NTA prison drug treatment note for HASC 2012 drug policy review

1. Prison drug treatment practice

1.1 Prisons in England and Wales get 130,000 admissions every year, about 70 per cent of whom have recently taken drugs. A busy remand prison treats over 3,000 new drug dependent prisoners a year.

1.2 The substance misuse team arranges treatment for any prisoner with a drug or alcohol problem. This includes psychosocial therapies (to encourage positive behaviour change) and/or medication (like detoxification, or substitute prescribing for opiate addicts). Detoxification is the most common prescribing response in local prisons.

1.3 Prisoners should receive regular reviews to check progress on their treatment goals and ensure links with appropriate community treatment and support services upon release.

1.3 Most drug-dependent prisoners are on short-term sentences (less than six months) that are not long enough to effectively tackle dependence. However, those on longer sentences are expected to get off drugs and work towards recovery while in custody.

1.4 Prisoners dependent on heroin are typically prescribed opiate substitute medicines such as methadone or buprenorphine. Revised clinical guidelines in April 2010 limited open-ended prescribing of substitute medication in prisons.

1.5 Close working between prison and community services ensures continuity of care, and reduces the costly revolving door of relapse, reoffending and re-imprisonment.

2. Government policy

2.1 Government policy on prisons is the responsibility of the Ministry of Justice, working with the Department of Health (DH) on the health of prisoners.

2.2 Current policy objectives include integrating prison, probation and youth justice agencies with other local health and community services to address the needs of offenders; identifying non-custodial options for drug dependent offenders to tackle dependence; and creating drug-free environments in prison by piloting Drug Free Wings and Drug Recovery Wings.

2.3 In 2011-12, DH allocated £108m for treatment and recovery services in prisons, on top of the £95m Drug Interventions Programme to engage drug-misusing offenders in community addiction treatment.

2.4 The NTA’s role is to facilitate the transition to locally-commissioned, outcome-focused and recovery-oriented services, working locally with prisons and drugs partnerships, and nationally with DH Offender Health and the National Offender Management Service (NOMS).
3. Integrating prison and community recovery services

3.1 A government review in 2004 found that prison drug treatment lacked a sound evidence base, and was out of step with treatment services in the community. This was against a backdrop of high levels of suicide and self-harm among drug-using prisoners, and also of fatal overdoses on release.

3.2 An evidence-based approach (the Integrated Drug Treatment System) was introduced in 2006 to improve the quality and consistency of treatment, and is now delivered across all 131 adult prisons.

3.3 However, disjointed funding and commissioning arrangements hampered progress. While local drug partnerships commissioned community treatment, Primary Care Trusts commissioned clinical treatment in prisons, and NOMS commissioned psychosocial interventions in prison.

3.4 In 2010 the Prison Drug Treatment Strategy Review Group chaired by Lord Patel exposed these arrangements and concluded that prison drug treatment was neither clinically effective nor cost effective.

3.6 In order to establish an integrated approach to commissioning, DH was given overall responsibility for treatment and recovery activity in prison through the 2010 Spending Review. In April 2011, local partnerships took responsibility for commissioning treatment services in both community and prison settings.

4. Future changes and challenges

4.1 The current arrangements promote integrated recovery pathways. These capitalise on the potential for prison to be a relatively safe and supportive environment where offenders take their first strides towards recovery. They also facilitate continuity of care when prisoners leave custody, and reduce the risk of overdose, relapse and reoffending.

4.2 From April 2013, subject to the passage of the Health and Social Care Bill, the NHS Commissioning Board (NCB) will take over responsibility for commissioning drug and alcohol treatment in prison, while local authorities will commission community treatment based on the ring-fenced public health grant from Public Health England.

4.3 This change poses a potential threat to the gains made through integration. The NTA is working with DH, NOMS and local authorities to ensure these new overarching commissioning responsibilities do not jeopardise existing improvements to the continuity of care created through the local integration of commissioning.