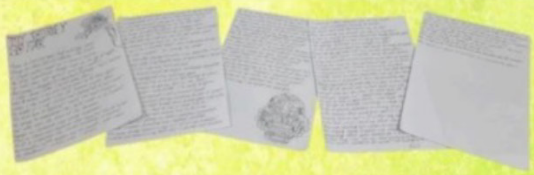
"We need NA specifically for ex-service members"

Leigh took matters into his own hands. After coming into a bit of money, he bought a one-way ticket to Greece in September 2024 and camped on a piece of waste land, detoxing on his own. He'd removed all old contacts from his life so he wouldn't be tempted to misuse substances again but kept one man who had proven to be a good friend during periods of recovery in the past. This friend informed Leigh about an organisation that runs high-quality dry houses. Leigh went back to England and Right Star helped him immediately, starting with a clean and safely run dry house following a housing first model. Five months later, Leigh is moving into Stage Two housing that provides supported program, has repaired his relationship with his family, has started volunteering, and enjoys exploring his talents as a creative writer. He wants to work with Veteran support agencies to bring Narcotics Anonymous for ex-service members to Birmingham. He believes if it's run correctly, with the unique needs of military personnel in mind, it could be successful.

"There are better ways to get people clean other than replacing one addiction with another. Just because it's [methadone] doesn't mean it's effective"

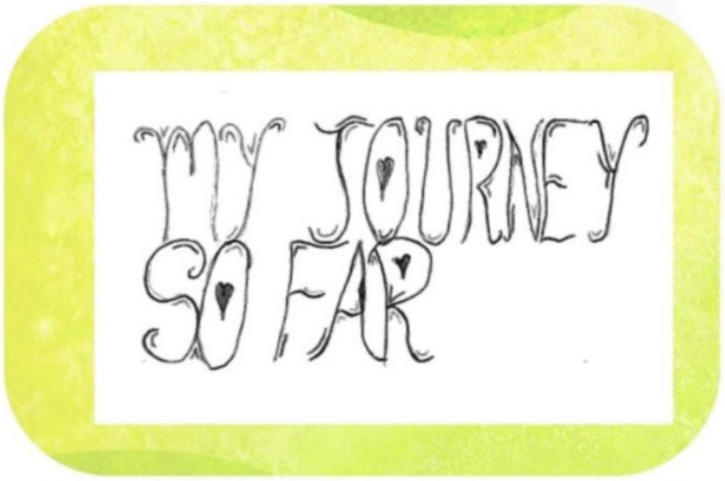
My story

Poetry



"...serving 12 months I was
released from prison,
With only four walls and my
thoughts, plenty of time to
make a decision,
Only three GCSEs not very well
educated,
Now with a criminal record, the
stigma and socially segregated...",

"...I just need a chance to get my foot in
the door,
Once they see what I have to offer, I'll
be harder to ignore,
Trying to secure employment, with a
criminal record,
Rejection after rejection feeling
worthless the more I'm ignored,
With all the obstacles, hoops to jump
through, the blame game is easy to
see..."



"...Most my life I've been
directed by the authorities,
Any chance of army success,
I must be selfish and make
myself priority,
So I stopped procrastinating
and finally got the ball rolling,
Finally signed on the dotted
line, finally I'm enrolling..."

"...I can't get these memories
out my mind,
Some kind of madness
startling to evolve,
We didn't have time figuring
out how we feel...",

"...That was only day 4 of my
introduction to pure terror,
I still had lots more to see
which will stay with me forever,
When you join the army the
world they teach you to hate..."

"...Leaving the army into civilian life, there is no training for re-
integration,
Their only parting gift the lovely memories of war,
All I've seen, and my mental health, not even a number I can call,
Even with family and friends who love me,
Still lonely, sad living in the past and now PTSD,
When I joined, didn't drink, drug free, care free, personally lived life
sporadically.
And today my name is Leigh and I'm a recovering addict..."

5. Health issues

5.1 Transition Periods and Continuity of Care

There are many potential transition periods within the CJS (for example, from community to custody, between custody settings, and from custody back into the community). Continuity of care is essential, ensuring that people within the CJS consistently receive the healthcare they require. Studies have shown that lack of continuity of care can lead to worse health outcomes and increased risk of reoffending, particularly for those with a history of substance misuse.[139] Effective continuity of care requires transparent communication and cooperation between different organisations including GPs in the community, education, healthcare providers within prisons, drug and alcohol services, and third sector organisations supporting people during their transitions, especially during resettlement into the community from prison. The Voices of Stoke case study provides a powerful representation of a resettlement journey and how external factors such as public transport waiting times, financial implication of travelling to appointments, and the social adjustment required on release can impact outcomes.[184] Many recalls to custody are associated with the challenges experienced during resettlement journeys, and recalls are a major source of the custody caseload in England and Wales – in 2024, there were 3,112 recalls representing 6.52% of the total license caseload.[187]

Evidence from qualitative research on resettlement experiences highlights how practical barriers can undermine continuity of care at the point of release. The Voices Legacy Evaluation[184] which examined the experiences of people transitioning from prison custody to the community, found that multiple external factors — including waiting times for public transport, difficulty securing timely benefit payments, and challenges registering with GPs and other health services — created barriers to attending appointments and maintaining treatment continuity after release. Participants described how these barriers contributed to stress, disengagement from services, and reduced access to ongoing care. These findings align with broader evidence that weak continuity arrangements during resettlement can exacerbate health inequalities and increase the risk of relapse, unmet need, and reoffending.

A review into HM Probation Service highlighted significant workload pressures and resource limitation. In response, a 'Probation Reset' was implemented in July 2024 with resource being focused on the early stages of a community order where it will likely have the greatest impact.[188]

Through the Gate (TTG) provision refers to coordinated health and wellbeing support that begins in custody and continues seamlessly into the community at the point of release. Evidence from HM Inspectorate of Prisons highlights that inconsistent TTG health arrangements contribute to medication gaps, missed appointments, and increased risk of recall or reoffending during the early post-release period.

5.1.1 The Birmingham Context

HMP Birmingham is a reception prison which means there is a high turn-over of residents with some staying only a couple of weeks and others staying for a few months. This high turn-over presents challenges for the delivery of safe and effective healthcare. Primary healthcare within HMP Birmingham is commissioned through NHS England as part of the national Health and Justice service specification. Primary care is delivered on-site by a multidisciplinary team and is intended to operate to standards equivalent to community general practice, including initial health screening on reception, ongoing GP-led clinics, prescribing, management of long-term conditions, and referral to secondary care where required. Individuals are automatically registered with the prison GP during custody. On release, responsibility transfers back to community primary care, requiring timely re-registration with a GP in the community to ensure continuity of medication, monitoring, and onward referrals.

