

Written evidence submitted by Dame Carol Black (TDP0028)

Dear members of the Justice Select Committee

I am the government's Independent Advisor on drugs, and in 2023 I was asked to carry out an internal, independent review of drug treatment in prisons which is enclosed.

I have tested my findings with stakeholders including providers, commissioners, the prison and probation Chief Inspectors, the Independent Monitoring Board and people with lived experience. What I have found are many systemic problems and inefficient practices that are based on legacy rather than what is fit for purpose. Whilst new policies have been introduced over the last 10 years at a national level, delivery on the ground has been far removed from the expressed ambition. Clearly, something has gone wrong in terms of oversight and accountability, and, going forwards, there needs to be clearer objectives and managed performance, both by the commissioners of treatment services and by HMPPS.

Some key things really must change. Firstly, there should be recognition that drug treatment has a unique impact on risk of reoffending. For this reason, it should be separated out from the rest of healthcare to become a specially commissioned service that aims to reduce drug-related crime, harms and deaths. There needs to be collaborative commissioning that involves the NHS, the Governor of the prison, and the local authority. Governors need to have much more of a say; their lack of vested interest is driving substance misuse down their priority list which is impacting adversely on the effectiveness of treatment.

Access to mental health support must improve. We clearly heard from prisoners that waiting lists are far too long. And they are not getting help to address the underlying trauma that leads to their substance misuse, setting them up to fail and remain in the revolving door.

Culture within prisons and probation needs to change. There is too little understanding of substance-misuse needs, and too much stigma attached to drug users. Because of this, prisons do not attach enough importance to treatment and recovery, and this leads to barriers to engagement in treatment. The current culture means that prisoners are often afraid to seek help for fear of being seen as a problem.

The risk-based culture within HMPPS is also a problem. Many of the drug-dependent cohort are categorised as medium or low risk and are deprioritised by probation with some services going undelivered. This doesn't allow for the disproportionate amount of damage done to the individual, their families and society. Inattention by probation will only result in high numbers returning to prison, putting further pressure on the overcrowded system.

There are also a number of lesser recommendations that should be quick to implement, such as carrying out joint needs assessments; linking in to local NHS Integrated Care Boards; understanding the right caseload for drug workers; greater availability of long-acting buprenorphine; standardised vetting for peer workers;

evening and weekend provision of mutual aid; a more therapeutic approach to adjudications; and expansion of the resettlement passport to include information about drug treatment appointments. These changes would make a real difference to the help and support that prisoners receive.

I welcome your inquiry and the opportunity to shine a light on the problems I have found. Both the Ministry of Justice and the Department of Health and Social Care have agreed that I can share my report with you, and, by having this internal report published as part of your evidence, I am hopeful that this will enable our stakeholders to press government to deliver on my recommendations. I would also welcome the chance to give evidence to your committee.

Yours sincerely

A handwritten signature in black ink, reading 'Carol Black'. The signature is written in a cursive style with a large, stylized 'C' and 'B'.

Professor Dame Carol Black GBE

Internal review of Drug Treatment in Prisons: Dame Carol Black – Final report

May 2024

Not for onward distribution

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Foreword

In my previous reviews on drug addiction, treatment, and recovery, I highlighted the importance of prisons. The single, largest group of people serving short-term prison sentences (around 50,000 a year) are there because of a drug addiction and the crimes they commit to fund it. Unless we succeed in making prisons places of rehabilitation, our best efforts to support people with treatment and recovery in the community will fail.



This short internal review seeks to understand the current provision of treatment and rehabilitation services in prisons, how they are funded and who is accountable. It looks at the journey from the perspective of prisoners themselves. It makes comparisons with treatment and recovery services in the community and asks whether prisoners receive continuity of care between the two.

I found many hardworking, dedicated people doing their best in a complex over-stretched system. However, there are far too many substance-dependent individuals going into prison, often on a 'hamster wheel' of frequent returns. As a result, prisons are crowded, all too often with an active drug trade operating in the secure estate, driven by the wretchedness of prison life. Added to this are many prisoners on remand, with too little support, who should be able to access the same services as convicted prisoners.

In theory, prisons should present a transformative opportunity. Prisoners have accommodation and three meals a day and are readily available for therapeutic and other meaningful activities. However, this is prevented from happening by a combination of resource constraints, burdensome data entry, lack of user-centred commissioning, and unclear accountability. There is also a fundamental workforce challenge across both substance misuse providers and His Majesty's Prison and Probation Service (HMPPS), meaning services are understaffed and staff undertrained.

Although serving many of the same people, drug treatment services are commissioned and delivered differently in prisons and the community. Treatment and recovery in the secure estate is the joint responsibility of NHS England (NHSE), their regional commissioners, the main providers, and sub-contracted drug and treatment services, working with HMPPS. In the community, these services are the responsibility of local authorities. This difference is one of the barriers to offering well organised discharge from prison and continuity of care thereafter.

This review, limited in time and depth, concludes that we need a much simpler system for commissioning drug treatment and recovery services in prison, that is both person-centred and aligned to provision in the community. Also, the release process needs to be much better streamlined and co-ordinated, with appropriate support including suitable accommodation, without which recovery will fail.

My heartfelt thanks go to Sarah Palmer and Robert Wolstenholme of the Joint Combating Drugs Unit (JCDU), without whose unfailing support and hard work this Review could not have been completed.

**Dame Carol Black,
Independent Advisor to the Government on Drugs**

Executive summary

This review concludes that substance misuse (SM) treatment and recovery in prison should be improved, by rectifying the defects outlined below, by reference to the new national outcomes' framework¹ and commissioning standards for local authorities², along with a simple co-ordinated release pathway.

Commissioning structure

Commissioning of SM services by NHS England has not been able to drive necessary improvement. Commissioners are too far removed from the delivery of substance-misuse services, and this is compounded by a lack of accountability via national standards and success measures. This means that the current service specification for SM treatment in prisons³ is not being delivered on the ground.

Including SM services within the prime provider contract for wider healthcare in prisons does not take adequate account of the special impact that drug-dependence has on wider society when offenders leave prison – in contrast to other healthcare needs affecting individuals. Successful treatment in prison will enable those released to engage better with local community services, integrate into society, and be less likely to re-offend.

The Governors I spoke to did not feel involved enough in the design or provision of SM services in their estates. This contributes to division between health and justice within prisons, and deprioritisation of treatment for drug dependence by HMPPS.

SM treatment and recovery should be separated out and directly commissioned. There are several possible models for commissioning, each requiring development work, and so I do not offer a conclusion about who ultimately should commission SM services. It should be for government departments to work together to develop options for who should commission in order to ensure collaboration between the NHS, local authorities and HMPPS. New objectives should be developed that meet the needs of all three organisations and align with cross departmental outcomes on drugs.

Transparency is needed on the amount of funding SM services are receiving nationally. Although I was provided with estimates, which suggest that the total spend in adult prisons has declined somewhat since 2010, these do not give sufficient detail of spending over time or value for money. It would be helpful if a more thorough investigation of spend were to be carried out.

Inside prison: treatment

¹ [Drugs strategy national outcomes framework - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/drugs-strategy-national-outcomes-framework)

² [Commissioning quality standard: alcohol and drug services - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services)

³ [NHS England » Service specification: Integrated Substance Misuse Treatment Service in Prisons in England](https://www.nhs.uk/england/service-specification-integrated-substance-misuse-treatment-service-in-prisons-in-england)

Prisons and the prison regime do not adequately prioritise or incentivise treatment/recovery, and the needs of prisoners with SM problems are not given sufficient consideration and attention.

Much SM staff time is used on recording data, often three times over (SystmOne healthcare, psychosocial provider's database, and the National Drug Treatment Monitoring System (NDTMS) entry tool) usually on paper first with entry later. This is done every time a provider engages with a prisoner and is repeated every time a prisoner moves between prisons, as currently data can often not be shared.

This is very wasteful of staff (and prisoner) time, potentially diverting staff from more useful psychosocial and therapeutic activities. This duplication should be eliminated forthwith. There should be a single data system (sensibly SystmOne) from which data can be extracted for various purpose including NDTMS, as currently happens in the community SM services.

Currently no agreed plan for care follows the individual when transferred to other prisons or released to community care. An individual treatment plan should be developed with each SM prisoner, to be 'owned' by the prisoner and go with them when moving between prisons or into the community.

SM prisoners need better access to mental health (MH) services and psychosocial support, and in particular support to overcome trauma – but there is often lack of time, space and appropriately-trained staff.

I heard that Narcotics Anonymous (NA) is the intervention most frequently sought by prisoners, yet there are too many barriers to volunteers entering prisons for this purpose. Additionally, there are also barriers to employing workers with lived experience, and limited peer workers available.

Incentivised Substance-Free Living wings (ISFLs) are to be welcomed, but only if implemented consistently in a national framework with a set of outcome measures.

Inside prison: culture

Prison culture stigmatises dependent drug use and deprioritises engagement with SM services. This is unlikely to change if Governors and staff do not feel a greater sense of involvement and ownership of the SM service. The culture in prisons is heavily driven by risk and perception of risk. Drug use is mainly seen as a threat to the regime rather than an opportunity to intervene. This needs to change.

The prison service regime places numerous barriers in the way of engagement in treatment. This is a terrible missed opportunity, as in the secure estate prisoners, who often do not engage when in their local community, are available 24 hours a day to be encouraged and supported to consider treatment and recovery. Engagement in prisons may be the best way to find and sustain engagement post-release, particularly in the case of opioid and crack users, whom we fail to engage sufficiently in community treatment.

The probation service pays too little attention to this cohort, in part because of the way risk is assessed. Drug-dependent offenders cause a vastly disproportionate level of harm in our communities, yet they are most often neglected by probation because of prioritisation policies adopted by a hard-pressed service. I concur with the HMIP joint thematic inspection report 'Offender Management in Custody – pre-release',⁴ that delivery of the model 'has failed'.

Patterns of drug use in prison differ from those in the community, with particular issues around Spice. There are too many illicit drugs available in prison and too many prisoners with time on their hands. Prisoners are often afraid to admit to drug use for fear of retribution from prison staff. There are not enough prison officers to escort prisoners to their appointments, and pay for entering treatment is often non-existent or lower than for other activities.

Offender Management and Release

Offender management and resettlement support provided by prisons and probation are complex and poorly co-ordinated, and thus inadequate to meet the needs of SM prisoners before or at release from prison. Inadequate provision on release drives reoffending as prisoners often leave without a coordinated treatment and recovery plan in place.

There are too many roles within HMPPS, and other service providers, each with some level of involvement in a prisoner's rehabilitation and resettlement, and co-ordination and co-operation between them is poor.

IT case-management systems between prisons and probation, as well as others, appear not talk to each other, and the different staff roles involved often do not have access to the same information on the individual prisoners they are supporting.

A single, simple and streamlined process for managing prisoners through release should be designed and implemented across the entire prison estate. This should be designed by HMPPS and incorporate the resettlement passport now being rolled out, as well as other necessary information about the person concerned.

Other challenges include there not being enough suitable accommodation available post-release, and an unmet high demand for residential rehabilitation.

Women

Lastly, drug treatment in prisons does not do enough to account for the specific needs of female offenders. I agree with the findings of the recent review of health and social care for female prisons,⁵ whose recommendations should be implemented as soon as possible and properly monitored.

⁴ [A joint thematic inspection of Offender Management in Custody – pre-release \(justiceinspectorates.gov.uk\)](https://www.justiceinspectorates.gov.uk/hmip/joint-thematic-inspection-offender-management-in-custody-pre-release/)

⁵ [A review of health and social care in women's prisons - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/reviews/a-review-of-health-and-social-care-in-women-s-prisons)

Recommendations

	Recommendation	Owner	Period
1.1	Prison-based SM services should be commissioned separately from other health services and directly with the provider. Commissioners should be directly accountable for the performance of the SM provider, and national performance indicators should be introduced.	DHSC and MoJ	Medium
1.2	Government should develop options for who commissions this separated service, and how it can be done collaboratively between the NHS, the prison, and the relevant local authority.	DHSC	Medium
1.3	Commissioners of SM services in prisons should be incorporated into the local Integrated Care Board structure and be on the local Combating Drugs Partnership.	NHSE and JCDU	Medium
1.4	NHSE, supported by OHID, should incorporate the community <i>Commissioning quality standard</i> into the national service specification.	NHSE and OHID	Medium
1.5	Needs assessments regarding SM treatment in prisons should be separated out and done jointly between NHSE, the local authority SM commissioner and HMPPS.	NHSE, OHID and HMPPS	Medium
1.6	A thorough investigation of spend should be carried out to determine changes over time and value for money.	NHSE	Medium
1.7	Objectives to reduce drug-related offending and deaths, to reduce drug use and violence in prisons, and to increase the proportion of prisoners moving towards recovery, should be developed, and jointly owned by SM commissioners and by Governors/HMPPS.	OHID and MoJ	Short
1.8	These objectives for prisons should be included in wider cross departmental work on drugs. NHSE should be included in cross departmental drugs governance structures.	JCDU	Short
2.1	Every prisoner engaging in treatment should have a tailored, integrated, personal care plan that is owned by the prisoner, travels with them throughout their journey through the prison estate, and outlines clear goals and milestones.	NHSE	Medium

