National Audit Office

REPORT

The costs of tackling drug harms in prisons

Ministry of Justice and Department of Health & Social Care

SESSION 2024–2026
04 FEBRUARY 2026
HC 1643

Key facts

The harms caused by illicit drugs in prisons are significant.

136

drug-related deaths investigated by the Prisons and Probation Ombudsman between December 2022 and December 2024

Approximately 40,000

people in prisons in England and Wales had an identified drug problem as at April 2025

Indicators such as prisoner surveys and drone sightings suggest the problem is widespread and worsening.

39%

of adult male prisoners surveyed by HM Inspectorate of Prisons in 2024-25 said it is easy to get illicit drugs in prisons

43%

increase in the number of drone sightings between 2023-24 and 2024-25

HM Prison and Probation Service (HMPPS) does not publish an objective measure of drug prevalence in its prisons.

21%

of random mandatory drug tests returned a positive result in 2017-18, the last time this national figure was considered robust

53,300

random mandatory drug tests conducted in 2024-25, over 3,000 tests below the levels required to produce a robust national estimate of the positive test rate

Measuring the total costs incurred tackling drug harms in prisons is impractical because so many business-as-usual activities serve multiple purposes.

£226.4mn

spent by NHS England (NHSE) on substance misuse and mental health treatment in adult prisons in 2024-25

Unquantified

total cost to government of tackling drug harms in prisons

HMPPS had significant underspends in major programmes with aims to reduce drug harms in prisons.

£25mn

underspend against original £100 million allocation of the security investment programme (2019-20 to 2021-22)

£47mn

underspend against original £114 million allocation of drug strategy funding (2022-23 to 2024-25)

HMPPS and NHSE must work together to ensure prisoners receive effective support.

Nearly 160,000

substance misuse appointments recorded as 'Did Not Attend' – 35% of all appointments – in 2024-25

24%

of prisoners were not triaged for substance misuse support within three weeks of their initial health screening in 2024-25

Summary

1 In April 2025, approximately 40,000 people in prisons in England and Wales (50%) had an identified drug problem. Misuse of illicit drugs by people in prison creates or exacerbates risks to their health, well-being and personal safety. Between December 2022 and December 2024, the Prisons and Probation Ombudsman investigated 833 deaths, of which 136 (16%) were drug-related. Conveyance, supply and use of illicit drugs also increase risks to the safety and stability of the prison regime. Availability of drugs inside prisons creates an illicit economy that can fuel debt, which can lead to assault, extortion or self-harm. Prisoners who are using illicit drugs often reoffend after leaving prison.

2 Effective interventions require HM Prison and Probation Service (HMPPS) and health service providers, commissioned for prisons in England by NHS England (NHSE), to work closely together.

- HMPPS is primarily responsible for action to detect illicit drugs and prevent their conveyance into prisons, and it also seeks to reduce demand for drugs through initiatives to encourage positive behaviour changes.
- Health service providers deliver drug treatment and recovery services inside prisons.
- The overall prison environment can support prisoners by providing a rehabilitative culture; education and other purposeful activities; building relationships; delivering a safe regime; and facilitating access to health interventions, including addressing mental health needs.

Focus of our report

3 This report focuses on how the prison and health services are using public funds to tackle drug harms in prisons. It examines:

- how well the Ministry of Justice (MoJ), HMPPS, Department of Health & Social Care (DHSC), NHSE and wider government understand the scale and nature of drug harms in prisons (Part One);
- the funding available for HMPPS and NHSE to tackle drug harms in prisons, and how resources are prioritised (Part Two); and
- how effectively resources have been used and how well the prison and health services work together (Part Three).

4 The report focuses only on illicit drug harms in prisons. We do not cover national and international work by the police and others to counter criminal activity supplying drugs to prisons, nor do we review interventions for people on community orders or the continuity of drug treatment services for prison leavers. 'Substance misuse' is a broader term often used in healthcare, which includes misuse of alcohol and diversion of prescription medicines, as well as illicit drugs. We touch on these broader issues where relevant, but they are not the focus of our report. While HMPPS is responsible for prisons in England and Wales, healthcare in Wales is a devolved function provided by NHS Wales, and therefore falls outside the scope of this report.

Key findings

Understanding the nature and extent of illicit drugs in prisons

5 The prison and health services know that they face substantial, increasing and rapidly changing threats from illicit drugs in prisons. In 2024-25, HMPPS reported 26,348 drug find incidents, 25% more than the previous 12 months. The proportion of adult male prisoners reporting that it is easy to get illicit drugs in prison increased from 24% in 2021-22 to 39% in 2024-25. Two recent developments present growing threats: the availability of novel substances such as synthetic opioids has increased – these are more potent in smaller quantities than traditional drugs, harder to detect and easier to convey into prisons; secondly, criminals are increasingly using drones to convey drugs into prisons, with drone sightings increasing by more than 750% between 2019 and 2023 and by 43% between 2023-24 and 2024-25 (paragraphs 1.5, 1.10 and 3.2, and Figures 1 and 2).