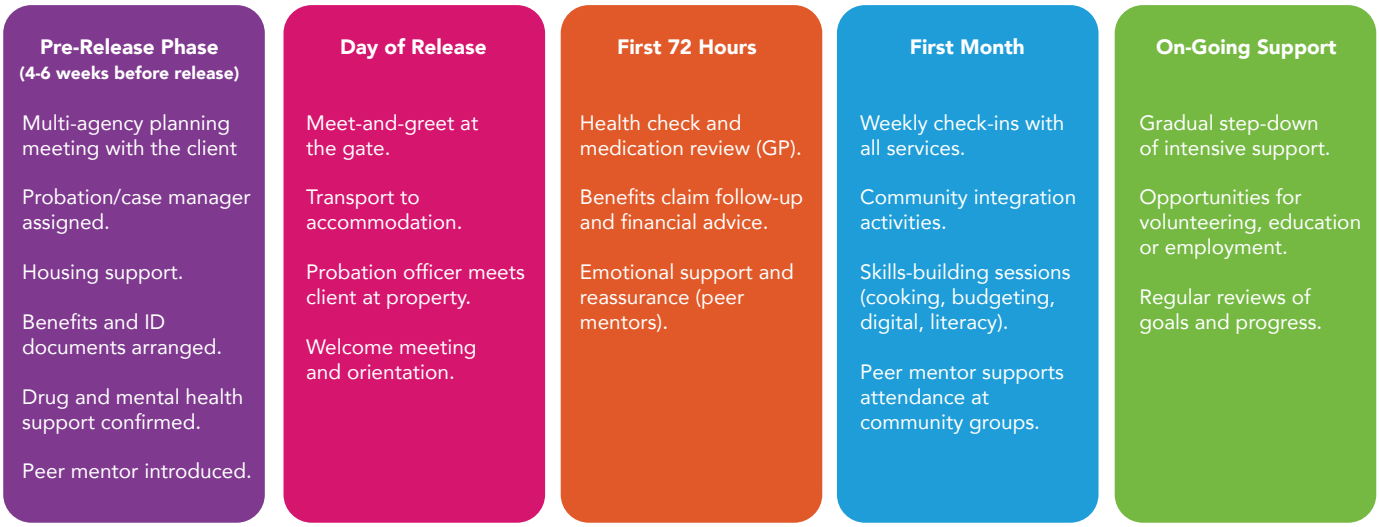
For example, ensuring that medication prescriptions are provided in a timely manner on admission, and care plans are transferred to ensure continuity of care. There are around 400 arrivals to HMP Birmingham per month who may all require some degree of primary or secondary care. The high turn-over also presents challenges in service delivery: many residents may commence a programme but will be unable to complete it due to being transferred prior to completion.

Additionally, where individuals move facilities but require specialist medical care, there are challenges to ensure they obtain the appropriate treatment and oversight.

The 2025 unannounced inspection of HMP Birmingham highlighted the challenges for accessing community mental health teams on release if the individual is not registered with a GP, but an outreach team was available for support if needed.[58]

However, there has been work to improve the transition from prison to community through the 'Ideal Pre-Move Preparation and Journey Design' pathway checklist (see Figure 21) that sets out services and facilities that should be in place from 4-6 weeks prior to release.[46] There is also the Care Programme Approach that is applied to complex mental health cases allowing coordinated care during transitions.[189]

Figure 21: The ideal prison release pathway



5.1.2 Insights From Experience

Continuity of care at the point of release was identified as a key gap. Stakeholders reported that individuals leaving custody often do so without a clear treatment plan, access to prescribed medications, or active referrals into community services. They noted that where prison release plans were not implemented sufficiently or aligned to the individual's needs, they saw increased risk of prison recalls. Stakeholders emphasised the need for improved pre-release planning, including in-reach engagement by community-based substance misuse services.

Additional engagement undertaken by the Public Health team highlighted similar concerns about continuity of care within custody and at transition points. One individual described how he had been transferred from another facility. To prevent a break in medication dose and ease the transition, the individual had been provided 'bridging' medication within prisons security standard packaging from the prison pharmacy.

However, on arrival at HMP Birmingham, the packaged medication was disposed of and the individual then had to wait days for the new prescription to arrive as it was not in stock within HMP Birmingham's pharmacy supplies. Another individual spoke of frustration in repeating stories to healthcare professionals in each facility they had been in.

Transition periods were also mentioned by people with lived experience and frontline workers described a recurring sense of being "dropped" by services:

> *"When I came out [of prison], I had no idea where to go. I didn't have a phone, no one met me. You're just back out there, and everything's overwhelming."*
>
> – Person with LE

Stakeholders described gaps in planning for release or discharge, especially when individuals have complex needs such as dual diagnosis, housing instability, or trauma histories. They emphasised the importance of consistent relationships and flexible support models that extend beyond the formal boundaries of services.

5.2 Communicable Disease

The prevalence of infectious diseases, especially those that are blood-borne or sexually transmitted, are higher amongst people involved in the CJS than the general population and are associated with substance misuse, homelessness, mental health issues.[190] Custody settings provide an opportunity to screen, diagnose and treat infectious diseases but they also pose risk for presence and transmission of infectious diseases due to the environment (e.g., cell sharing), population (e.g., the high turn-over), and prevalence (prison populations are at higher risk of infectious diseases).[191] Other contributing factors include poor ventilation, limited facilities for diagnosis, treatment and isolation, and limited knowledge amongst staff around principles of managing infectious diseases.

Female prison populations are particularly at risk: syphilis prevalence is 6.4% amongst female prisons compared to 0.5%-3.5% in male prisons.[193] The UKHSA has produced guidance outlining the recommended response to infectious disease outbreaks within secure settings.[194]

Prevalence of Hepatitis C is particularly high amongst individuals in the CJS, likely associated with high levels of injected drug use in this population. Figure 22 shows that the rates of Hepatitis C are four times greater in the female prison population (1.2%) compared to the male prison population (0.3%), both of which are higher than the rate within the England and Wales population (0.1%). There is a UKHSA initiative to improve surveillance and incorporate prison Hepatitis C screening data into routine surveillance.[195] There is also impetus to incorporate Hepatitis C harm reduction strategies into prisons to help reduce risk of infection upon release. Rates of tuberculosis in prison is also a growing concern with the recent Chief Medical Officer report into the health of people in prison recommending introduction of routine targeted latent tuberculosis (TB) screening (Figure 23).[191] Figure 23 shows that the rate of TB per 100,000 is four times greater in the prison population compared to the general population in England.