2.2	Provision of evidence-based psychosocial treatments should be adequately resourced, enabled by the prison regime and readily available to all prisoners, including those on remand and serving shorter sentences, in line with their personal care plan.	NHSE and HMPPS	Medium
2.3	Long-acting buprenorphine (Buvidal) should be available in all prisons for those who meet the criteria for it and made available by local authorities on discharge in all local areas.	NHSE and OHID	Short
2.4	Provision of evidence-based psychosocial treatments should be adequately resourced, enabled by the prison regime and readily available to all prisoners, including those on remand and serving shorter sentences, in line with their personal care plan.	NHSE	Short
2.5	The 5-day and 13-week assessments should be a clinical discussion informing the personalised care plan and apply only to those on OST.	NHSE	Short
2.6	NHSE should commission their clinical healthcare data system provider to record SM treatment information on SystmOne, ensuring local data continuity and reducing duplicated data collection, and provide data extracts across the entire secure estate (with implementation support from DHSC/OHID).	NHSE (with OHID support)	Long
2.7	A maximum caseload for SM workers at each prison should be determined and the number regularly reviewed.	NHSE (with OHID support)	Short
2.8	OHID and NHSE should adjust their workforce strategy to include the prison SM workforce.	OHID and NHSE	Medium
2.9	Every prison should adopt a multi-disciplinary team approach to SM and MH, as seen at HMP Styal, with shared office space wherever possible and daily 'check-ins'.	NHSE	Short
2.10	There should be a maximum waiting time for MH services, especially for those spending only a very short time in custody. Availability and levels of access to talking therapies should be monitored and addressed.	NHSE	Medium
2.11	All SM staff should be trained and supported to identify and respond to trauma.	NHSE	Medium
2.12	A trauma-focused therapies 'phase one' programme should be piloted, delivered by	NHSE	Medium

	drug workers supervised by guiding psychologists.		
2.13	ISFLs should be available at every prison, within a national framework based on evidence, including success measures and evaluation.	MoJ/ HMPPS and NHSE	Long
2.14	Vetting should be standardised with a fully transparent decision-making process which should apply to all establishments.	HMPPS	Short
2.15	Peer and volunteer interventions should be available at evenings and weekends.	HMPPS	Short
2.16	Prisoners should be able to engage in mutual aid meetings taking place in the community virtually via laptop.	HMPPS	Medium
3.1	The risk-based approach to drug use in prisons should be more appropriately balanced with the need for a therapeutic approach. Use of KPIs and other incentives to drive this cultural change should be explored.	MoJ/ HMPPS	Short
3.2	Better HMPPS staff training on SM and trauma should be provided, and accreditation should be explored.	HMPPS	Long
3.3	Adjudications, when necessary, should seek therapeutic rather than punitive action, and there should be treatment alternatives to other regime responses to drug use.	MoJ/ HMPPS	Short
3.4	Access to health appointments should have a higher priority, and those that last less than 30 mins should still count as purposeful activity.	MoJ/ HMPPS	Short
3.5	‘Enablement’ should be properly resourced, employing more staff if necessary, and missed appointments should be recorded and staff performance managed by HMPPS via KPIs.	MoJ/ HMPPS	Long
3.6	Engagement in SM interventions should have a higher priority, and potential disincentives (such as lower pay) and blockers should be removed.	MoJ/ HMPPS	Short
3.7	Purposeful activity should be available all day.	MoJ/ HMPPS	Medium
3.8	More out-of-hours and weekend intervention should be provided.	MoJ/ HMPPS	Medium
3.9	Greater use of ‘medical holds’ should be considered, based on criteria to be developed between NHSE, OHID and HMPPS, to reduce transfers of this cohort to other prisons.	NHSE, OHID and HMPPS	Medium

3.10	Each existing prison should develop an action plan to improve therapeutic use of space (e.g. including chapels and libraries).	HMPPS	Medium
3.11	Every prisoner should have access to an in-cell laptop to access health systems and engage in virtual appointments.	HMPPS	Long
4.1	The risk definition of prisoners as categorised by MoJ should be reassessed to take proper account of the disproportionate levels of harm caused to communities and public services by dependency-driven, drug-related offending.	MoJ	Medium
4.2	Community Offender Managers (COMs) should be resourced and supported to deliver their role over the 12 weeks before release, as intended by MoJ.	MoJ	Medium
4.3	Prison staff serving as Prison Offender Managers (POMs) should be appropriately trained and supported.	HMPPS	Long
4.4	COMs should be required to meet face to face pre-release with prisoners with a SM dependency.	HMPPS	Short
4.5	There should be one HMPPS-designed simple, streamlined process for release and resettlement, supported by a single IT system accessible to the right people at the right time with no duplication of effort.	HMPPS	Medium
4.6	The 'resettlement passport', an essential part of the streamlined process, should contain all the necessary elements and be 'owned' by the probation Community Offender Manager who should be held responsible.	NHSE and HMPPS	Medium
4.7	NHSE should work with HMPPS to ensure that sharing agreements are in place with SM providers to allow information about appointments to be contained within the resettlement passport, which would take over from the current PNAP function.	HMPPS and NHSE	Long
4.8	Within the streamlined process, the SM treatment provider in the prison should be accountable for the clinical data, the personalised care plan and the individuals transfer to the community SM provider. They should liaise with the COM to ensure the care plan is delivered properly in resettlement.	HMPPS and NHSE	Long

4.9	Responsibilities of staff should be clear, understood and adhered to, and staff should have the right skill sets. Proper performance-management of these roles will be required.	NHSE and HMPPS	Medium
4.10	The role of Health and Justice Co-ordinators should be assessed to see whether they are having a positive impact on processes and outcomes.	MoJ/ HMPPS	Medium
4.11	The RECONNECT service should be reviewed to ensure that it provides a useful additional function, is understood and utilised appropriately by HMPPS and treatment providers in both the community and prison.	OHID and NHSE (with HMPPS support)	Medium
4.12	DHSC and OHID should review the provision of residential rehabilitation to prisoners who meet the criteria for it and ensure that there is sufficient availability to meet need.	OHID	Medium
5.1	The recommendations of the women's prisons health and social care review should be delivered as soon as possible, with robust monitoring of implementation.	NHSE and HMPPS	Short
5.2	Women-specific alternatives to custody should be available in all areas and promoted to the courts. Drug Rehabilitation Requirement and other Treatment Requirement provision should be linked or co-located with women's centres where available.	OHID and MoJ/ HMPPS	Long
5.3	Women-specific treatment services should be specified and developed, addressing the needs of remand prisoners and those on short sentences, as well as those on longer sentences. This should include high-quality structured psychosocial interventions which respond to complex needs and trauma.	NHSE	Medium
5.4	The recommendations of section 4 on release planning should apply equally to the female estate, paying special attention to the provision of safe accommodation.	See section 4	
5.5	Women's prisons should be prioritised for provision of laptops and access to online communication to enable engagements with community services where in-person visits are not feasible.	HMPPS	Short

Introduction

The overarching goal of this review, commissioned in June 2023 by ministers from three departments,⁶ was to review drug treatment and recovery provision in prisons in England, and to assess the current situation and ability of the service to contribute to the 2021 10-year Drugs Strategy's ambitions of reducing drug deaths, harms, crime, and use.

Throughout this report I will refer to substance misuse (SM) services. Although the review was commissioned to look at drug treatment specifically, drug treatment is not commissioned separately from alcohol. But it is the services that are available to those with a drug misuse need that I have been concerned with.

The number of prisoners is growing and exceeding safe capacity levels, and drug misuse among prisoners is much higher in comparison to the general population. Drug treatment is evidenced to have a significant impact on reducing reoffending.

The context below has informed this review:

- The estate is varied. There are 112 adult prisons in England including high secure, reception / training / resettlement, open and women's prisons.
- The prison population is increasing beyond capacity, with growth of 4% to 87,869 between March 2023 and March 2024.⁷
- Levels of need are high, with 49% of people in prison and 35% of offenders in the community having a SM problem.⁸
- The availability of drugs inside prisons is a challenge, with 14,724 drug finds in prisons in 12 months to March 2023 (although this is a decrease of 17% from the previous year).⁹
- There has been growth in recall to prison – 7,152 license recalls between October and December 2023, a 17% increase on the same quarter in 2022, placing further strain on services within a revolving door context. Many of these recalls will be for prisoners who are misusing drugs.¹⁰
- A joint MoJ and PHE study found a 43% reduction in number of people offending, and a 33% reduction in the number of offences, in the 2 years following treatment.¹¹
- 64% of prisoners on short sentences of less than 12 months have an identified drug misuse need.¹²

In particular, the review has sought to identify successes and challenges across the following key themes:

⁶ Minister for Crime and Policing (in his role as the cross-government Combating Drugs Minister), Minister for Prisons and Probation and the Minister for Public Health

⁷ Offender Management Statistics Bulletin, England and Wales [OMSQ_Q4_2023.pdf \(publishing.service.gov.uk\)](#)

⁸ [Identified needs of offenders in custody and the community from the Offender Assessment System, 30 June 2021 - GOV.UK \(www.gov.uk\)](#)

⁹ HMPPS Annual Digest 2022/23 [HMPPS Annual Digest 2022/23 \(publishing.service.gov.uk\)](#)

¹⁰ 7

¹¹ [PHE-MoJ-experimental-MoJ-publication-version.pdf \(publishing.service.gov.uk\)](#)

¹² 8

- **Commissioning of treatment services and accountability** – including spending, implementation of the SM service specification, looking at variation, and how services interact to ensure best outcomes for individuals.
- **The drug treatment and recovery support that is available** – looking at treatment options based on clinical need, and join-up with wider services, including mental health, housing and employment.
- **Incentives and barriers to engaging in treatment** – including the prison regime.
- **Continuity of care between prisons and the community** – looking at effective transfer between prisons and the community upon release, including protecting and building on personal gains for continuity of treatment and recovery
- **Workforce** – looking at capacity and capability of treatment and recovery service staff as well as HMPPS prison staff.

This review, although relatively broad in scope, was completed in a short timeframe. I have been supported throughout by a small hardworking team but was only able to visit a small number of prisons. However, these prisons, and the SM-related services they provide, were selected with guidance from colleagues across MoJ, HMPPS and NHSE to give a fair selection of prison and SM service type. Although each prison is technically different, I have been reassured by officials that the prisons I visited were representative of the whole prison estate. I also had the benefit of speaking to the Chief Inspectors of both Prisons and Probation, as well as several members of the Independent Monitoring Board, who were able to give me a broader perspective across the estate.

In addition to my onsite visits, the review has gathered national evidence and data, supplemented by consultation with stakeholders about treatment provision. Evidence gathering can be summarised as:

- **Interviews and meetings with key stakeholders** including people with lived and living experience, providers of SM and wider healthcare services, regional commissioners of prison healthcare and SM services, probation staff and prison staff, the Independent Monitoring Board, members of the Magistrates' Leadership Executive, and probation, prison and healthcare inspectorates.
- **Visiting services in prisons** HMP High Down, HMP Styal, the RECONNECT service at HMP Durham, HMP Pentonville, HMP Dovegate and HMP Birmingham.
- **Lived experience engagement** during every visit; via a Health Patient Engagement report (at Annex A) specifically commissioned for this review with the support of NHS England and provided by ABL Health; and a discussion of findings with a group of individuals with lived experience.
- **Analysis of data** provided by OHID, MoJ, NHSE regional commissioners and prison healthcare services.
- **Reviewing published reports and research** including the Patel Report¹³, HM Chief Inspector of Prisons Annual Report¹⁴, The National Women's

¹³ [Report by Professor Lord Patel of Bradford OBE \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

¹⁴ [HM Chief Inspector of Prisons annual report: 2022 to 2023 - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

Prisons Health and Social Care Review¹⁵, the National Audit Office's Mental Health in Prisons¹⁶, the drug recovery prison process evaluation¹⁷ and improving continuity of care between prison and community.¹⁸

I found that, in many cases, the national policy, ambition or specified operational framework was sound, but the operational reality on the ground bore little resemblance to what was intended. At the start of each section there is a summary of the national context, to compare with my findings, and underpin my recommendations.

Given the complexity of the systems I encountered, my proposals for change are both deep and detailed. I have endeavoured to set them out as succinctly as possible, giving conclusions and corresponding recommendations. It will be for departments to take these forward including the costing of recommendations.

¹⁵ [A review of health and social care in women's prisons - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/612222/a-review-of-health-and-social-care-in-women-s-prisons.pdf)

¹⁶ [Mental health in prisons - NAO report](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/612222/mental-health-in-prisons-nao-report.pdf)

¹⁷ [Process evaluation of the drug recovery prison at HMP Holme House - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/612222/process-evaluation-of-the-drug-recovery-prison-at-hmp-holme-house.pdf)

¹⁸ [Continuity of care between prison and the community: self-assessment tool guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/612222/continuity-of-care-between-prison-and-the-community-self-assessment-tool-guidance.pdf)

1. Commissioning and Accountability

National Position

At the beginning of the 21st century, healthcare in prisons was the responsibility of the prison service, and governors contracted in GPs and other health provision at an establishment level. In 2010 the NHS (from 2013 NHS England) became responsible for both clinical and psychosocial components of drug treatment in prisons, aiming to provide parity of service with the general population.

With this change, NHS England inherited a complex network of existing contracts with NHS trusts and third sector providers and began a process of rationalisation leading to fewer contracts. Over recent years the “prime healthcare providers” model was adopted in many regions, with one contract covering all the health services inside each prison in the region, aiming to improve integration of services.

There is a fully satisfactory NHSE National Service Specification of April 2018 setting out what should be delivered by substance-misuse services in prison (see the start of Section 2).

NDTMS collects data from services providing structured SM interventions to adults and young people in about 140 prisons and secure settings across England. Data collected includes information on the demographics and personal circumstances of people receiving treatment, as well as details of the interventions delivered and their outcomes.

Findings

Commissioning of SM services, in current practice, does not drive improvement. Much of what I saw reflected findings made in the Patel report of 2010, pre-NHS England. Service models tend to be inherited and there seems to have been little change. Opportunities have been missed, both by NHS England and HMPPS, to take stock and reassess what a good therapeutic service should deliver.

Despite the stated intention, the prime provider model has not driven integration of health services. The only real difference seems to be that services are now further removed from the regional commissioner who has less sight of the front-line service and its quality, since the final providers of services are now sub-contractors to the prime provider who commissions them.

There are no national commissioning standards, measures of successful outcomes, or means of holding SM services or commissioners to account. So, there is no performance or outcome management of the service at a national level, too much variation across the country, and the National Service Specification is not being adequately delivered on the ground.

Although NHSE Health and Justice Indicators of Performance (HJIPs) do exist, these are very limited and do not measure outcomes. For SM, HJIPs capture initial 5-day

and subsequent treatment assessments every 13 weeks. These assessments are currently formulaic rather than therapeutic, meaning that activity and measurement is more about ticking boxes than delivering outcomes. Use of HJIPs is not mandated, and HJIP data, if collected by regions, is not studied by the national team in NHSE. This means that there are no national performance indicators for SM.

Healthcare needs assessments for the prison population are infrequent and do not place enough emphasis on SM (examples I saw were very limited in content). Data collection and sharing is poor and can lead to unreliable needs assessments.

Including SM services within the prime provider contract for wider healthcare in prisons does not reflect the special impact that drug-dependence has on wider society when offenders leave prison – in contrast to other healthcare needs of individuals. Successful treatment in prison will enable those released to engage better with local community services, integrate into society and be less likely to reoffend. Measurements of the effectiveness of SM interventions in prison, on behaviour upon release into the community including reoffending, are much needed. Separate commissioning of SM services would enable this.

The Governors I spoke to did not feel involved enough in the design or provision of SM services in their prisons. This contributes to division between health and justice within prisons, and de-prioritisation within HMPPS of treatment for drug dependence.

It would be desirable to have clarity about the amount and flow of funding for SM services and related MH services in the seven regions. Some information about this was provided to me, but it arrived very late. More time is needed to assess the implications of this information. It does however put an estimate of current spend on SM services across adult prisons at £89.4m yearly, a good deal lower than the 2009/10 spend of £95.8m in the Patel report. Whilst the figures are not likely to be directly comparable, this does correspond with the findings of this review that there has been little improvement since Patel, and possibly some real term disinvestment.

Good practice

In one region, I saw how an NHSE commissioner has introduced innovative performance management of SM services, meeting weekly with the regional manager for the SM service provider and monthly with the prime provider and prison governors (who sit on procurement panels, attend contract review meetings, and receive healthcare data on which to comment). This enables close relationships, direct links, and a more flexible response to problems. For example, it was pleasing to see that the SM provider was able to make an evidence-based case direct to the commissioner for more drug workers in one prison.

As part of the whole-prison approach to tackling drugs at HMP Holme House, health and justice services work closely together, and health services are commissioned collaboratively for work in multi-disciplinary teams. This approach has been replicated across all prisons in the North-East region.

In the North-East and in Yorkshire, commissioning teams have been supported by NDTMS colleagues to use their data to understand better where continuity of care is

failing. This partnership working has improved performance management across the region and continuity of care performance has increased from 47% in March 2023 to 63% in Feb 2024.

One service provider who delivers a fully integrated MH and SM service model in 11 prisons across England has seen a range of benefits from this approach where resource pressures have been reduced, interventions are more tailored, and there can be a smoother transition between the services without need for further assessment.

Conclusions

Who and how

SM services should be commissioned separately from other health services and directly with the provider delivering the service. Steps should be taken to ensure no adverse impact on integration with other health services, or the recommendation (further down in this report) to introduce multi-disciplinary teams.

Different models could achieve this separation: either NHSE continues to commission the service directly as a specialised service; the local authority in which a prison is based commissions the service (as they do social care); or there is a co-commissioning model involving local authorities, governors and HMPPS. The important thing is to achieve collaboration between the commissioner, the prison, and the local authority. Parity with the community and alignment of services should be supported by close working with Integrated Care Boards and Combating Drugs Partnerships (ICBs and CDPs).

To support the above, the prison service specification should be updated to ensure that it incorporates OHID's [Commissioning quality standard](#) (2022)¹⁹, and aligns with community service provision.

SM needs assessments should be separated out and done jointly between the commissioner, local authority SM commissioners and HMPPS. Needs assessments should be uniformly and routinely undertaken to support every new commissioning round, using an agreed national template and in consultation with all relevant stakeholders including both prison and community-based service providers, prison governors. In addition, they should ensure meaningful involvement of service users as part of the process.

Accountability

Commissioners should be held directly accountable for the performance of providers, and there should be transparency in relation to the contract value so that NHSE can be accountable to DHSC for actual spend. NHSE should introduce national performance indicators for SM to effectively monitor outcomes.

¹⁹ <https://www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services>

To ensure commissioning adequately takes into account the need to deliver to the the same objectives as treatment in the community, and to make this relevant to prison staff, both the commissioner and HMPPS should work in partnership to develop new objectives for prisons, aimed at reducing drug-related offending and deaths; reducing drug use and violence in prisons; and increasing the proportion of prisoners moving towards recovery. Collective ownership of these objectives could be strengthened with formal agreements for shared decision-making by relevant stakeholders. NHSE and OHID should work together to develop intermediate metrics that are treatment-specific, contribute towards these overall strategic objectives and can form part of local performance management.

Funding

Transparency is needed on the amount of funding SM services are receiving nationally. Although I was provided with estimates, these do not give an idea of spending over time or value for money. It would be helpful if a more thorough investigation of spend were to be carried out.

Recommendations

- 1.1. Prison-based SM services should be commissioned separately from other health services and directly with the provider. Commissioners should be directly accountable for the performance of the SM provider, and national performance indicators should be introduced.
- 1.2. Government should develop options for who commissions this separated service, and how to promote collaboration between the NHS, the prison, and the relevant local authority.
- 1.3. Commissioners of SM services in prisons should be connected into the local ICB structure and CDPs.
- 1.4. OHID's community *Commissioning quality standard* should be incorporated into the National Service Specification.
- 1.5. Needs assessments regarding SM treatment in prisons should be separated out and done jointly between NHSE, the local authority SM commissioner and HMPPS.
- 1.6. A thorough investigation of spend should be carried out to determine changes over time and value for money.
- 1.7. Objectives to reduce drug-related offending and deaths, to reduce drug use and violence in prisons, and to increase the proportion of prisoners moving towards recovery, should be developed, and jointly owned by SM commissioners and by Governors/HMPPS.
- 1.8. These objectives for prisons should be included in wider cross departmental work on drugs. NHSE should be included in cross departmental drugs governance structures.

2. Inside Prison – Treatment

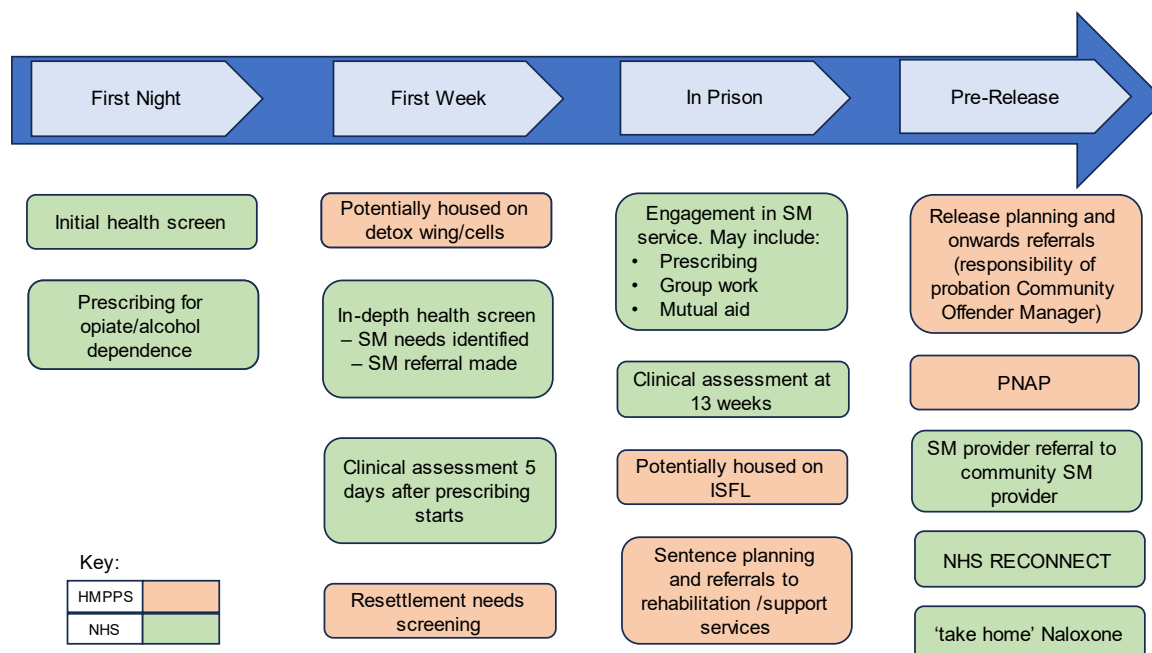
National Position

NHS England maintains a national service specification which sets out their expectations for SM services in prisons:

To provide an adequate and suitably safe service, it is crucial to integrate reception, initial assessment, and the initiation of prescribing and psychosocial interventions at entry with continuing availability of recommended evidence-based pharmacological and psychosocial treatments during further imprisonment, and with systems for the management of mental ill health, throughcare, and risk management planning that support continued service provision on release and integration back in to the community. Exactly how these elements are organised may vary but clinicians need to plan for, and contribute/share when appropriate to, all these elements to ensure 'equivalent' and proper care. It is important that clinicians do not focus unduly only on the initial period of need but on the opportunities and the risks that will face a patient with dependence across this whole pathway, including immediately after release and the transition to community services on release²⁰

This specification outlines a creditable ambition for a high quality, effective and joined up service. The additions I would like to see are incorporation of the 2022 Commissioning quality standard (recommendation 1.4) and for the service to tackle the underlying trauma that leads many to use drugs.

Fig 1. **Intended Journey of prisoner in contact with prison substance misuse service**



²⁰ NHS England Integrated Substance Misuse Treatment Service, Prisons in England (2018)
<https://www.england.nhs.uk/publication/service-specification-integrated-substance-misuse-treatment-service-prisons-in-england/>

Findings

Formulaic services

Disappointingly, the treatment I saw in prisons, what prisoners told me, and the data I looked at, bear little resemblance to the ambition outlined in the Service Specification. There is much variation in provision, with some pockets of good practice (though they are not widespread). The proportion of newly arrived prisoners who enter treatment varies markedly, from 19% in London to 42% in the North-East. Such numbers in some specific prisons are much lower than expected (HMP Wormwood Scrubs 11%) and in others much higher (HMP Birmingham 75%).

There is a lack of people, places and time to create the necessary therapeutic environment for drug users, so a great opportunity to improve people's lives is missed. Available staff time is greatly reduced by repetitive and detailed data collection. Prison can provide people with a unique moment of change. Some prisoners told me that they would never have considered treatment in the community, as they were not looking for help, but prison gives them time to reflect. This review's Patient Engagement Report²¹ (PER, see Annex A) found that prisoners *are mostly committed to change, and it is "easier" to be motivated whilst in custody.*

Little is officially known about the extent and type of drug use in a prison. In addition, services are currently tailored to cope with the numbers who go into treatment, but there is a sad lack of data on outcomes and the effect of various interventions.²² The service on offer appears to be a 'one size fits all' approach which probably pre-dates NHS commissioning. It is disappointing that not much has changed over the last 10 years. All prisoners are assessed with formulaic follow ups that do not relate to differing levels of need. There is very little personalised care. This review's PER states: *Prisoners were asked if they were involved in their care planning in regard to clinical treatments, and most stated that they were not, and that it was more a decision that was put on them, rather than something that they had an active voice in.* The report also found that *prisoners felt there was a lack of information to enable them to make informed decisions about a plan that could be continued after release.*

Records and treatment data stop and start again from scratch when someone moves to another prison, is released into the community, or returns to prison. NDTMS data shows us that only half of prisoners take up treatment within three weeks of transfer to another prison,²³ possibly an indication of the impact of this stop start approach on motivation.

This inflexible system of generic 'tick box' provision leads to poor utilisation of treatment staff time; high caseloads; and non-delivery of some services. In at least one prison, while I could see on paper that psychosocial sessions were offered and

²¹ ABL Health in partnership with Revolving Doors were commissioned to conduct patient engagement for this review across a range of secure estates to gather feedback about drug and alcohol recovery prison services.

²² For example, from data received that showed the numbers of prisoners in engaging in the different interventions within a prison, the numbers did not show individuals, and it was impossible to show 'double counting' where it is the same set of individuals engaging in everything.

²³ NDTMS data – included in Annex C

available to prisoners, the reality was that they were not held, or only infrequently held. Again, the PER (Annex B) finds the following: *Group work was discussed in all prisons, and most understood the benefits of these sessions, but felt that they were not very innovative or creative and were repetitive in each prison they went to. They talked about it feeling like a “tick box” exercise and gathering certificates rather than it making meaningful change to their life. They felt that real investment in psychosocial work may build real motivation in custodial settings and a culture of recovery, rather than a focus on clinical treatment.*

The generic approach does not provide a thoughtful personalised approach to Opioid Substitution Therapy (OST). A recent positive intervention, that could release time for both prisoner and drug-worker as well as prison officers, is long-acting injectable depot buprenorphine, but this is markedly underused, due to financial constraints and/or inadequate staff training. I have heard of some prisoners being switched on admission from long-acting buprenorphine to daily doses of a different kind of OST, or not being started on it for fear of lack of availability post-release.

Workforce

Overall, there appears to be too few drug workers and caseloads are far too high. There is no national guidance on the expected number for prisons (in contrast with the new workforce calculator that has been developed by OHID to support SM commissioning in the community), and staffing levels seem to be based on legacy services. One prison visited had 70 prisoners to one drug worker. No-one had challenged this, and the commissioner seemed unaware that it might be a problem. SM providers struggle to find enough people with the right skill set (particularly trauma-informed service provision), and struggle to retain them. This stifles innovation and leads to compassion fatigue.