Figure 22: The prevalence (%) of Hepatitis C Virus (HCV) within the England and Wales Male and Female prison populations and the general population in 2024.[191]

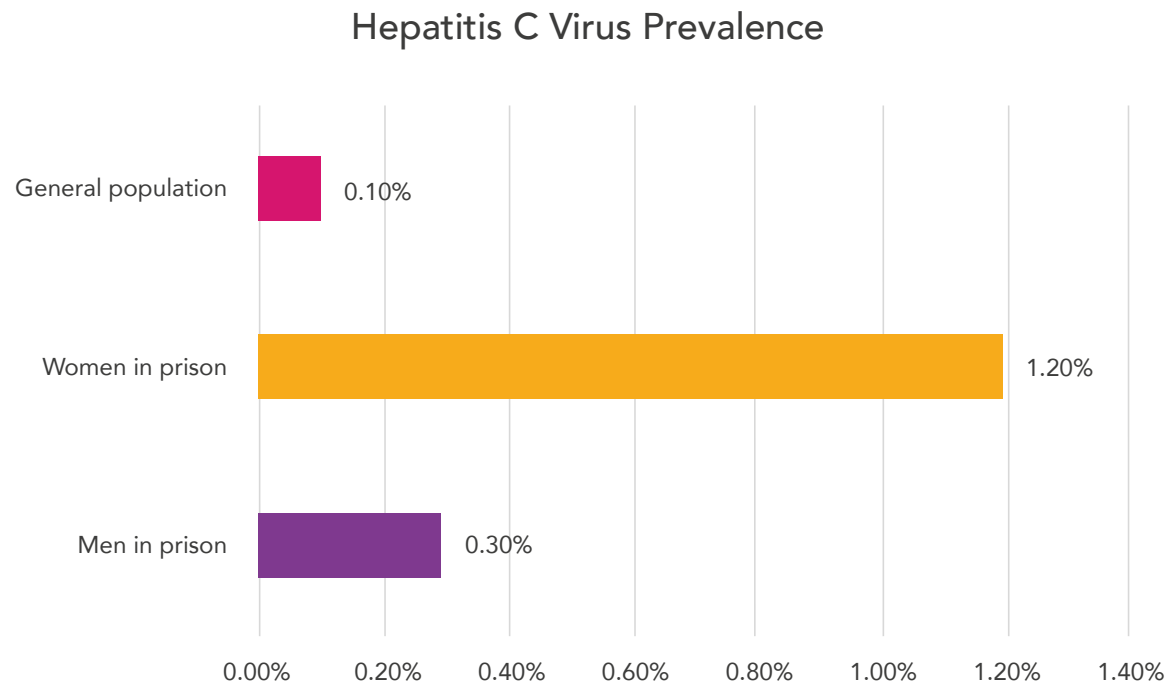
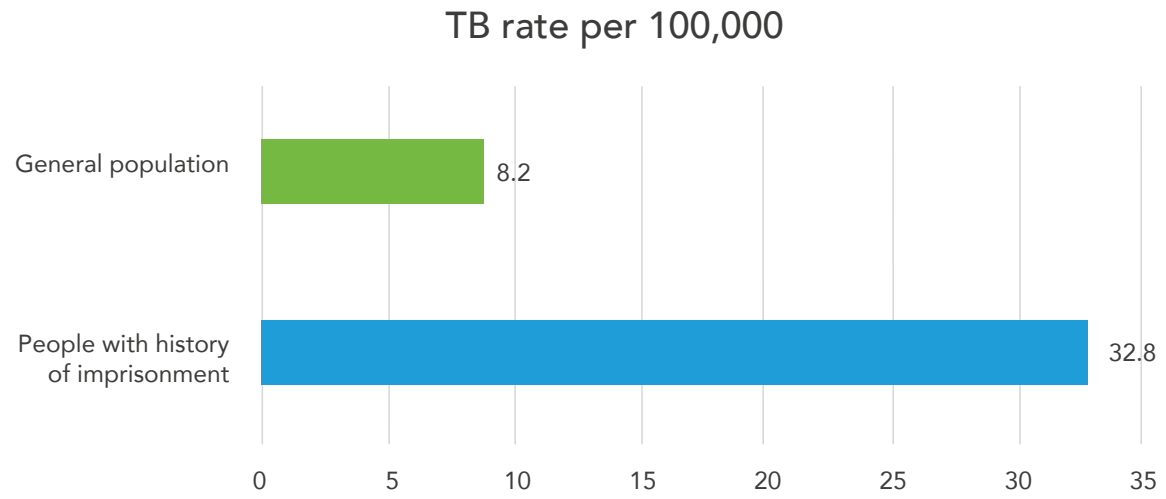


Figure 23: The rate of tuberculosis (TB) per 100,000 people in the England population compared to the England prison population in 2024.[196]



Managing infectious diseases within secure environments not only requires response to outbreaks but also requires screening and prevention. Since 2014, all prisons in England have offered opt-out blood-borne-virus screening which has improved testing rates from 5.3% in 2010 to 71% in 2023, for those who consent.[195] In 2020, a Prison Special Interest Group for Sexual Healthcare was set up to address the need for more effective provision of HIV testing, pre-exposure prophylaxis, vaccine availability, treatment, and infection control.[198] National oversight of sexual health provision within prisons is delivered through NHS England's Health and Justice Commissioning framework, in alignment with UKHSA guidance on BBV screening, HIV prevention, and infection control.

5.2.1 The Birmingham Context

A review of surveillance and seroprevalence data on sexually transmitted infections highlighted that prisons in the West Midlands had the highest rate of testing across England.[93] However, the high turnover of people within HMP Birmingham may mean that vaccination coverage within this prison population is challenging to maintain.[199]

In the 2025 unannounced inspection of HMP Birmingham by HM Chief Inspector of Prisons (5-16 October 2025), inspectors identified areas for improvement in infection prevention and control, including handwashing facilities and aspects of sexual health provisions. The report noted that some of these issues had been addressed since the previous inspection but required continued oversight to ensure sustained compliance.[58]

The probation services within Birmingham trialled Fibro-scanning and Hepatitis C Testing. In 2024, 210 tests for Hepatitis C were conducted in Birmingham City Centre, Perry Barr, Centenary House, and Selly Oak probation centres which returned a 4% positive result. 17 scans were conducted across Perry Barr, Centenary House and Selly Oak, of which 17% had fatty liver and received lifestyle advice.

5.2.2 Insights From Experience

Staff within the probation services reflected on the experiences of integrating healthcare services into their offices positively. They recognised the value on-site infectious disease testing could have within probation offices and explained how they see first-hand how challenging it is for the CJS population to engage in standard healthcare services due to several barriers such as digital literacy and financial constraints. Given that individuals in the CJS are required to attend probation offices regularly, it is a prime time to screen for infectious diseases and provide treatment to those in need and there was interest from probation to explore future opportunities to integrate healthcare services within probation like the liver fibro-scanning project.

Members of the HMP Birmingham healthcare team mentioned how their working environment impacted their ability to deliver quality care. One mentioned how challenging it is to adhere to infection prevention and control guidelines within the prison environment.