In addition to the 5-day and repeated 13-week treatment assessments, much SM data for prisoners must (by mandation) be entered by staff at least twice – first into the clinical IT system (SystmOne) for all healthcare across the prison, secondly into the psychosocial provider’s own database and often thirdly (using a separate data entry tool) into NDTMS. Often forms are first filled in on paper, and the data is transferred on to the relevant databases when the caseworker is back at their office. This is done every time a provider engages with a prisoner and is repeated every time a prisoner moves between prisons. Where the provider’s case management system is different, as often happens with different SM providers, case histories and records cannot be shared when a person moves.

Mental health and trauma

Many prisoners have a history of underlying trauma which leads to and fuels their drug use. Recovery is very difficult unless such trauma is addressed. However, trauma is rarely addressed in prison – a serious missed opportunity. Typical SM psychosocial provision seen by this review does not consider past trauma.

MH and wider psychological support are often inadequate with long waiting lists and are not well connected with SM services. According to NDTMS data, most people

exiting SM treatment say they had not received any MH treatment. Some prisoners suggested that lack of access to MH treatment is a key influence on Spice use.

Incentivised Substance-Free Living units (ISFLs)

ISFLs hold considerable therapeutic potential, are well received by prisoners and staff, and provide an opportunity to take learning from successful Therapeutic Community models in other settings or jurisdictions. Although there are 80 across England (with a target of 85 by the end of 2024/25), there are not enough of them, or enough spaces within them to house everyone who would be eligible. Unfortunately, the entry criteria are inconsistent and prison specific. There is no commonly applied national framework or evaluation for ISFLs, and no agreed outcome measures.

The review's PER found that due to overcrowding in prisons, spare beds on ISFLs were often filled with prisoners who could not reside on other units due to their vulnerable status.

Peer work and Vetting

There are not enough peer-support or drug-recovery workers. Good and reliable lived-experience peer support is hampered by delays in vetting, meaning staff are lost along the way. Some Governors are slow to give permission and apply their own criteria – resulting in a 'post-code lottery'.

Voluntary and mutual aid interventions are often required to take place during the working week when volunteers may be unable to go to the prison. I also heard of instances when volunteers had arrived but been turned away as the session was unable to run due to lack of a room or HMPPS staff. This is despite the obvious value that someone who has lived experience can bring.

As part of the PER for this review, ABL Health interviewed prisoners employed as recovery peer mentors and found that they were doing really powerful work in their prisons. The ABL report also found that, when prisoners were asked about what could improve services, the most common themes included *having an increased presence of people with lived experience, for example more peer support networks, and increased access to recovery champions*.

Good practice

I saw good evidence of collaboration between MH and SM services at Styal, where office space was shared, and daily huddles held. There was also multi-disciplinary team working which included HMPPS Safer Custody teams.

I also agree with the intention of *New Models of Care* in London prisons which support a more integrated approach with multi-disciplinary teams for the different stages of care: Early Days in Custody; Planned Care Team; and Unscheduled Care Team.

At HMP Holme House dedicated multi-disciplinary teams have been set up to deliver wing-based community care. This includes SM and MH services as well as the use

of lived experience to reduce stigmatisation for those in recovery. Case consultation reviews are held with prisoners, with SM and primary MH teams in attendance. Each person who needs one is provided with a tailored assessment of need and a care plan to support their recovery.

At HMP Birmingham I saw the beginnings of a good pathway from induction wing to treatment wing, to a Drug Recovery Wing (DRW) where prisoners could work towards reduction in drug use or OST, through to an ISFL to consolidate their recovery. Officers on the DRW carry out daily one-to-one sessions with prisoners.

HMP Birmingham has a very high proportion (75%) of newly arrived prisoners entering SM services. I heard that this was partly because the same SM provider covers the arrest referral service at all custody suites across the West Midlands. Many individuals are identified at this early stage and are followed through to their arrival in prison. This shows the benefits of having one provider across the community and in prison, and of making links into prison.

The review's PER found examples of good practice at HMP Manchester where Recovery Peer Mentors were working well. They talked about how they reduced the caseload on staff by co-facilitating creative therapy groups, supporting with applications, and helping complete in-cell work. Doing this work had encouraged them to consider working in substance-misuse on release. Prisoners highlighted 'We are Survivors' a trauma-therapy programme over 20 weeks benefitting individuals with complex trauma. They talked about how tackling deep-rooted trauma can lead to building a sustainable recovery.

Conclusions

Treatment

To move towards meaningful recovery, as well as better utilisation of drug worker resource, every prisoner engaging in treatment should have a tailored, integrated, personal care plan (which includes the features set out in the clinical guidelines for SM treatment²⁴) that is owned by the prisoner, with clear goals and milestones.

The care plan must accompany the prisoner wherever they go, and care should continue as set out. Doing this would promote parity with care in the community. It is clearly wrong that prescribed medication is changed depending on the prison not the clinical need.

Psychosocial interventions should be much more readily and frequently available. NDTMS data reveals a high level of need for psychosocial treatment, but I heard of problems with delivery, some of which related to a lack of staff, and some to lack of space.

²⁴ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health https://assets.publishing.service.gov.uk/media/5a821e3340fb62305b92945/clinical_guidelines_2017.pdf

Psychosocial interventions are as crucial as clinical interventions to change lives, build recovery and maintain sustainable change, and both types of intervention should be readily available.

Assessments

Formulaic tick-box assessments should be adjusted in favour of a therapeutic approach depending on patient need or ambition. Treatment assessments should be a clinical discussion informing the personalised care plan. Everyone in treatment should have clinical assessments according to need but the specified 5 day and 13-week clinical assessments should apply only to those on OST.

Currently there is unnecessary and wasteful duplication of data entry into SystmOne the psychosocial provider's database and NDTMS, and SM providers often have incompatible case-management IT systems. A single data entry into SystmOne is required, incorporating all necessary substance-misuse data and enabling its extraction for various purposes including NDTMS. Such a single universal standard case-management and data system would considerably reduce the resource burden on SM service providers, free staff time for therapeutic activity, ensure that only one record follows a prisoner wherever they go, assist the functioning of NDTMS, and enable performance management by the commissioner.

Workforce

Staffing levels do not seem to reflect current service need and caseloads are high. A maximum caseload for SM workers at each prison should be determined, dependent upon its case mix, and be regularly reviewed. The prison SM workforce should have been included in DHSC/OHID/NHSE's workforce strategy in order to provide adequate numbers and quality of SM workers in prison.

Links with mental health provision

Every prison should adopt a multi-disciplinary team approach as seen at HMP Styal, with shared office space wherever possible and use of daily 'check-ins'.

Integrated planning of care delivery should be monitored to ensure consistent and timely availability of psychosocial support, MH and physical health. There should be maximum expected waiting times for MH services, monitored at a local and regional level. Availability and levels of access to talking therapies should also be monitored.

As part of mandatory induction and ongoing Continuing Professional Development for treatment staff in prisons, staff should be trained and supported to identify trauma, be able to respond with effective psychosocial interventions and refer to specialist MH services where appropriate.

NHSE and OHID should work together to design a pilot for a trauma-focused therapies 'phase one' programme. This should look at life events related to each person's use of drugs and incorporate this into the personal care plan. The pilot should include symptom stabilisation and working to manage uncomfortable

situations or memories without using substances. This should be delivered by drug workers under the guidance of a supervising psychologist.

ISFLs

The number of ISFLs should be increased to meet demand across the prison population at risk of misusing substances. In principle, they should not be available to people who have never had a SM problem, as separate facilities should be provided for such people.

ISFLs should have a national framework based on evidence from evaluation, and clear success measures.

Peer work and vetting

Enablement of external peer work and mutual aid must be improved, allowing the community to come in on a regular basis, including at evenings and weekends as many volunteers will need to come outside of working hours.

There should be full transparency for the vetting process and what is required of the applicant to mitigate potential delays on their side. The 'post-code' lottery should be eliminated through standardisation of the decision-making process which should apply to all establishments.

Prisoners should be able to access mutual aid like Narcotics Anonymous virtually via a laptop from prison, and every effort should be made to link to NA in the community so that prisoners have a safety net and some continuity on release.

Recommendations

Treatment

- 2.1. Every prisoner engaging in treatment should have a tailored, integrated, personal care plan that is owned by the prisoner, travels with them throughout their journey through the prison estate, and outlines clear goals and milestones.
- 2.2. Provision of evidence-based psychosocial treatments should be adequately resourced, enabled by the prison regime and readily available to all prisoners, including those on remand and serving shorter sentences, in line with their personal care plan.
- 2.3. Long-acting buprenorphine (Buvidal) should be available in all prisons for those who meet the criteria for it and made available by local authorities on discharge in all local areas.

Assessments

- 2.4. Every prisoner should be drug tested on entry as part of the reception health screen. In addition to informing the personal care plan, data from this testing

should be used to inform a SM needs assessment for the prison, and aggregated results should be shared with HMPPS as a 'diagnostic' to assess types of use and need.

- 2.5. The 5-day and 13-weeks assessments should be a clinical discussion informing the personalised care plan and apply only to those on OST.
- 2.6. NHSE should commission their clinical healthcare data system provider to record SM treatment information on SystmOne, ensuring local data continuity and reducing duplicated data collection, and provide data extracts across the entire secure estate (with implementation support from DHSC/OHID).

Workforce

- 2.7. A maximum caseload for SM workers at each prison should be determined and the number regularly reviewed.
- 2.8. DHSC and NHSE should adjust their workforce strategy to include the prison SM workforce.

Links with mental health provision

- 2.9. Every prison should adopt a multi-disciplinary team approach to SM and MH, as seen at HMP Styal, with shared office space wherever possible and daily 'check-ins'.
- 2.10. There should be a maximum waiting time for MH services, especially for those spending only a very short time in custody. Availability and levels of access to talking therapies should be monitored and addressed.
- 2.11. All SM staff should be trained and supported to identify, and respond to, trauma.
- 2.12. A trauma-focused therapies 'phase one' programme should be piloted, delivered by drug workers supervised by guiding psychologists.

ISFLs

- 2.13. ISFLs, provided they are restricted to drug dependent people only, should be available at every prison, within a national framework based on evidence, including success measures and evaluation.

Peer work and vetting

- 2.14. Vetting should be standardised, with a fully transparent decision-making process which should apply to all establishments.

- 2.15. Peer and volunteer interventions should be available at evenings and weekends.
- 2.16. Prisoners should be able to engage in mutual aid meetings taking place in the community virtually via laptop.

3. Inside Prison – Regime

National Position

The *Purposes of Prisons* White Paper of 2021²⁵ sets out the Ministry of Justice's ambition for rehabilitation and substance-misuse support in prisons:

Our prisons and prison regime must protect the public: this means holding prisoners securely whilst they serve the punishment handed down by the courts, and disrupting criminal activity from within the prison walls. Crucially they must also ensure good order and discipline; work to prevent future victims of crime by tackling the underlying causes of offending; and promote rehabilitation and reform to reduce reoffending.

This includes an ambition to ramp up work to tackle the substance misuse and mental health issues which for too many prisoners pose a barrier to rehabilitation reform by deploying the full range of treatment options, including abstinence-based treatment, to support recovery from drug dependency.

The White Paper also sets out that delivery will be informed by HMPPS' values:

- We treat prisoners fairly, safely and decently whilst they are serving their sentences of imprisonment: offering them the chance to turn their lives around whilst ensuring that prisoners who disrupt the good order and discipline of our regimes face swift and certain consequences;
- We support prisoners to address the causes of their behaviour, encouraging them to take advantage of all the opportunities available to them whilst emphasising the consequences of failure to take responsibility for their rehabilitation;
- We offer our staff rewarding careers, treating them with respect, and offering them the support they need to do their jobs safely and effectively;
- We seek out best practice and evidence of what works to inform all that we do.

The references to reducing reoffending and rehabilitation are welcome and align well with the aims and ambitions of the 2021 Drugs Strategy.

HMPPS have also developed a rehabilitation strategy which states:

Our rehabilitation strategic ambition is to reduce reoffending, protect the public and help people turn their lives around by believing people can change and working together as one agency to achieve evidence-based excellence in our approach to rehabilitation.

At a collective and an individual level, for us to be successful at reducing reoffending and protecting the public through rehabilitation, we all need to create and support the

²⁵ <https://assets.publishing.service.gov.uk/media/61af18e38fa8f5037e8ccc47/prisons-strategy-white-paper.pdf>

right environments. Environment, in this context, reflects the sum total of the surroundings people experience whilst they are with us in courts, custody or probation offices. It includes the cultures we create, the pro-social modelling we demonstrate, the attitudes we hold, the way we treat all people in our interactions, and the relational practice we adopt when working with others.

Findings

Culture

Tension exists between health and prison culture. The culture in prisons is heavily driven by risk and perception of risk, with drug use mainly seen as a threat to the regime rather than an opportunity to provide therapeutic interventions for a chronic health condition. This risk-based culture drives both policy and decision-making locally in prisons, and targets and Key Performance Indicators (KPIs) do not sufficiently prioritise engagement in substance-misuse treatment.

I heard clearly that prison stigmatises drug-dependent people and turns them away from seeking help for fear of a punitive response or being labelled as a risk, which could impact on visits or being singled out for searches. Prison Officers often lack knowledge or experience of drug dependency and trauma. Drug dependency is not empathised with, but simply seen as a problem.

Our Patient Engagement Report (PER) states that many *prisoners talked about the worry that they have about admitting to having drug or alcohol problems and the fear that they would be targeted, and it seen as a weakness. They suggested that having a culture of recovery within a prison would reduce this stigma and encourage more individuals to come forward and seek the support that they need.* Prisoners also talked about the importance of staff being trained on drug and alcohol awareness and the links between trauma and addiction. Having specialist operational staff in each prison with in-depth understanding of this topic would help build a culture of recovery supporting prisoners to leave custody drug-free and ready for their journey in the community.

Prisoners are often moved at short notice to another prison, sometimes within days of release. This impacts on continuity of care and release planning.

Barriers

The PER also found that services and programmes are frequently cancelled due to a shortage of prison staff, regime curtailment and incidents.

In most prisons treatment is not classed as purposeful activity, and often carries no, or insufficient, financial incentives. As such, a prisoner may lose out by opting for treatment rather than work or education.

There are often too few prison officers to escort prisoners to SM appointments, which are considered low priority. Attendance at appointments of less than 30 minutes in duration is not measured at all, and this may negatively impact on engagement in some treatment services.

This is exacerbated by the prison regime's nine to five, five-day working week, creating difficulties in finding time for activities to happen, given competition with other activities such as education, and the growing and ageing prison population with an increasing level of health needs.

Lack of, or inability to find, suitable therapeutic spaces often means that sessions are cancelled, and prisoners may not be keen to engage in confidential discussions in open spaces. There is little willingness to schedule use of frequently empty rooms such as libraries and chapels.

Laptops can be very effective in allowing prisoners to access treatment from their cell, as well as to 'own' their own care by requesting appointments and contacting health practitioners. But laptops are not generally available.

Lack of Purposeful Activity

Imprisonment itself may well drive drug use, even for those who have not used them before. Drugs are too readily available, which impacts on motivation to change behaviour, and use is also driven by the lack of purposeful activity by which prisoners may fill their days. The latest HMI Prisons report stated that many prisoners are spending 22 hours in their cells²⁶. Around 15% of inmates have developed a drug problem in prison.²⁷

Although many prisoners are keen to work or engage in training, regimes struggle to provide more than a half-day schedule, and workshops are often empty due to lack of resources. Prisoners vulnerable to drug use are more at risk if left unoccupied, and remand prisoners, potentially most at risk of drug use, are excluded from work and training programmes.

Good practice

One of the strategic aims of the *Drug Recovery Prison* pilot at HMP Holme House is to improve the environment and culture to make it more conducive to treatment and rehabilitation. This included work to improve the physical environment (such as houseblocks, treatment rooms, and the prison grounds). A workforce development plan included training and education for prison staff and the introduction of adjudications²⁸ promoting rehabilitation.

The culture, attitude, and knowledge of prison staff at HMP Grendon, which houses a Therapeutic Community for offenders with personality disorders, are most

²⁶ HM Chief Inspector of Prisons for England and Wales, Annual Report 2022-23

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1167739/hmip-annual-report-2022-23.pdf

²⁷ Analysis of HM Inspectorate of Prisons, annual reports for years 2013 to 2019 [The-prison-system-final-version.pdf \(reform.uk\)](#)

²⁸ Adjudications are formal disciplinary hearings held within the prison to address rule violations or misconduct by inmates. These are internal proceedings that aim to maintain order and discipline within the prison environment.

impressive. Band 4 specialist prison officers, recruited specifically for the role, are given comprehensive psychosocial training and work alongside psychologists who clinically supervise them. The Governor and the Director of Clinical Services work collaboratively to lead the SM service.

At HMP Styal every woman gets a laptop in their cell and is helped to use it. Women can receive and respond to emails from outside, arrange GP appointments and order their meals. There is also a Virtual Campus where they can access education and/or health and wellbeing support like Breaking Free Online. This has greatly encouraged prisoners to engage directly with healthcare.

Conclusions

The regime in prisons is mostly focussed on risk management, with little opportunity for development of a therapeutic approach.

Culture

Prison staff need help and support to create such a therapeutic approach towards SM prisoners, supplementing their current risk-management approach, learning from good examples such as HMPs Grendon and Holme House. Better training, preferably jointly between HMPPS and NHS staff, and accreditation should be explored, as should use of incentives and KPIs to drive behaviour change. The prison regime should recognise that drug dependency is a chronic condition and that treatment alternatives to punishment should be available. Adjudications, if necessary, should seek therapeutic rather than punitive action.

Support to engage in treatment

Access to health appointments should have a higher priority, and those that last less than 30 minutes should still count as purposeful activity. 'Enablement' (escorting prisoners to their appointments) must be properly resourced, employing more staff if necessary, missed appointments should be recorded and staff performance managed by HMPPS via KPIs.

People should not be moved between prisons without considering the impact on their treatment. Greater use of 'medical holds' should be considered, based on criteria to be developed between NHSE, OHID and HMPPS.

Purposeful activity should be available all day and engagement in SM interventions (including volunteering and peer work) should be recognised as worthwhile and prioritised alongside other top-tier activities. Potential dis-incentives and blockers (e.g. pay differentials) should be removed.

Consideration should be given to what out-of-hours or weekend provision could be accommodated. This could support mutual aid volunteers who cannot attend during normal working hours.

Place

Design of the future prison estate should ensure adequate space for one-to-ones and group interventions. Each existing prison should develop an action plan to improve therapeutic use of space (e.g. including chapels and libraries).

Greater use of laptops should be encouraged, to access health systems and hold virtual appointments, including with community providers.

RecommendationsCulture

- 3.1. The risk-based approach to drug use in prisons should be more appropriately balanced with the need for a therapeutic approach. Use of KPIs and other incentives to drive this cultural change should be explored.
- 3.2. Better HMPPS staff training on SM and trauma should be provided, and accreditation should be explored.
- 3.3. Adjudications, when necessary, should seek therapeutic rather than punitive action, and there should be treatment alternatives to other regime responses to drug use.

Support to engage in treatment

- 3.4. Access to health appointments should have a higher priority, and those that last less than 30 mins should still count as purposeful activity.
- 3.5. 'Enablement' should be properly resourced, employing more staff if necessary, and missed appointments should be recorded and staff performance managed by HMPPS via KPI.
- 3.6. Engagement in SM interventions should have a higher priority, and potential disincentives (such as lower pay) and blockers should be removed.
- 3.7. Purposeful activity should be available all day.
- 3.8. More out-of-hours and weekend intervention should be provided.
- 3.9. Greater use of 'medical holds' should be considered, based on criteria to be developed between NHSE, OHID and HMPPS, to reduce transfers of this cohort to other prisons.

Place

- 3.10. Each existing prison should develop an action plan to improve therapeutic use of space (e.g. including chapels and libraries).

- 3.11. Every prisoner should have access to an in-cell laptop to access health systems and engage in virtual appointments.

4. Offender Management and Release

National Position

Offender management is key to rehabilitation as well as keeping our communities safe. Prisoners need support to change. HMPPS have developed the Offender Management in Custody (OMiC) model²⁹ to grip and support the offender from their entry into prison through their sentence and out into the community. They state that:

Offender management lies at the heart of Her Majesty's Prison and Probation Service (HMPPS); it is central to the aims of reducing reoffending, protecting the public and preventing victims by changing lives. It is a central pillar of our work to rehabilitate and give hope to those in prison; and it remains one of the key purposes of custodial sentencing.

The way prisoners are case managed through the custodial sentence has been revised within the OMiC model. The purpose of the changes is to ensure that:

Every prisoner should have the opportunity to transform their lives by using their time in custody constructively to reduce their risk of harm and reoffending; to plan their resettlement; and to improve their prospects of becoming a safe, law-abiding and valuable member of society.

The OMiC model provides the framework to co-ordinate and sequence an individual's journey through custody and post release. The OMiC model places prisoners and the development of rehabilitation cultures in prisons at the heart of offender management processes and supports the reduction of re-offending in custody and the community, the rehabilitation culture and re-integration into the community.

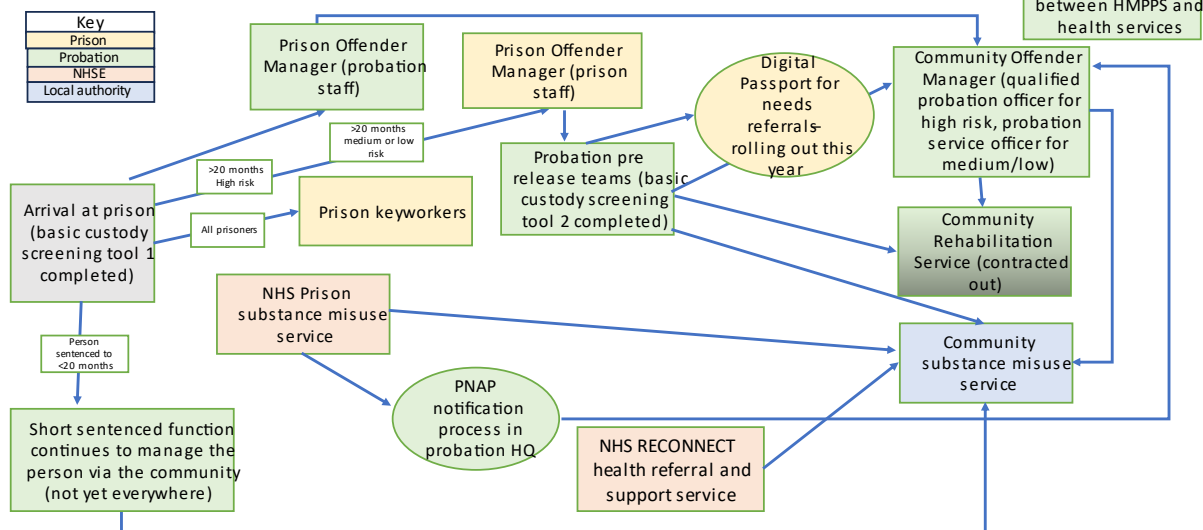
MoJ's policy intent is that from 12 weeks before release the Community Offender Manager (COM) is the responsible officer for an offender's release and transition into society.

²⁹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789926/manage-custodial-sentence-pf.pdf

Fig 2. The roles, teams and processes currently involved in the release and resettlement of prisoners in contact with prison SM services.

Release and resettlement: People and processes involved in prisoner handoffs to substance misuse treatment in the community

Release and resettlement processes are complex and disadvantage prisoners with substance misuse needs.



Findings

Offender management

The Offender Manager in Custody (OMIC) model was not seen in practice at the prisons we visited. Prisoners were unable to describe having received any discernible case-management, inside or reaching in from probation on the outside. Prisoners told us of a lack of meetings with their 'probation officer', virtual or face-to-face. I concur with the HMIP joint thematic inspection of Offender Management in Custody³⁰ that delivery of the model 'has failed'. Additionally, I feel that remand prisoners do not get adequate resettlement support.

Many of the prisoners we spoke to lacked hope for the future, because so little was happening to support their release.

Although I was informed that the probation Community Offender Manager (COM) is the person responsible for the rehabilitation and resettlement needs for all prisoners in the 12 weeks leading up to release, they were not seen to be engaging with this cohort or with their Prison Offender Manager (POM) or other HMPPS colleagues. I was told of emails and phone calls from POMs consistently going unanswered by their COM counterparts³¹.

In one prison that I visited I was told that, due to workforce pressures and high caseloads, the probation service locally had been given permission to stop delivering some of its responsibilities for medium and low risk offenders. Drug-dependent

³⁰ [A joint thematic inspection of Offender Management in Custody – pre-release \(justiceinspectorates.gov.uk\)](https://www.justiceinspectorates.gov.uk/hmip/joint-thematic-inspection-of-offender-management-in-custody-pre-release/)

³¹ HMPPS have mandated face to face handover arrangements only for long term prisoners (where there is a high risk of harm, high risk of violent recidivism or they are MAPPA eligible)

prisoners are often categorised as low to medium risk, and so suffer from this reduced delivery of services, although this categorisation does not properly reflect the collective harm they cause to society or their impact on public services. Access to HMPPS' Attitudes Thinking and Behaviour programmes was being prioritised by risk rather than need which seems to reduce the opportunity to reach those offenders who would most benefit.

Roles and Responsibilities

Within HMPPS and other service providers there are too many roles, each with some level of involvement in a prisoner's rehabilitation and resettlement. Many people I spoke to struggled to articulate what the different roles were for, or how and why they should work together. Many complete similar assessments using similar forms, with little evidence of outcome or impact.

IT case-management systems for prisons and probation (and therefore POMs and COMs as well as others) appear not to talk to each other, so that the staff involved do not have access to the same information on the individual prisoners they are supporting.

Probation-staffed pre-release teams should support COMs with needs assessments, referrals to community services, and the new 'resettlement passports', but no-one I spoke to seemed familiar with these teams who have not been linked into the SM treatment services responsible for making onwards treatment referrals.

Offender management within prisons has been split in two; a legacy of *Transforming Rehabilitation: a revolution in the way we manage offenders*³². High risk prisoners are managed by probation staff (POMs), whilst medium and low risk prisoners are managed by prison staff who tend to lack skills and experience in rehabilitation. Retention of staff in the probation-officer roles can be a problem.

HMPPS and NHSE have worked together to develop the Prisoner Notification and Actioning Project (PNAP - where the prison SM provider passes on treatment referrals to HMPPS HQ who forward them to the COM). But how can PNAP be effective if COMs are not adequately managing this cohort? As one person put it, "*the PNAP email may arrive in an overfull inbox, relating to a deprioritised offender, and never be opened*".

Release

Although there is some good practice, too often there is little or no communication between prison and community treatment services about the individual. Even where information is shared there is no shared care plan. There is widespread lack of suitable accommodation post-release – a crucial reason for return to prison. At two of the prisons I visited some prisoners had been provided with tents and sleeping bags.

³² [Transforming rehabilitation: a revolution in the way we manage offenders - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/transforming-rehabilitation-a-revolution-in-the-way-we-manage-offenders)

There are many third-sector services involved but little or no co-ordination between them inside or outside, no clear lead, and a lack of input from probation pre-release. I am unclear how the well-intentioned new Health and Justice Co-ordinators will improve the safety, efficiency, and quality of the release process.