5.3 Non-communicable Disease

Non-communicable diseases, such as cardiovascular disease, are the leading cause of death in prisons in England and Wales.[170] People in prison in England and Wales are three times more likely to have cardiovascular disease, stroke, or chronic obstructive pulmonary disorder (COPD) compared to the general population.[11] Epilepsy, obesity, and diabetes are also prevalent amongst the CJS population. This health inequality has many driving factors relating to socioeconomic background, lifestyle behaviours, and environmental influences. There is also poor health literacy amongst people involved in the CJS.[1] Whilst it is well known that diet and physical activity are key factors to reducing risk of non-communicable disease, often, it is challenging within custodial settings to facilitate a health-promoting environment due to limitations in the facilities available but also due to staff shortages which prevents ability for supervision of activities such as gym visits. There are also studies that report a disparity between men's and women's custodial environments with women being less likely to have the opportunity to achieve sufficient physical activity levels compared to men.[153]

The Core20PLUS5 report into prison health also identified challenges around delivering screening programmes within prisons.[202] Limited health literacy amongst people in prison and a lack of awareness of eligibility from staff were seen to impact the uptake and provision of screening within custodial settings. There are also complexities that may arise where individuals serve short sentences and miss their screening invitation. Screening programmes that require imaging such as lung screening or breast screening have to be arranged as a healthcare visit and lack of staff can mean that people in prison miss their screening appointments.

Oral health is of particular concern within prison populations. Poor oral health can affect nutrition, self-esteem and act as an early indicator of wider physical health conditions such as diabetes and cardiovascular disease. National evidence has identified variation in access to and prioritisation of oral health screening across the prison estate, particularly where staffing pressures and competing healthcare demands exist.

However, the 2025 unannounced inspection of HMP Birmingham reported that dental services were good, NHS-equivalent services were available, and treatment plans were of a high standard, although non-attendance remained a challenge.

A national study highlighted the importance and relevance of co-morbidity, with more than one in five people (21%) on custodial mental health caseloads also having chronic physical health issues – including respiratory issues (33.9%); diabetes (12.5%), epilepsy (10.3%), cardiac problems (10.3%), mobility and skeletal conditions (9.6%) and sensory disabilities (audial and visual 2%).[146]

5.3.1 Mobility Impairment, Disability and Frailty in Custody

Disability and mobility impairment represent a significant and growing area of need within the prison population. National survey data from the Surveying Prisoner Crime Reduction (SPCR) study indicate that approximately 11% of prisoners report a physical disability. However, local findings suggest substantially higher levels of need. A 2023 survey at HMP Birmingham reported that 47% of respondents identified as having a disability, with 59 respondents indicating that they were not receiving the support they required.

Inspection and monitoring reports have identified persistent environmental and structural barriers affecting prisoners with mobility impairments. These include broken lifts, inaccessible showers, restricted wheelchair movement within cells, and difficulties accessing medication, healthcare appointments, visits, and other prison services. Such barriers may result in delayed care, reduced independence, and compromised dignity.

Nationally, the limited number of accessible prison facilities means that individuals with mobility impairments are frequently held at establishments far from their home area.

This has implications for family contact, social support, and continuity of care, and may compound existing inequalities.

The ageing prison population further intensifies these pressures. National analysis by the Nuffield Trust found that among male prisoners aged 50 years and over who experienced emergency hospital admission between 2018 and 2020, 44% were identified as having intermediate or high-risk frailty, with frailty strongly associated with mobility impairment. This highlights the intersection between ageing, chronic disease, and disability within the custodial population.

Evidence also indicates that prisoners living with physical disability experience intersecting vulnerabilities. Compared to prisoners without disability, they are more likely to report prior substance misuse, childhood exposure to violence, experiences of homelessness, and the need for employment support on release. These patterns suggest that mobility impairment is rarely an isolated need but rather sits within a broader context of social and health disadvantage.

Taken together, this evidence indicates that mobility impairment in custody is not solely a clinical issue but also a structural and environmental one. Physical infrastructure, accessibility of services, geographical placement decisions, and release planning processes all influence outcomes for prisoners with disabilities.

5.3.2 The Birmingham Context

Most health conditions are identified during admission processes within HMP Birmingham. Individuals are asked to declare any outstanding hospital appointments, investigations, screening visits, medications, and general past medical history to nurses based within the healthcare wing. Where needs are identified, healthcare staff are required to contact relevant teams within prison, hospital, and community healthcare services to ensure that needs are met.

There are services available within the healthcare wing including physiotherapy, psychiatry, sexual health, general practice, dentistry, optometry amongst others, and individuals can request review through the kiosks present on the wings.

5.3.3 Insights From Experience

In Birmingham, local professionals and people with lived experience identified gaps in access to basic health services upon release from prison. They reported that individuals are often released from prison without glasses, dentures, or medication, disrupting continuity of care and compromising wellbeing.

> *"A lot of people are released with no dentist. They haven't been to the dentist for a number of years. Opticians is another one. They get released without any glasses or their eyesight's really poor. […] Dentist, again, is another difficult one, to get a registration with a dentist."*
>
> – Stakeholder (NHS)

Furthermore, high rates of chronic physical health issues - including respiratory disease, circulatory problems, and infections - were reported, particularly among those with substance misuse histories or unstable housing. These conditions are often compounded by poor nutrition, inadequate healthcare access during custody, and limited follow-up care on release.

> *"Obviously, it depends on what they're using, but mostly, heroin and crack users. The COPD is a huge one [...] There's lots of different things going on. Then you've got your alcohol cohort, obviously. You've got liver disease. Again, malnutrition with that as well because they're not eating properly while they're drinking."*
>
> *– Stakeholder (VCFSE)*

The healthcare department at HMP Birmingham explained how they perceive that individuals choose to report longstanding health issues upon admission to prison as they have been unable to access services in the community.

For example, they recalled how some individuals requested dental review upon admission to prison despite having long-standing dental issues.

Stakeholder engagement highlighted additional challenges for people in prison with sensory or mobility impairments, particularly where prison infrastructure and staffing models were not adapted to support their needs. Stakeholders also noted the limited availability of Birmingham-specific data on these populations, suggesting a need for improved health needs monitoring and more disaggregated data collection.

National and local discussions have also considered the potential development of more specialist accommodation for prisoners with neurodivergent conditions, with the aim of creating more supportive environments for individuals with sensory sensitivities and complex needs. However, implementation would depend on governance decisions and operational capacity. Care would also be needed to ensure that any specialist provision addressed unmet need equitably, without inadvertently creating stigma or perverse incentives.

Additional staff engagement highlighted challenges arising during prison admission. Staff reported that admission healthcare interviews could take around 40 minutes and require a qualified member of staff to complete them, which could contribute to delays where staffing capacity was constrained. Staff also described delays in medication review as a source of frustration and distress for some individuals entering custody.

Probation staff also described recent initiatives across the West Midlands to use probation settings as access points for health screening and checks. They identified further opportunities to strengthen the integration of community healthcare within probation services.

Finally, it was felt that addressing the issue of complex needs requires a holistic approach that integrates health, social care, and criminal justice services, while also addressing the underlying social and economic factors that contribute to these issues.

It is not enough to simply combine systems that retain a punitive and non-supportive approach; labelling language, stigma, and processes that re-victimise can cause more harm and further setbacks.