There was much support for the concept of RECONNECT, an NHSE service developed to contact prisoners pre-release; help with onwards health referrals; and provide support and peer worker availability post-release. However, there was little awareness of this RECONNECT offer, even within prison SM services. The numbers engaging in RECONNECT are disappointing, considering the time and funding already expended.

There is a post-code lottery on placement into residential rehabilitation in the community. Some residential rehabilitation beds stand empty, and some prisoners are refused access, or told to wait for six months to see if they can first maintain recovery in the community.

Stigma/culture barriers

In some areas there appears to be a 'cultural barrier' for some community SM providers against accepting people referred from the Criminal Justice System. So, it can be difficult for released prisoners to access the care they need.

I also found little evidence of a (much needed) connection between the external community (LAs, ICBs, CDPs etc) and the secure estate.

Good practice

At HMP Holme House a Connecting Communities team was set up to provide support to prisoners on release from prison to help the transition process from custody to community, both before and after release. This has included helping prisoners to arrange and attend appointments and treatment, and mapping community support provision in release areas. This process has now been expanded to all prisons in the North-East region.

The national target for continuity of care, where people released from prison with an SM treatment need are referred to and subsequently engage with a community treatment provider, is 75%. National figures have been steadily increasing towards this, and have now reached 53%, but there are considerable regional variations.

Conclusions

Offender Management

MoJ's policy intent is that from 12 weeks before release the Community Offender Manager (COM) is the responsible officer for an offender's release and transition into society. However, in reality COMs are too stretched, and other cohorts have been prioritised over drug-dependent prisoners, who often lack offender management oversight and support both pre- and post- release.

In all likelihood this contributes to the high re-offending rates seen in this group.

The government's ambition to reduce drug-related crime and drug-related harm is unlikely to be well served by defining drug-dependent prisoners as of only medium or low risk. The way risk is defined overall should be reassessed.

Given the high levels of complexity in this drug-dependent cohort, COMs should be required to meet these prisoners face-to-face pre-release – better use of existing space could support and facilitate this.

Roles and Responsibilities

It would be a great improvement if there were a single simple streamlined process for release, supported by IT systems accessible to the right people at the right time without duplication of role or effort. Responsibilities of staff must be clear, understood and adhered to, and staff should have the right skill sets. Proper performance management of these roles will be required to ensure full delivery of HMPPS's national aspirations.

The new resettlement passport currently being rolled out brings together all referrals and appointments into one place and should be a more suitable vehicle than PNAP. NHSE and HMPPS should work together to ensure that sharing agreements are in place with prison providers to allow all information about appointments to be contained within the resettlement passport.

Release/resettlement

This streamlined process for resettlement should incorporate a number of elements including the sentence plan; information about SM and the personalised care plan (including details of onwards appointments); recovery, rehabilitation, housing, bank account etc. Information about SM appointments should also be contained within the resettlement passport and be 'owned' by the probation Community Offender Manager who should be held responsible.

The SM treatment provider in the prison should be accountable for the clinical data and personal care plan and their transfer to the community SM provider, as well as liaising with the COM to ensure a shared understanding of the needs of the person being released.

This short review is unclear as to the impact of Health and Justice Co-ordinators or the added value of the RECONNECT service.

Recommendations

Offender Management

- 4.1. The risk definition of prisoners as categorised by MoJ should be reassessed to take proper account of the disproportionate levels of harm caused to communities and public services by dependency-driven, drug-related offending.

- 4.2. COMs should be resourced and supported to deliver their role over the 12 weeks before release, as intended by MoJ.
- 4.3. Prison staff serving as POMs should be appropriately trained and supported.
- 4.4. COMs should be required to meet face-to-face pre-release with prisoners with a SM dependency.

Release and resettlement

- 4.5. There should be one HMPPS-designed simple streamlined process for release and resettlement, supported by a single IT system accessible to the right people at the right time with no duplication of effort.
- 4.6. The 'resettlement passport', an essential part of the streamlined process, should contain all the necessary elements and be 'owned' by the probation Community Offender Manager who should be held responsible.
- 4.7. NHSE should work with HMPPS to ensure that info sharing agreements are in place with SM providers to allow information about appointments to be contained within the resettlement passport, which would take over from the current PNAP function.
- 4.8. Within the streamlined process, the SM treatment provider in the prison should be accountable for the clinical data, the personalised care plan and their transfer to the community SM provider. They should also liaise with the COM to ensure the care plan is delivered properly in resettlement.
- 4.9. Responsibilities of staff should be clear, understood and adhered to, and staff should have the right skill sets. Proper performance-management of these roles will be required.
- 4.10. The role of Health and Justice Co-ordinators should be assessed to see whether they are having a positive impact on processes and outcomes.
- 4.11. The RECONNECT service should be reviewed to ensure that it provides a useful additional function, is understood and utilised appropriately by HMPPS and treatment providers in both the community and prison.
- 4.12. DHSC and OHID should review the provision of residential rehabilitation to prisoners who meet the criteria for it and ensure that there is sufficient availability to meet need.

5. Women

National Position

The Female Offender Strategy³³ outlines a commitment to earlier intervention and improved community sentences, reducing the number of women going to prison, and making custody more effective.

Findings and Conclusions

I agree with the findings of the women's prisons health and social care review³⁴ and endorse its recommendations, which I would like to see delivered as soon as possible.

Alternatives to custody including community sentences with Drug Rehabilitation or Alcohol Treatment Requirements may be more appropriate for many women, especially where short sentences disrupt treatment, childcare, accommodation etc.

Although the NHSE service specification for SM treatment acknowledges the specific needs of women in prison, in practice the delivery of treatment and recovery is generic and is not designed to meet women's specific needs.

Some women prisoners stated that they felt safer in prison than in the community (including probation accommodation).

Women prisoners have reduced opportunities to access community-based treatment services in their local area because the small number of establishments in the female estate mean they are more geographically dispersed. This also makes both official and family visits more difficult. This works against effective release planning and continuity of care.

Good practice

In one prison the women were keen to have certificates to mark milestones such as negative drug tests that could be used when applying for Release on Temporary License (ROTL) or to share with their families.

I saw a part-business part-charity which provided employment for 20 women working 8 hours a day 4 days a week. These women also got support with housing, MH and SM, and also ROTL.

³³ [Female Offender Strategy - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61442/fos.pdf)

³⁴ [A review of health and social care in women's prisons - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61442/fos.pdf)

Recommendations

- 5.1. The recommendations of the women's prisons health and social care review should be delivered as soon as possible, with robust monitoring of implementation.
- 5.2. Women-specific alternatives to custody should be available in all areas and promoted to the courts. Drug Rehabilitation Requirement and other Treatment Requirement provision should be linked or co-located with women's centres where available.
- 5.3. Women-specific treatment services should be specified and developed, addressing the needs of remand prisoners and those on short sentences, as well as those on longer sentences. This should include high-quality structured psychosocial interventions which respond to complex needs and trauma.
- 5.4. The recommendations of section 4 on release planning should apply equally to the female estate, paying special attention to the provision of safe accommodation.
- 5.5. Women's prisons should be prioritised for provision of laptops and access to online communication, to enable engagements with community services where in-person visits are not feasible.

Annex A – Prisoner engagement report commissioned for this review



Drug and Alcohol Recovery Service Review

ABL Health

Rebecca Fecitt

December 2023

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Executive Summary

ABL Health have been commissioned in partnership with Revolving Doors to conduct patient engagement across a range of secure estates to gather feedback about drug and alcohol recovery prison services.

The prisoners residing in these establishments have been engaged with via 1:1 interviews, informal 'outreach' and focus groups. Their feedback is anonymised and written in the report below comprising of their thoughts on services and suggestions and recommendations for improvement.

This report details feedback from prisoners regarding drug and alcohol recovery services within custodial settings, but also looks at service users who have engaged in community services.

The engagement took place over 5 days, 93 prisoners were interviewed by The ABL Health Patient Engagement Team across; HMP Preston, a local reception prison, HMP Manchester, a CAT B prison part of the High Security Estate. Interviews also took place at HMP Holme House, a dedicated recovery prison, and HMP Kirkham, an open prison. In addition to this, prisoners at HMP Newhall, a female prison were also engaged with.

Prisoners were engaged with who had previously worked with drug and alcohol recovery services, some who were currently working with services and ABL Health also engaged with prisoners who did not have any drug and alcohol support needs to gain feedback regarding how drug use is perceived in custody and what their understanding is of services and drug use in prison.

Prisoners were asked about previous experience of services, services available in their prison, barriers to accessing treatment and they were also asked about the most impactful interventions they had received and release planning. Some of the most common themes feedback included

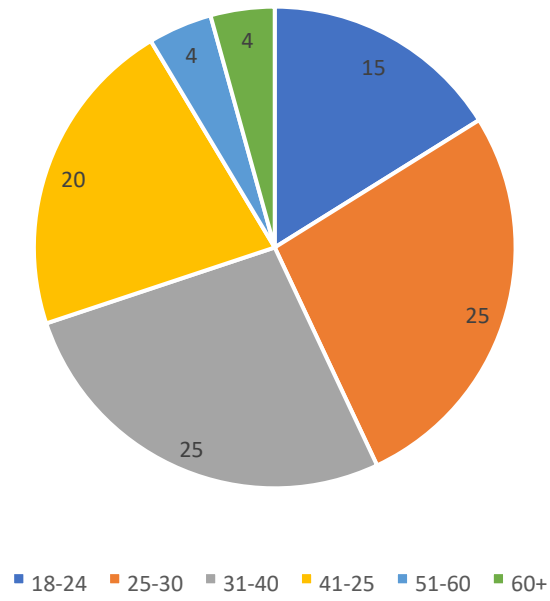
- Access to clinical treatment including Buvidal
- Importance of psychosocial interventions
- Peer Support programmes
- Staff training
- Drug supply reduction

Throughout this report the individuals interviewed will be referred to as "prisoners".

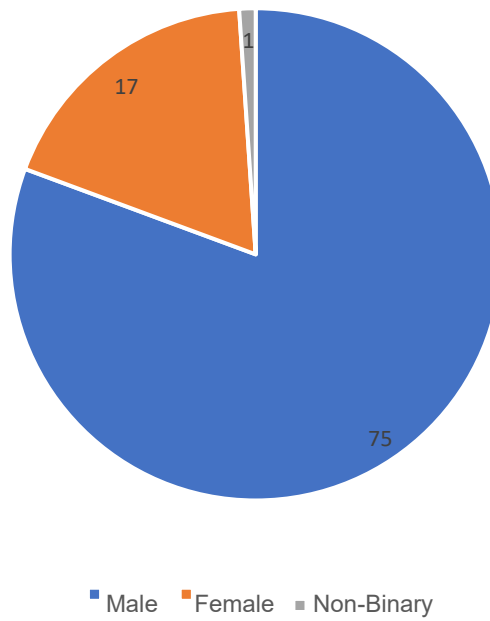
Demographics

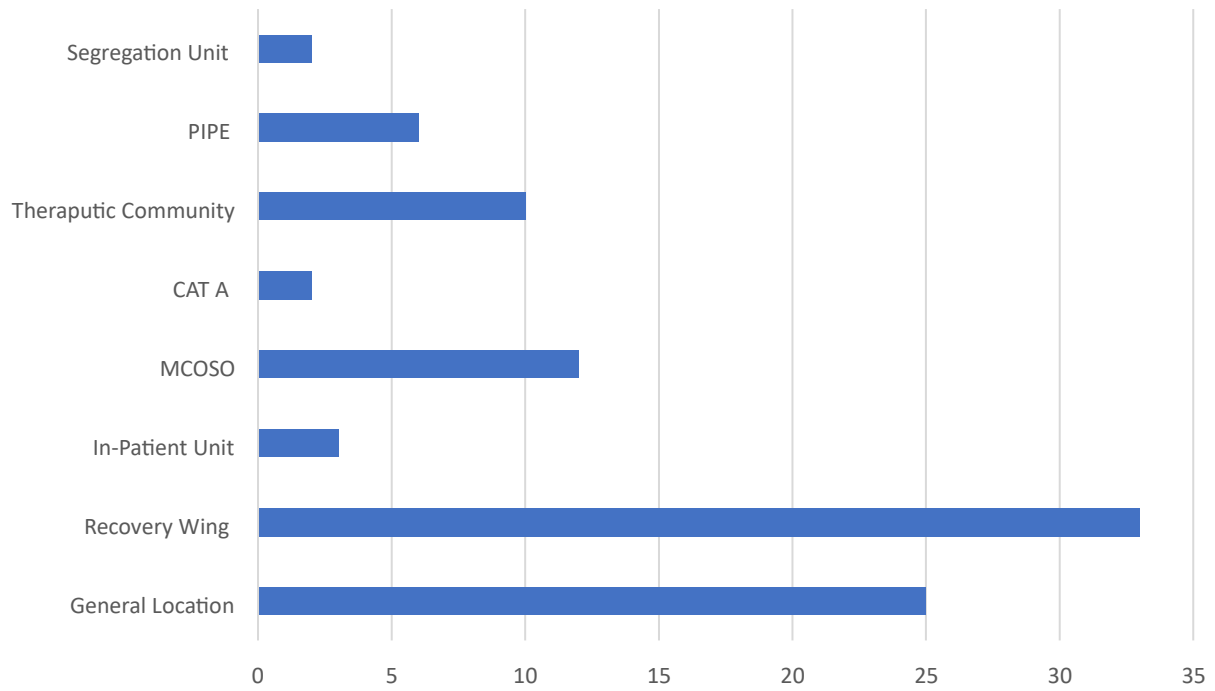
During the engagement, ABL Health engaged with prisoners across a range of characteristics. The graphs below highlight the information found across the establishments.

Age Range

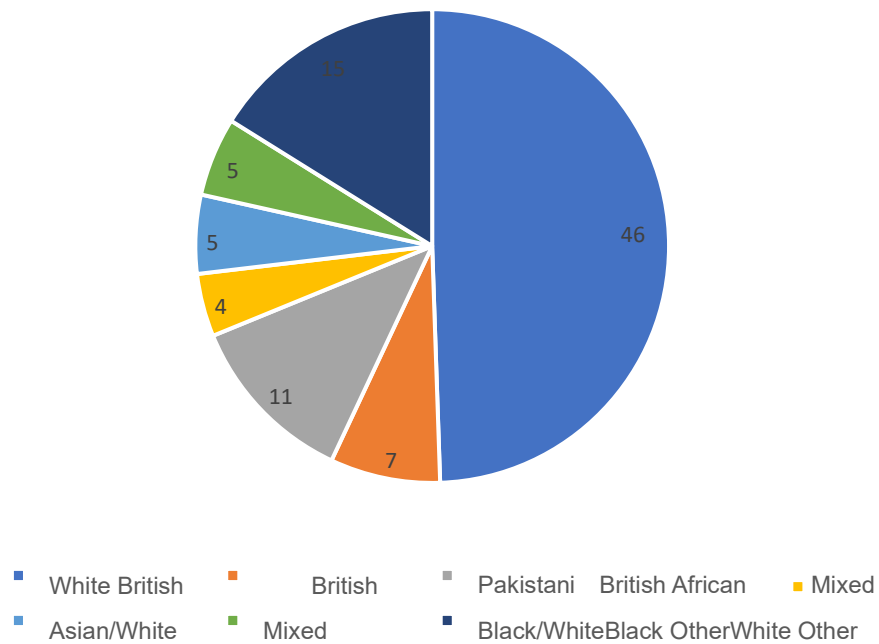


Gender





Ethnicity



Themes across the engagement

This section of the report highlights the key themes that were concurrent across all of the prisons that ABL Health engaged with.

Access to treatment prior to custody

The prisoners were asked about their previous experience of recovery services prior to their current custodial sentence. Most reported being signposted to community services but this followed a previous prison sentence, and many said they struggled to engage with community services when they were in the midst of their addictions due to their chaotic lifestyle.

For those who did engage with services, most reported mainly accessing clinical services with mandatory psychosocial intervention to continue clinical treatment, but most reported this being 1:1 sessions with a key worker to satisfy the requirement. Experience with group work in the community was limited and was mainly linked to mutual aid sessions such as AA, NA or CA.

The prisoners who had been to formal rehabilitation or community detox programmes spoke highly of these interventions, and spoke fondly of this period of time in their lives, being full of hope and motivation. These individuals spoke about the support they received being holistic, and wrap around care, utilising clinical interventions with psychological support and looking into the trauma of their past that has led them into addiction. This was a common theme of those engaged with who had made significant progress, highlighting the importance and power of recognising and treating trauma, the “cause” of their addiction, allowing them to manage the “symptoms” in a more thorough way.

When asked about their expectations of custody in regards to drug and alcohol recovery services, most stated that they expected to be able to continue any clinical prescriptions such as Opiate Substitute Therapy, and any other medications that they have been prescribed in the community. They also talked about expecting access to key work support, having someone that they can confide in, talk to about their plans and help them plan for release. Many talked about their expectation of accessing counselling, talking therapies, and highlighted that they expected being seen on a more intensive basis due to their location, and not having the outside world to compete with.

Services available in custody

Prisoners were asked about the services that they can access in custody and their perceptions of these services. Firstly, those engaging with clinical interventions reported having access to methadone, limited access to Buprenorphine and Buvidal, and there being eligibility criteria for being on these treatments.

Prisoners were asked if they were involved in their care planning in regards to clinical treatments, and most stated that they were not, and that it was more a decision that was put on them, rather than something that they had an active voice in. Those who had reported to being involved stated that this was due to them being motivated to detox and requesting changes to their prescription, rather than them being approached or suggested that this might be something they could do.

There was a general consensus regarding medication in custody that it was something that service users did not have any accountability over, and it was a process that throughout their custodial experience was done to them without education or knowledge

being provided for them to make informed decisions, which they could continue to do in the community.

Many prisoners commented on the new injectable treatment of Buvidal and the positive impact that this had on their lives. They talked about the stigma and challenges that come with collecting their Methadone prescription, the derogative comments made by staff members when they collect it and for some the pressure to conceal it to give to others. They stated that the Buvidal injection reduced the time spent in queues for medication, and allowed them to attend daily activities that clashed with medication times. There were some “rumors” around Buvidal, and due to how new it is, some were talking about withdrawal and other symptoms that meant that they were hesitant to switch over to it and suggested more awareness and information provided to service users to provide answers to FAQs, and myth busting.

When asked about naloxone, there was a general awareness and recognition of the name of the treatment, but limited awareness of what it is, how it is used and what it is used for. When ABL Health staff informed prisoners about its uses, many more said they did know of it, but not what it is called. There was an overall general positive perception of Naloxone and all understood it’s positive implications.

When asked about psychosocial services available in custody, the following was listed as available across most of the prisons; 1:1 sessions with a key worker, in-cell workbooks, group work, peer worker programmes and mindfulness activities such as yoga and meditation.

When asked about the importance of this work, it was a common theme that they found when done properly, psychosocial interventions have as much power as clinical interventions to change lives, build recovery and maintain sustainable change.

Prisoners stated the most powerful interventions with their keyworkers involved learning about tools to combat cravings, urges, and looking at ways to challenge negative thinking patterns. Some of the most powerful stories were from prisoners who had opened up for the first time with their key worker about past trauma and the impact that this had on their lives and how it fed into their addiction. Many talked about abuse, violence and mental health issues that they had suffered throughout their lives which had prevented them from being able to maintain a pro-social life and avoid addiction and criminality. Some of the good practice highlighted regarding 1:1 sessions was regarding working in partnership with their recovery worker, mental health, OMU and other departments in the prison. They talked about all departments having a shared responsibility and goal to work together to support the individual rather than all having competing interests.

Group work was discussed in all prisons, and most understood the benefits of these sessions, but felt that they were not very innovative or creative and were repetitive in each prison they went to. They talked about it feeling like a “tick box” exercise and gathering certificates rather than it making meaningful change to their life. They felt that real investment in psychosocial work may build real motivation in custodial settings and a culture of recovery, rather than a focus on clinical treatment.

The power of peer mentorship and recovery champions was highlighted in most of the prisons, with service users talking about the importance of seeing someone “walk the walk” and knowing that they have been in their shoes and understand the barriers and challenges that they will have faced. ABL Health interviewed recovery peer mentors

across each prison where employed, and found that real powerful work was being done in these pockets. They talked about providing support to the wings they were on and Prison Officers turning to them for advice and guidance when handling complex prisoners. They said that although they felt valued, they would benefit from structured supervision and support as they took on so much.

Exercise programmes was important to most of the prisoners, with them talking about the benefits of exercise in recovery, and the ways in which they use exercise as a distraction and a form of therapy. In some of the prisons, they had recognised recovery gym sessions which had previously been running which discussed how exercise can be used in their journey, as well as providing additional gym sessions which was a massive incentive for joining the programme.

Barriers to access services

When asked what the barriers to accessing services were, prisoners listed a host of reasons. Stigma and embarrassment being highlighted across all of the establishments. Many talked about the worry that they have about admitting to having drug or alcohol problems and the fear that they would be targeted and it seen as a weakness. They suggested that having a culture of recovery within a prison would reduce this stigma and encourage more individuals to come forward and seek the support that they need.

One of the biggest barriers to accessing treatment was the regime of the prisons. All prisoners talked about the frustrations that they faced when trying to have structure and purpose to their day which consisted of working with recovery services to attend groups, do exercise, attend appointments, but the constant change to the regime meant that these things are often cancelled leading to boredom and “overthinking” which they felt was unhelpful in their recovery. There was frequent talk about the changes to the regime and how drug and alcohol recovery services are trying to offer a range of services and programmes but are constantly blocked by the prison due to short staffing, regime curtailment and incidents leading to sessions being shortened or cancelled.

In the prisons where there was a recovery wing or Incentivised Substance Free Living units, prisoners talked about the residents of those units and the challenges that those units face. It was a common theme that due to overcrowding if these units have spare beds, they are filled with prisoners who cannot reside on other units due to their vulnerable status, being in debt or being complex. They stated that these prisoners often are drug users, or due to their debt may sell drugs. They talked about the implications that this can have in a recovery community and when drugs get brought onto these settings this can have fatal consequences. A common theme was the essential need for a prison wide commitment to ensuring that those in recovery have a safe space to maintain their sobriety, build recovery capital and be in an environment that enables them to make positive changes.

Linking in with this, the availability of substances within custodial settings was highlighted as a barrier to accessing recovery services. When asked what the most common substances used in custody were they stated that “spice” was the most common, but stated that any substance that an individual could want is accessible. They also talked about the increase in prisoners brewing their own alcohol. When asked what they thought were the main reasons that prisoners used “spice” they stated;

- Boredom

- Availability
- Price (the average costing just £5 compared to costing £50 12 months ago)
- Not being able to get Mental Health treatment
- Wanting to “escape”
- Lack of purposeful activity
- Not understanding what it is, presuming that it is cannabis.

When asked what could be done to reduce this, they stated more access to purposeful activity, the prison committing to training staff about drugs, more access to psychological therapies, and reducing lockdowns.

In addition to the above, other barriers included; long waiting times to access services, lack of advertising, lack of awareness and decreased visibility of recovery staff on the wings.

Potential improvements to services

The prisoners were asked about what could improve services, the most common themes included having an increased presence of people with lived experience, for example more peer support networks, increased access to recovery champions.

They also talked about the importance for staff to be trained on drug and alcohol awareness as well as what might lead to someone being in recovery and the links between trauma and addiction. They felt that having specialist operational staff in each prison with a more in-depth understanding of this topic, this would make a start building a culture of recovery and a commitment to supporting prisoners leave custody drug free and ready for their journey in the community.

The most common feedback was related to psychosocial support and as mentioned throughout the report, the need for a financial commitment to developing more innovative and interesting psychosocial interventions to go hand in hand with clinical treatments to encourage sustainable lasting change.

Release Planning

When asked about release planning, there was limited feedback. Prisoners talked about the lack of prison wide planning for release, and individuals within departments supporting release, but this not being part of a wider strategy which they felt was important in recovery.

The most common theme was that there was only basic information provided on release, for example address of local services, address of pharmacy for collection of prescription, and mainly focused around signposting. When asked how this could be improved, they talked about community workers visiting more complex prisoners before they are released to build rapport and encourage the individual to engage with community services.

Many of the prisoners talked about the challenges of being in the community and how whilst they are in prison they are mostly committed to change and its “easier” to be motivated whilst in custody. They stated that when they are in the community they have conflicting appointments, for example with probation, family commitments, trying to balance all of the challenges that they face and thus they can eventually drop out of services.

Some talked about working with recovery services to be released to a rehab or a recovery housing. They stated that these are an ideal situation, but there are not always spaces available which can lead to stress and disappointment. They suggested that more awareness and linking in with recovery housing providers within prisons could improve awareness of what is available in the community and encourage individuals to begin planning for their future throughout their sentence.

Prison Specific Feedback

This part of the report highlights some of the feedback specific to each prison highlighting any key themes relevant to this topic.

HMP Preston

As a busy local reception prison, those engaging at HMP Preston acknowledged the quick turnover of prisoners residing at the establishment. When asked what services were available, they talked with confidence about clinical treatments such as Methadone, and also talked in detail about detox programmes available and some reported going through a reduction or detox which they found to be beneficial.

The prisoners were aware of the services available within HMP Preston and talked about their 1:1 key worker sessions with their recovery worker where they looked at their personal goals, looked at their past traumas and supporting them to be released into the community.

They stated that one of the challenges they face is the regular change of key workers and not having time to build rapport and a strong working relationship with their worker before they either leave or move to other clients. They felt that consistency is really important in recovery. They felt that waiting times were longer than expected, and understood the challenges that staff face in their role, and felt that more resources could be put into peer support to reduce some of the waiting times and workloads of this team and this prison whilst continuing to support clients.

HMP Manchester

As part of the High Security Estate, and also a long term prison, the individuals residing in HMP Manchester felt that they did have a unique offer within HMP Manchester, and talked about the innovative resources that they could access, especially on G wing, the designated recovery wing. They talked about the Acorn programmes such as RAMP (Reduction and Motivation Programme) ran by someone with lived experience from the community, but did mention that the current regime did not allow for this to run the way it was designed and made reference to the challenging regime throughout the engagement.

Prisoners on the recovery wing talked about their excitement of the new recovery wing opening in the coming months, where prisoners would have to apply and have specific criteria of being selected to be on the unit, and the programmes that would be available to them. They did mention their anxieties about this running in the prison and their fears that the regime and the current issues they have with vulnerable individuals being placed on the unit, but hoped it would be a positive change which they were excited about.

Recovery Peer Mentors were working well in HMP Manchester, and were interviewed by the ABL team. They talked about how they are able to reduce some of the caseload of the staff by co-facilitating groups such as creative therapy, and supporting with applications, and helping complete in-cell work. They felt that his programme was an example of good practice and it had encouraged them to look into working in this industry on release.

In addition to 1:1 work and group sessions, some prisoners highlighted 'We are Survivors' a trauma therapy that runs in the prison over 20 weeks and the benefits that this has had on individuals with complex trauma. They talked about how tackling deep rooted trauma can lead to building a sustainable recovery.

HMP Holme House

As a dedicated recovery prison, a large number of prisoners were engaged with to gather feedback about how the recovery prison was working, what it involved and any evidence of good practice that could be shared in this report.