5.4 Prisoner on Prisoner Violence and Gang Culture in Prison

In 2024-25, there were 356 assaults per 1,000 prisoners reported in England and Wales, a 10% increase on the year previous.[203] In total, there were 7 homicides from June 2024-25 compared to 0 reported homicides the year previous. The rate of assaults is higher in female prisons compared to male prisons (rate of 573 per 1000 female prisoners versus 347 per 1,000 male prisoners). There were 122 assaults on staff per 1,000 prisoners reported in 2024-25 which is an all-time high, thought to be linked to uncontrolled drug ingress.[203] Data on drug ingress into prisons is limited.

5.4.1 The Birmingham Context

The 2025 prisons inspectorate report highlighted how incidents of violence within HMP Birmingham had risen since the 2023 inspection, attributed to the increase in illicit drug supply.[138] The Challenge, Support and Intervention Plan (CSIP) programme was variably implemented and funding for charity support to support those at risk of gang involvement had ended. There is a focus on understanding the cause of violence with actions taken in response to try and reduce violence.

However, 25% of respondents to a survey reported feeling unsafe within HMP Birmingham. Violence within the prison not only impacts those directly involved in the violence, but also impacts the wider prison community who are unable to attend activities and appointments due to limited officer availability.

5.4.2 Insights From Experience

Prison officers explained how they perceived prisoner on prisoner violence to be commonplace within the prison. They described how if an incident occurs, officers are required to attend which then means that there are fewer available officers to accompany residents to education, healthcare, work, and recreation. Officers spoke of careful planning required to reduce the risk of prisoner-on-prisoner violence including ensuring rival gang members are not placed on the same wing, and people with conflicting viewpoints are kept apart.

Members of the healthcare team in HMP Birmingham explained how prisoner-on-prisoner and prisoner-to-staff violence varied and speculated that it could be related to supply of illicit substances within the prison. One member of staff mentioned how verbal abuse towards staff was often driven by desire for additional prescription medication.

Healthcare staff described tensions arising around medication management in the context of high levels of complex need and substance dependence. National evidence indicates that co-morbidity is common in prison populations, with high prevalence of both mental health disorders and substance misuse.[146] Managing controlled medication safely in custodial settings presents additional challenges, including diversion risk and dependence.[204]

Where mental health, trauma and substance use needs are not adequately addressed prior to custody, individuals may present in heightened distress, contributing to behavioural escalation.[71] This reinforces the importance of integrated pathways and continuity of care across custody and community services.[224]

6. Health Related Services within the CJS

The provision of healthcare within the CJS is a state responsibility, as set out in the United Nations Standard Minimum Rules for the Treatment of Prisoners, 2015.[205] Access to healthcare does not form part of punishment. The healthcare landscape for people involved in the CJS is complex especially for those within prison, with different services commissioned by NHS England, Local Authorities, and Integrated Care Boards (Figure 24).

Figure 24: A diagram to represent the commissioning and provision of healthcare within the prison system.[224]

6.1 Services for Children and Young People

Prevention and arrest

Birmingham Says No: a charity taking a holistic approach to knife crime prevention offering youth empowerment sessions, counselling, family outreach, as well as incident response with bleed control training.[208] They offer sign-posting to support available in Birmingham for young people including housing, food banks, and victim support, acknowledging the role social setting and environment might have on youth involvement in the CJS.

EMPOWER U: safeguarding hub set up in collaboration with West Midlands Police, NHS, the charity sector, and BCC providing support and guidance to children and young people as risk of involvement in CCE and county lines.[209]

Redthread: a charity supporting children and young people at risk of youth violence. They work within hospital emergency departments, identifying individuals who may be at risk and providing holistic support delivered by specialist youth workers. Redthread work within the Queen Elizabeth Hospital and Heartlands Hospital emergency departments.[207]

Turnaround: a nationally funded early intervention programme for children aged 10-17 to prevent offending or reoffending. Eligible individuals include any child who has come into contact with any aspect of the CJS.[210]

Youth Justice System

AssetPlus: a Youth Justice Board assessment and planning interventions framework aiming to ensure that each child has one record to follow the young person through the youth justice system.[212] The assessment consists of core information such as the young person's personal circumstances and needs, but it also focuses on drivers to CJS involvement such as family and social factors, offending behaviours, opportunities and self-assessment. Information gathered using AssetPlus aims to explain offending behaviours based on the individual context, consider potential future behaviour and risk of harm to the young person and community to inform the young person's intervention plan.

Aquarius: a charity offering specialist support within each Youth Offending Team across Birmingham. Aimed at children and young people up to 25 years who have a substance misuse need or addiction. Support is accessed by referral from a professional or self-referral and provide drop-in advice, structured psychological and psychosocial support, resources, and group work.[215]

Chatterbug: two speech and language therapists and one communication and language specialist provide services 5 days a week within the YJS. They share YJS offices and attend regular team meetings. Access has been provided to Birmingham Children's Trust systems to allow booking and information sharing between services.[214]

Comprehensive Health Assessment Tool (CHAT): a physical and mental health screening tool for use within the YJS. The screening is usually completed if physical or mental health issues are identified within the AssetPlus assessment. CHAT aims to prompt early identification of needs and improve continuity of care.[213]

Enhanced Youth Justice Offer: staff at the Birmingham YJS described a pilot in progress placing YJS staff in custody to improve early intervention and referral to appropriate services.

Radar alert system: a trial aiming to alert YJS staff when a child is in custody, coordinated by YJS worker. There is also trial for the radar alert system to be linked to Aquarius who will become aware of any children associated with a drug/alcohol related offence in custody.

Restorative justice: Birmingham YJS has been awarded registered service provider status from the Restorative Justice Council.[216]

Sergeant training: staff within the YJS reported that from October 2025, all police sergeants will receive training around children in custody to help improve referrals to the YJS.

The Skill Mill: an initiative within the YJS offering supported employment opportunities.[217]

The Youth Justice Service (YJS): aims to support children and young people within the CJS and deliver services to prevent future involvement in the CJS.[211] It is funded by local government and the Youth Justice Board. Within Birmingham, the YJS is delivered by Birmingham Children's Trust. Children who receive a diversionary method or court appearance are eligible for the YJS. Youth Offending Teams are part of the YJS and are responsible for delivering local youth crime prevention, supporting young people at police stations and in court, supervising young people who are serving community sentences, and supporting young people in custody.[211]

Youth Custody Service: a part of His Majesty's Prison and Probation Service (HMPPS). Responsible for the youth secure estate and deciding where a young person is placed.[218]

6.1.1 Service Gaps for Children and Young People in the CJS

- There is no under 18s health pathway in custody meaning children are often not prioritised despite their inherent vulnerability.
- There is currently no neurodivergence assessment as part of the YJS - referrals are made through GPs but waiting lists. There is a need to increase awareness and strengthen relationships with partner organisations to ensure children and young people receive the support they need. There may be a role for a dedicated healthcare practitioner within the YJS to conduct comprehensive health and wellbeing assessments, including neurodiversity screening.
- Substance misuse support is only available to over 18s from Cranstoun meaning children and young people are unable to receive the support they require.