On the TC Unit the prisoners were very complimentary of the support and interventions available which included peer support from Peer Facilitators, courses, Groups, Holistic therapies, in cell workbooks etc. There was mention of the courses available with several prisoners talking about the psychology and counseling courses which are enabling prisoners with qualifications which are transferable to the community. Other courses included the Life Maps which could be completed twice a week for 6 months or once a week for 12 months.

They reported to having Groups run on Monday, Tuesday, Wednesday and Thursday and consist of seven different groups. They include Mood management, Physical groups, behavioral, cognitive, Triggers, Cravings and Urges, Recovery, Relapse prevention and Joharis Window to name a few. Joharis Window was singled out by several prisoners as a great self-reflection tool which helped them identify previously unknown triggers for them.

Holistic therapies such as; Thai chi, Acupressure/Acupuncture, relaxation techniques are available and run regularly on the TC unit and were described as very helpful and a great distraction. Yoga is available every morning through the TV in cell.

Peer mentors and Facilitators were mentioned as great avenues of group support or 1:1 if preferred, where they listen, advise, refer, and signpost those in need. They also introduce themselves to prisoners new to the TC unit and make them aware of all the help and support available for them. The Peer Facilitator also takes/leads group sessions with a member of DART staff present for support.

Prisoners on the PIPE unit mentioned DRP Drug Rehabilitation Programme which they said is excellent and very helpful in their recovery. They also mentioned the exclusive specialist Prison staff on the PIPE are very supportive, approachable and excellent and felt that this expertise is essential in building a culture of recovery.

Clinical treatment was reported as mostly Methadone, they stated that Buvidal is available when the prisoners have been stable on 30mg Methadone for 6-8 weeks. There were delays in these times reported by several prisoners who said that they have been recommended Buvidal yet they claim to have been stable on 30mg methadone for over 12 weeks without any indication of being switched to Buvidal.

HMP Kirkham

As an open prison, the prisoners spoken to in HMP Kirkham talked of the hesitation in working with recovery services due to the fear around being moved back to closed conditions. Nonetheless, the prisoners talked about the innovative support that HMP Kirkham recovery team provides and the positive reputation that they have.

Prisoners were pleased with the 1:1 support available and also the group work that is on offer to prisoners such as yoga, craft groups, nature walks, meditation and also access to mutual aid SMART. They understood that the open conditions of the prison enabled this to occur, but stated that they felt HMP Kirkham had a community of recovery embedded amongst it, which encouraged prisoners to be involved.

They talked of lived experience and being able to talk about their opinions through 'Recovery Voice' which is held on a Friday afternoon and service users are invited to look at potential changes to the service and to air any suggestions or problems.

There was a lot of talk about the changes to the prison with current overcrowding and the increased number of more complex prisoners being transferred to open conditions and still involved in drug use and organised crime. They talked about the struggles that this can bring to a recovery focused community and the temptation that this can bring upon prisoners who are in recovery. They felt that HMP Kirkham was an example of a really good recovery service and mostly a safe place for people trying to keep away from drugs and alcohol.

HMP Newhall

As a female prison, HMP Newhall prisoners talked about the overall positive perspective of recovery services within the prison. They talked about ease of access to clinical services such as Buvidal, and methadone for those with opiate requirements.

Regarding psychosocial interventions, prisoners reported group work being available and advertised within the prison such as; NA, AA, CA. They stated that mutual aid sessions were able to be ran consistently and discussed the 1:1 key work sessions with recovery workers where they looked at their triggers for using substances, healthy coping strategies and some talked about some of the more family orientated motivations that they had for becoming drug free, for example being able to look after their children on release and to appease social services.

Those residing on the Incentivised Substance Free Living units talked about the access to more specific groups, and the peer support programme that is currently being developed and the acupuncture holistic treatment that is starting in the coming months.

The prisoners at HMP Newhall talked about a generic approach to recovery within HMP Newhall, and female specific groups would be beneficial looking at the unique needs of women and the challenges that they face in recovery.

Conclusion

In conclusion, prisoners talked about the services that are available within their establishments and the need for a multi-disciplinary approach to supporting those in

recovery and building a prison wide culture of recovery, building systemic change in the sites, rather than individuals taking on additional responsibilities that are not sustainable through staff and regime changes.

Hope for a better future was the theme of the engagement from the prisoners across all of the sites, wanting to be drug free, understanding that there was a future without addiction and when staff talked with prisoners about their ambitions and goals it was filled with positivity and a desire to make change that would lead to them living a pro-social life free from crime and addiction.

ABL Health would like to thank all of the Governing Governors, staff members and the service users who enabled this work to take place.

Annex B – Glossary

ABL Health – A Better Life Health are a lived experience focused service who were commissioned in partnership with the Revolving Doors charity to conduct patient engagement across a range of secure estates, to gather feedback about drug and alcohol recovery prison services.

Adjudications – Formal disciplinary hearings held within the prison to address rule violations or misconduct by inmates. These are internal proceedings that aim to maintain order and discipline within the prison environment.

Buvidal – The brand name for prolonged release buprenorphine (an opioid substitution treatment) which is administered as a subcutaneous injection.

CDP (Combating Drugs Partnership) – Multi-agency forums that are accountable for delivering the cross departmental drugs outcomes.

COM (Community Offender Manager) – Someone based in the probation service in the community who works with the prisoner to help them not to re-offend after they leave prison. They may also visit the prisoner before they are released and make decisions about what they should be doing in prison.

DRR (Drug Rehabilitation Requirements) – A sentencing option with flexibility to tailor requirements to individual need, changing patterns of substance misuse and moving towards a recovery-focused approach to treatment.

DRW (Drug Recovery Wing) – A specialised abstinence wing in a prison.

HJIP (Health and Justice Indicators of Performance) – Performance indicators for health justice including 5-day and 13-week treatment assessments for substance misuse.

ISFL (Incentivised Substance-free Living units) – ISFLs offer prisoners, who wish to be free from substance use, regular drug testing, peer support, and incentives such as extra gym time for good progress.

ICB (Integrated Care Board) – NHS organisations responsible for planning health services for their local population – there is one in each Integrate Care System area.

NA (Narcotics Anonymous) – Nonprofit society of men and women providing 12-step mutual help programmes for recovery from addiction.

NDTMS (National Drug Treatment Monitoring System) – NDTMS collects individual client data from drug and alcohol treatment services on their engagement with structured drug and alcohol treatment – both pharmacological and psychosocial.

OMiC (Offender Management in Custody Model) – A practice model with the intention of putting rehabilitation at the centre of custodial and post-release work and reducing reoffending and promoting community reintegration.

OST (Opioid Substitution Treatment) – OST has 2 core elements: pharmacological and psychosocial. The pharmacological element involves replacing illicit opioids with a prescribed replacement opioid, such as methadone or buprenorphine. The

psychosocial (talking) element supports people to stabilise on the replacement opioid and to then make positive changes to their lives and recover from their drug use.

PNAP (Probation Notification and Actioning Project) – PNAP aims to support effective handover between prisons and probation on treatment requirements.

POM (Prison Offender Manager) – POMs should work with prisoners inside the prison and are part of the team called the Offender Management Unit (OMU). They should work with Community Offender Manager to help prisoners complete the goals on their sentence plan.

RECONNECT – Care after custody service seeking to improve continuity of care of people leaving prison.

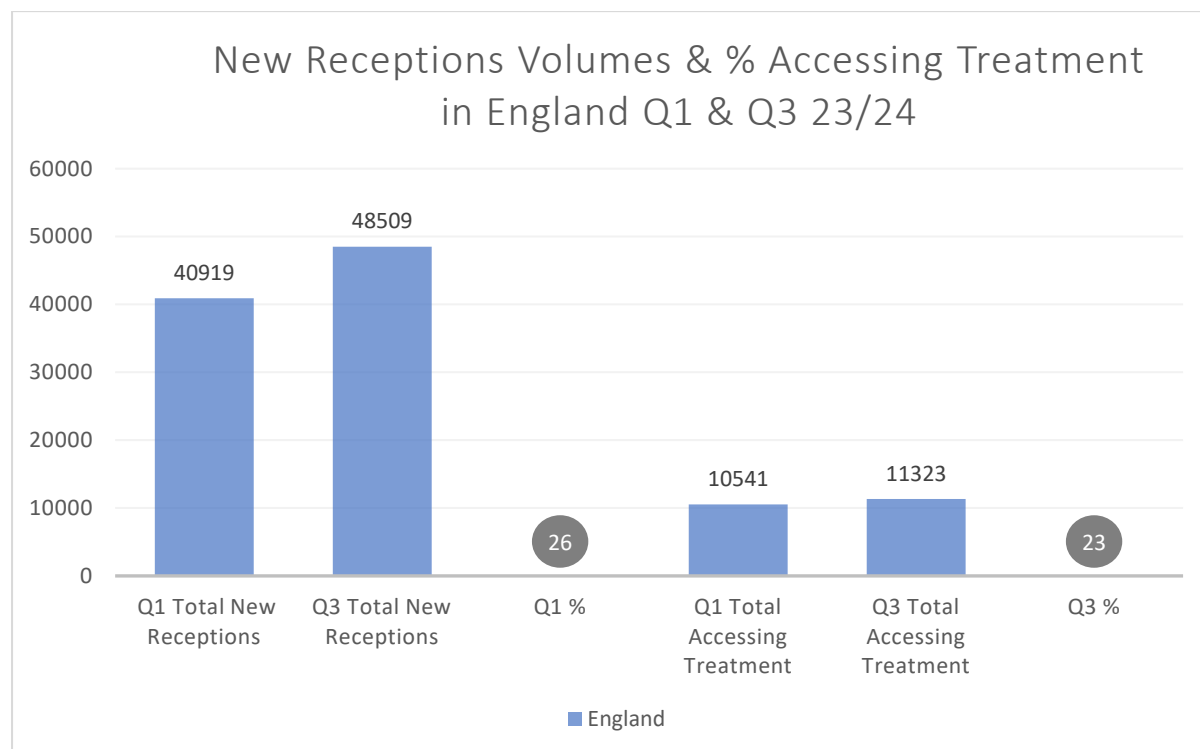
ROTL (Release on Temporary License) – ROTL is a license condition in advance of prisoner release where the Governor agrees to prepare a prisoner for resettlement in the community through work experience and contact with family, for example. It is intended that this will lead to reduced reoffending in the long-term.

SystmOne – SystmOne is a centrally hosted clinical computer system developed by The Phoenix Partnership (TPP). It is used by healthcare professionals in the prison estate.

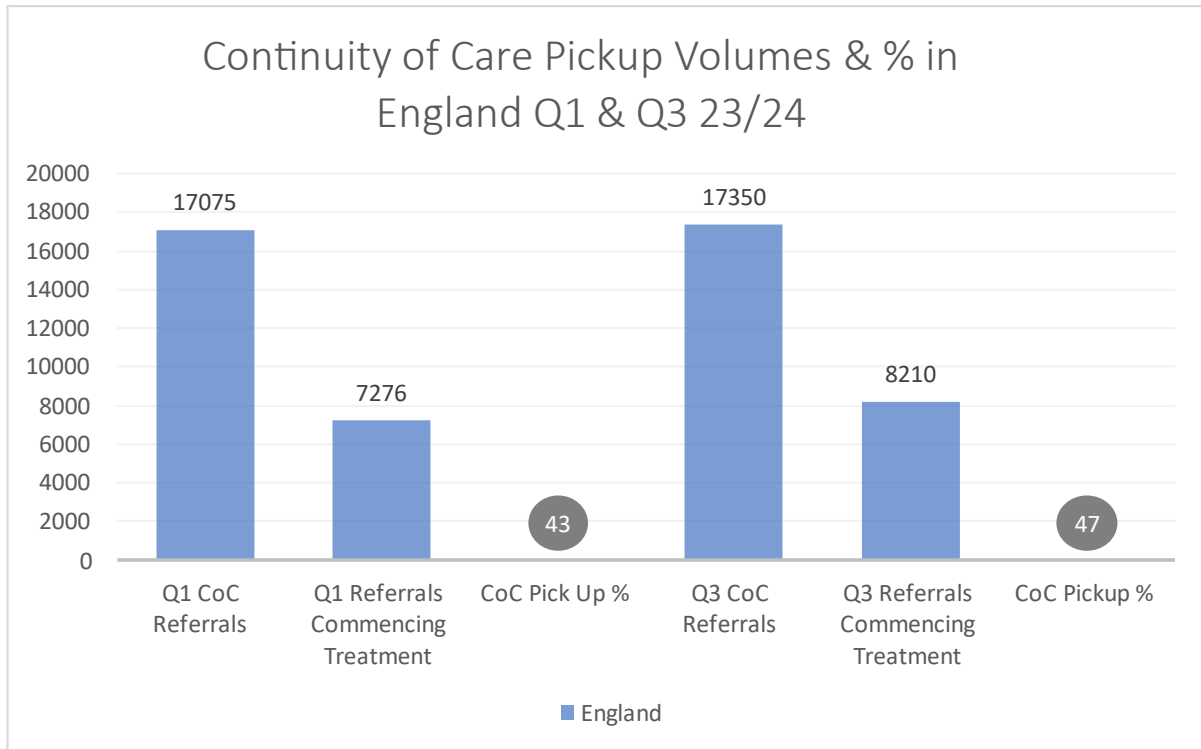
Annex C – NDTMS data

The data below was supplied on request by OHID to inform the review. Two time points were selected during the year the review took place – one for quarter 1, 2023/24, and the second for quarter 3, 2023/24.

Between these two time points NDTMS records rising numbers coming into prison but there is a smaller proportion of those people accessing treatment - around a quarter of new receptions are accessing treatment in England.



Continuity of care is gradually increasing for those released from prison with a SM treatment need that are referred to, and subsequently engage with, a community treatment provider.



Around half of people in treatment who transfer from one prison to another commence treatment in their new prison.