- The health team based within the YJS only work 8am-8pm in the week and 8am-4pm on the weekend within the YJS. Many children and young people are arrested out of hours and limited handover means many children and young people do not receive the support they require.
- There are limited data sharing and communication between partner organisations meaning children and young people may not be known to appropriate services. There is a need to strengthen data sharing and communication between health, social care, education, and justice systems to ensure comprehensive support is provided.
- Services for neurodivergence, substance misuse, speech and language therapy, and mental health are better equipped to support young people in custody than those in the community.
- The CHAT assessment is being completed in custody, but the YJS have limited capacity to complete it. It is therefore challenging to quantify and demonstrate the health and wellbeing needs of children and young people in the YJS in Birmingham. There is a need for dedicated health practitioners within the YJS.

6.2 Adults within the CJS

Prevention and arrest

Intensive supervision court: an alternative court process to prevent sentencing to custody for those with drug misuse needs. A multi-agency approach is adopted where individuals receive regular review meetings, supervision from the Probation Service, and access to mental health, education, employment and housing support as well as specialist drug and alcohol treatment as conditions of their sentence. There are specific pathways designed for women with Birmingham Magistrates Court hosting the women's ISC pilot.[157]

Out of Court Resolution course: a programme run by Cranstoun for alcohol related violence and domestic abuse. The course provides information about safe drinking, managing consumption and self-awareness around conflict.[220]

West Midlands Arrest Referral Service: provided by Cranstoun where specialist arrest referral drug workers are placed in custody (including evenings and weekends) to complete assessments. When not on site, a referral system is in place. Harm reduction advice and equipment is provided alongside holistic assessments and education around substance misuse and crime.[221]

West Midlands DIVERT: a programme provided by Cranstoun for people found in possession of small quantities of controlled substances, providing education to individuals to help them make informed decisions about their drug use and refer to support services where needed. The aim is to obtain an Out of Court Resolution.[219]

Service Gaps within prevention and arrest

- There are limited screening and support services available to individuals with learning disability or neurodivergence who are arrested and taken into custody.

HMP Birmingham Health and Care

Drug and alcohol support: support services are provided by the charity Cranstoun, in-reach is provided by Change, Grow, Live, and there are opportunities to be involved with mutual aid such as Alcoholics Anonymous and Narcotics Anonymous. Comprehensive description of available services for substance misuse can be found within section 4.8 of this report.

HMP Birmingham Prison Health Service: within the prison, services reflect community healthcare services. People in prison have access to dental services, GP, optometry, therapy services, general nursing. Individuals within the prison can request review by healthcare services through kiosks on each wing. Healthcare assessment begins upon arrival at the prison where a screening health check takes place. Any health conditions identified will be reported and managed by the healthcare team within the prison, where possible. The healthcare team will also liaise with hospital services for specialist advice and follow-up.[222]

Mutual aid: Alcoholics Anonymous, Narcotics Anonymous

Naloxone training and supply: training is provided to officers by the charity Cranstoun. Officers are taught how to recognise signs of opioid overdose and administer Naloxone.

Neurodivergence assessment: neurodivergent individuals can be referred for assessment and diagnosis by the neurodiversity support

manager and can be provided with resources and reasonable adjustments to navigate the CJS. There is also a peer support process with a paid neurodivergence representative who acts as a link between individuals within the wings and the neurodiversity support manager.

Psychosocial Support and Treatment Service: provided by Cranstoun involving one-to-one interventions including trauma-informed advice, relapse prevention plans, and release planning. Initial screening takes place in the first day in custody, information about service and advice are given. If the individual agrees, they are allocated a key worker who completes a care plan, community referral and harm reduction advice. Prior to release, there is planning of treatment continuity, arrangement of community appointments, relapse prevention and naloxone training. There is a bespoke offer for the Drug Recovery Wing.[223]

Smoking cessation: smoking cessation support is provided within prison. Smoking cigarettes is not permitted.

Service Gaps within Healthcare in HMP Birmingham

- Staff reported challenges in timings for admission screening. Qualified nurses are required to complete healthcare screening but are only commissioned to do so from 14:00, after other responsibilities have been completed. Sometimes, individuals will arrive at the prison several hours before the admissions process begins and are held waiting which leads to frustration and sometimes, aggression, especially where medication reviews are required. The admissions process is commissioned until 20:00 but often, arrivals are delayed and registered nurses and officers are required to stay over-time to complete the admissions process.
- There are increasing numbers of individuals entering the prison with complex health and care needs. Staff reported how some individuals require hospital beds and personal care but the facilities and staff are not equipped to provide this. They discussed how with increasing numbers of older people in prison, there is a need for a nursing home-style wing in order to safely accommodate for their needs.
- Whilst support services for drug addiction are comprehensive within HMP Birmingham, often, it is not possible for individuals to complete the treatment as they are moved to other facilities and transfer of care is often not possible. Care provided is reactive and acute and longer-term health issues and primary care needs are often unaddressed.
- Support for drug addiction is comprehensive within HMP Birmingham but support for other addictions such as gambling is less developed.

Supporting the wider determinants in HMP Birmingham

Activities on the HMP Birmingham drug treatment unit: there are multiple activities provided to individuals enrolled into the drug treatment unit. There are art activities, cooking classes, gardening sessions, fitness classes.

Cranstoun Housing First: an emphasis is placed on securing accommodation as soon as possible and prior to release alongside services to support wider needs such as financial support and drug and alcohol services.

Job Centre Plus/Citizens Advice Resettlement unit: a service providing housing, benefits, and employment support within HMP Birmingham.

Keeping in touch with approved family members and friends: people in HMP Birmingham are able to keep in touch with family members by secure video call through the Prison Video app. They also have access to phones in their cells and can make calls every day between 7am and 11pm once phone credit has been purchased. There is also the Email a Prisoner service and letters can be sent to the prison addressed to the person via a prison number.[225]

Novus education and work: bricklaying, plumbing, painting and decorating, carpentry, forklift truck driving, industrial cleaning, and catering courses are available. Other courses available include IT, social and life skills, business skills, and creative arts. Novus provide recognised qualifications on course completion.

Prison Advice and Care Trust (PACT) family and friends' support: PACT provide guidance and resources for travel and transport, financial assistance for prison visits, and support children and young people affected by imprisonment.[225]

Service Gaps in Custody

- Being a reception prison, it is not always possible to predict when people will be released from HMP Birmingham meaning community support can be challenging to arrange. Whilst services for continuity of care and smooth transitions may be available, it is not possible for all individuals to benefit from these due to the unpredictable nature of reception prisons.
- Activities are provided to individuals enrolled within the drug treatment unit but are less accessible to others. There is an inequality in access to activities with those who have a drug misuse need being offered more opportunity, whilst others who may have other addictions such as gambling do not qualify.

Post-release

Change Grow Live (CGL): drug and alcohol support services provided by four hubs across Birmingham (Central/West, South, East, and North) accessed by appointments. They also provide an in-reach service within HMP Birmingham. They have dedicated services for veterans, asylum seekers, and migrant communities.

Probation offices: findings from this report highlight the informal but key role probation offices play in helping individuals navigate healthcare system. Probation officers provide ad-hoc advice around accessing healthcare and other services.

RECONNECT: a service post-release from custody aiming to improve continuity of care. Individuals are contacted prior to release and are provided with liaison, advocacy, signposting, and support to engage with community services. RECONNECT is not a clinical service, but it aims to ensure health needs of individuals leaving prison are met, ensuring follow-up is maintained and support services are accessed.[226]

Enhanced RECONNECT: a service delivered by Birmingham and Solihull Mental Health NHS Foundation Trust supporting high-risk offenders with complex health conditions following release from prison. The service adopts a psychologically informed approach to ensure safe transitions back into the community. The aim is to make contact with people in prison prior to release to build relationships, set goals, provide skills and knowledge, and ensure needs are being met. The service is based in Phoenix House in Erdington where people can also attend post-release to access support and meet new people, by appointment. Staff include psychologists and therapists, mental health nurses, social workers, occupational therapists, substance misuse workers, support, time, and recovery workers and peer support workers.[227]

Service Gaps in the Community

- There are no neurodivergence support services within the community that are tailored to the CJS population. Waiting lists for neurodivergence assessments are reported to be several years long. The probation service provide advice about attending GPs for referral for assessment but there are no neurodiversity services available within probation offices.
- Services to support individuals with alcohol misuse needs are limited. Given individuals are abstinent whilst in prison, they may not be classified as having an alcohol misuse need upon release from prison. They may therefore be unlikely to be referred to support on release which may risk relapse.
- Services are usually designed to address a particular need, but the challenge lies in designing services that can address the complex and intersectional needs of individuals such as those in the CJS population. For example, an initiative may aim to improve access to appropriate housing but may not address key influencing factors such as neurodivergence or substance misuse needs. It can be possible that upon evaluation, housing targets are seemingly being met, but when considering outcomes at the individual level, the experiences are not as expected. There is a need for improved connectedness and communication between agencies.

Recommendations

The recommendations have been developed from the evidence presented in this needs assessment and are set out below.

The recommendations are organised under five thematic conclusions and are grounded in the demographics, need and risk identified within the assessment. They are designed to support system-wide action across health, local authority, probation, youth justice, custody and the voluntary and community sector, rather than the creation of a standalone justice health strategy.

To support delivery, recommendations have been phased:

- Phase 1 (0–12 months) focuses on immediate system safety, statutory compliance and continuity of care, using existing governance and commissioning mechanisms.
- Phase 2 (12–36 months) focuses on system maturity, equity and evidence-building, strengthening data quality, reducing inequality and supporting longer-term commissioning decisions.

This paper is provided for information, with the intention of supporting shared understanding, coordinated delivery and future prioritisation through existing governance arrangements, including the Health and Wellbeing Board, Integrated Care System and Reducing Reoffending structures.

7.1 Definition of Phase 1 and Phase 2 Recommendations

7.1.1 Phase 1: System safety and stabilisation (0–12 months)

Phase 1 recommendations address immediate and known risks within the justice health system and focus on actions that are already supported by strong evidence in the needs assessment.

These recommendations:

- Reduce acute risk of harm, including suicide, self-harm, safeguarding failures and unsafe release
- Address statutory and legal duties, including Equality Act reasonable adjustments and continuity of care
- Focus on transition points where risk is highest (custody entry, transfer and release)
- Can be delivered using existing governance, commissioning and partnership arrangements.

Phase 1 actions are foundational and necessary to make the system safe, lawful and clinically appropriate. Without these in place, longer-term improvement and evaluation will not be effective.

7.1.2 Phase 2: System maturity, equity and optimisation (12–36 months)

Phase 2 recommendations build on Phase 1 foundations and focus on quality, equity and sustainability.

These recommendations:

- Strengthen equity and proportionality, including ethnicity-disaggregated analysis
- Improve system learning and accountability through better data and evaluation
- Require stable data flows or embedded practice to be meaningful
- Support future commissioning and investment decisions
- Reduce variation and inequity over time.

Phase 2 actions are essential for ensuring the system becomes fairer, more consistent and more effective, but they depend on Phase 1 actions being established first.

Category	Phase	No.	Recommendation	Sub Recommendations
Workforce	Phase 1	1	Increase awareness of Zero Suicide Alliance and expand suicide prevention training for staff, prisoners and families, including peer-support schemes (Samaritans Listener) and evaluation, with consideration of women-specific adaptation.	
Workforce	Phase 1	2	Deliver education and training on PTSD, domestic abuse, autism, ADHD to staff within the criminal justice system and other services supporting justice involved populations.	

Category	Phase	No.	Recommendation	Sub Recommendations
Service	Phase 1	3	Provide sustainable trauma-informed, gender-responsive tailored wraparound services and interventions for groups with distinct justice health needs, including women, older and frail adults, veterans, children of prisoners, and children in care, to ensure support addresses their specific health, wellbeing, safeguarding, social needs and end of life care.	
Service	Phase 1	4	Promote and deliver educational, sports and arts-based programmes to support prevention, early intervention, diversion and rehabilitation of people at risk of or in contact with the criminal justice system. Evaluate and embed proven interventions into core commissioning plans and mainstream delivery.	
Service	Phase 1	5	Introduce a systematic Vitamin D assessment and supplementation approach across custodial and community justice settings, aligned with national guidance, with particular focus on high-risk groups (e.g. individuals who are indoors for prolonged periods, older adults, people with higher levels of skin pigmentation, and those in institutional settings).	
Service	Phase 1	6	Strengthen implementation of LGBTQ+ inclusive practice across custodial and community services.	

Category	Phase	No.	Recommendation	Sub Recommendations
Service	Phase 1	7	Ensure justice and post-release pathways identify and address domestic abuse to reduce re-traumatisation and risk of harm.	
Service	Phase 1	8	Review time spent in cell and increase access to outdoor space, physical activity, and purposeful activity to encourage behaviour change, support health improvement, rehabilitation and future employment prospects.	
Service	Phase 1	9	Prioritise access to stable, safe accommodation for justice-involved women, children and young people, and people with repeat contact with the criminal justice system who have unmet housing support needs.	
Service	Phase 1	10	Embed employment support, literacy support, digital inclusion, and benefits advice within resettlement as core outcomes, to support stability on release and reduce the risk of poor health and reoffending.	
Service	Phase 1	11	Ensure access to routine screening across the CJS for both communicable and non-communicable diseases to improve access to treatment and reduce the risk of transmission.	(a) Training staff in secure settings in principles of managing infectious diseases and ensure adherence to infection prevention and control guidance. (b) Improve facilities for diagnosis, treatment and isolation in secure settings. (c) Introduce routine screening of BBVs and TB across the CJS and facilitate access to other routine screening programmes which may require healthcare visits, e.g. breast screening.
Service	Phase 1	12	Introduce reasonable adjustments and accessible information for sensory needs, emotional regulation and specific learning difficulties, also recognising the intersectionality of trauma, neurodivergence, ethnicity, language and cultural needs.	

Category	Phase	No.	Recommendation	Sub Recommendations
System	Phase 1	13	Strengthen cross-sector collaboration to improve identification and support for neurodivergent individuals and those with experience of trauma across education, health, justice, and other services to mitigate risks of exclusion, exploitation and/or criminalisation.	
System	Phase 1	14	Strengthen neurodivergence-informed practice across the criminal justice system by improving workforce capability and embedding reasonable adjustments for neurodivergent people and people with learning disabilities. This should include input from people with lived experience and consideration of environmental and custodial design adaptations to improve access, support, and outcomes. Consider alignment with the recommendations from the JSNA Neurodivergence Deep Dive.	(a) Implement Oliver McGowan mandatory training. (b) Implement universal neurodivergence and mental health screening across police, courts, prisons, and youth justice. (c) Improve screening for learning disability and neurodivergence at the point of arrest. (d) Introduce neurodivergence peer support roles to improve practice and communication/language.
System	Phase 1	15	Embed trauma-informed training and ensure robust early help in schools and community settings to provide appropriate support, address behaviour issues and mitigate risks of first time entry into the CJS. This includes scaling up school based early intervention and alternatives to school exclusion.	

Category	Phase	No.	Recommendation	Sub Recommendations
System	Phase 1	16	Adult justice health pathway: co-produce and implement an integrated adult justice health pathway for people in contact with the criminal justice system, providing coordinated, trauma-informed support for mental health, substance misuse, neurodivergence, physical health, disability, and wider needs linked to multiple disadvantage. The pathway should ensure dual/ multiple diagnosis, continuity of care between custody and community, include clear referral and intake processes, support multidisciplinary working across agencies, and make use of co-located or one-stop-shop community hub models where appropriate. It should be underpinned by shared outcomes, data-sharing arrangements, and joint commissioning or pooled-budget approaches where feasible to support joined-up delivery.	(a) Implement Oliver McGowan mandatory training. (b) Implement universal neurodivergence and mental health screening across police, courts, prisons, and youth justice. (c) Improve screening for learning disability and neurodivergence at the point of arrest. (d) Introduce neurodivergence peer support roles to improve practice and communication/ language.
System	Phase 1	17	Children and Young People justice health pathway: co-produce and implement an integrated youth justice health pathway for children and young people at risk of, or in contact with, the criminal justice system, providing coordinated, trauma-informed support for mental health, substance misuse, neurodivergence, physical health, and wider needs linked to multiple disadvantage. The pathway should ensure continuity of care across education, community, health and justice settings, reduce fragmentation between services, include clear referral and intake processes, support multidisciplinary working across agencies, and make use of co-located or one-stop-shop models where appropriate. It should be underpinned by shared outcomes, data-sharing arrangements, and joint commissioning approaches where feasible to support joined-up delivery.	(a) Ensure a sustainable in-house provision of neurodivergence and speech & language specialist role within the Youth Justice Service. *To include: early help and trauma-informed support in schools and community settings, alternatives to school exclusion, coordinated support for mental health, substance misuse and neurodivergence, support for children and young people experiencing multiple disadvantage, clear links across education, health, youth justice and community services, transition arrangements into adult services where needed*
System	Phase 1	18	Develop system approaches to improve continuity of care for people experiencing frequent prison transfers. Ensure those undertaking the Recovery Unit programme remain in situ until completion, with an operational agreement that participants can complete the programme without transfer disrupting progress.	

Category	Phase	No.	Recommendation	Sub Recommendations
Data	Phase 1	19	Introduce quantified continuity-of-care indicators to monitor and measure the effectiveness of health and care pathways and transitions between community and secure settings.	
Data	Phase 1	20	Develop secure interoperable digital health and justice records.	
Data	Phase 2	21	Advocate for improved granularity in coroner reporting to identify suicide deaths with recent criminal justice contact through either a Real Time Suspected Suicide Surveillance System or through Coronial Audits.	
Data	Phase 2	22	Agree and implement a minimum shared justice health dataset and linked dashboard across youth and adult justice pathways, using ONS Harmonised Standards where applicable, to improve the routine collection, disaggregation, linkage, and analysis of local place data on health needs, inequalities, risk factors and outcomes, with data reported separately for children and young people, and for adults.	(a) Improve the collection and analysis of local data on first-time entrants to the youth justice system, including primary reasons for entry and the health and wellbeing needs, to support whole system early intervention and diversion programmes. (b) Develop access to disaggregated local data on terrorism and knife-crime related arrests involving children and young people to identify trends and inform early intervention. *This should include, as a minimum: protected characteristics and inclusion health variables; ethnicity; care experience; disability/ neurodivergence; educational attainment; deprivation; residence, locality and housing/homelessness status; nationality/migration status; alcohol and drug dependence; domestic abuse experience where appropriate; sex work experience where appropriate; type of contact with the criminal justice system; system-wide data linkage; a shared dashboard; improved local data on first-time entrants to the youth justice system including relevant primary care factors associated with first time entry where available; and disaggregated local data on terrorism-related arrests involving CYP.*

Category	Phase	No.	Recommendation	Sub Recommendations
Research	Phase 2	23	Undertake further analytical research to understand the drivers of Birmingham's higher imprisonment rate compared to the national average, including age profile, migration status, education outcomes, family structure, and other social risk factors.	
Research	Phase 2	24	Commission a programme of research into the impacts of criminal justice system involvement and imprisonment on women across the life course, including women with and without parental responsibilities, to better understand the short, medium, and long-term health, social, economic, and family impacts, and to inform gender responsive policy, commissioning, and service design.	
Research	Phase 2	25	Develop and embed lived experience co-research roles.	
Research	Phase 2	26	Commission and undertake targeted research and evaluation to address priority evidence gaps relating to neurodivergence, disability and wider inclusion health needs among people at risk of or in contact with the criminal justice system, to inform equitable service design, workforce development and investment decisions.	(a) Research where a Child First, trauma-informed and neurodivergence-aware approach across schools, youth justice, police custody and CAMHS has happened elsewhere. Find examples of best practice. *This should include, as a minimum: lived experience research with people with learning disability who have experienced the criminal justice system; research on the lived experience of people with mobility impairment who have come into contact with the criminal justice system, including disability-related harm where relevant; evaluation of the effectiveness and cost-benefit of neurodivergence-informed interventions across the criminal justice pathway; research into neurodivergence within the criminal justice workforce, including awareness, support, reasonable adjustments, training needs and inclusive workforce development.*

Category	Phase	No.	Recommendation	Sub Recommendations
Governance	Phase 1	27	Establish a Justice Health Partnership Board (or formal subgroup of Inclusion Health Partnership) to own delivery and report into HWBB / ICS / Reducing Reoffending governance.	

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