6 HMPPS's information on the availability of illicit drugs in prisons has limitations that undermine its ability to prioritise interventions. The type of prisoner population, location and physical attributes of a prison all affect the quantity of drugs in a prison and how they are smuggled in. It is inherently difficult to collect complete information on illicit activity, but HMPPS has a range of sources that could provide useful insights to help target its resources. This includes drug finds, prisoners reported as 'under the influence', prisoner surveys conducted by HM Inspectorate of Prisons, and drug testing in prisons. However, there are significant limitations with some data. For example, 'under the influence' data are now mandatory but are not yet collected, reported or shared consistently. Further, HMPPS has not published a robust estimate of the random mandatory drug testing (rMDT) national positive test rate since 2017-18, when the figure was 21%. This is due to insufficient testing volumes to ensure statistical validity, and limits to the range of substances detectable by the test as synthetic drugs evolve. Prison staff collate some of this information in local tactical assessments, but those assessments are focused on broader security considerations and do not seek to identify or understand trends or patterns of drug prevalence (paragraphs 1.8 to 1.13 and 3.4).

7 HMPPS has been trialling an innovative method of identifying drug prevalence which may help focus testing where it is most useful. Since 1998-99, HMPPS has carried out rMDT on prisoners every month, the full cost of which it estimated in 2023 was around £8 million a year. In 2024-25, HMPPS conducted 53,300 random mandatory drug tests but prison staff told us that these random tests were operationally resource-intensive. They considered that using constrained testing resources on targeted testing (for example, where staff had suspicions of drug use) was much more useful in managing prison operations. Since 2023, HMPPS has been trialling prison wastewater testing for traces of illicit drugs, which, if successful, could reduce disruption to the prison regime and reduce staff resources required (paragraphs 1.13 to 1.15).

The government's leadership, funding commitments and prioritisation

8 The government's commitment to tackling drug harms in prisons requires renewed funding and partnership arrangements. In 2021, the then government published a cross-government, 10-year strategy, *From harm to hope*, to tackle drug-related issues. This strategy included a significant component to tackle drug harms in prisons, with £114 million funding between 2022-23 and 2024-25. To oversee this strategy, the then government established the cross-government Joint Combating Drugs Unit (JCDU), including MoJ, DHSC and four other government departments. In addition, HMPPS and NHSE signed a National Partnership Agreement, setting out core objectives and priorities for tackling drug harms in prisons for 2022 to 2025. In early 2025, the government announced that NHSE would be abolished by 2027. Arrangements for commissioning healthcare in prisons after 2027 have not yet been confirmed. The current national partnership agreement was due to end in 2025 but, in January 2026, signatories agreed to extend it until 2027. The government has not announced dedicated funding for cross-government work to tackle drug harms from 2025-26 onwards (paragraphs 2.3 to 2.6 and Figure 5).

9 HMPPS has significantly underspent on two investment programmes that aim to reduce drug harms in prisons. Quantifying the total costs incurred by HMPPS in combatting illicit drugs in the prison system is impractical because so many of its business-as-usual activities serve multiple purposes. However, between 2019-20 and 2021-22, HMPPS spent only 75% of its £100 million security investment programme budget, with the largest underspend in gate security. HMPPS told us that the unspent funding was used to cover other operational activities. HMPPS was also allocated £114 million between 2022-23 and 2024-25 for prison-based and cross-cutting initiatives as part of the cross-government drug strategy *From harm to hope*. The actual budget was revised to £97 million to make savings and, of this, HMPPS spent only £67 million (69%). Reasons for the underspend included delays to spending approvals in the first year, reducing the scope of some projects as part of its wider efficiency savings commitment, and delayed staff recruitment (paragraphs 2.2 and 2.6 to 2.10, and Figures 6 and 7).

10 NHSE spending on mental health and substance misuse treatment in prisons in England was lower in real terms in 2024-25 than it was in 2020-21. The combined spend on mental health and substance misuse treatment in prisons in England, not including primary care staff costs, was £226.4 million in 2024-25. Looking at the last five years, this represents a cash increase compared with the £202.9 million spent in 2020-21, but a real-terms decrease of 5%. NHSE was required to make 1% efficiency savings each year in the period. NHSE does not identify separate costs for substance misuse treatment and mental health treatment, as the two are linked. We estimate that about 39% of the combined expenditure (£88.8 million in 2024-25) relates to substance misuse treatment. An increasing proportion of prison healthcare funding is drawn from in-year bids to NHSE's contingency fund (paragraphs 2.13 and 2.15, and Figures 8 and 9).

11 NHSE does not use regional health needs assessments to decide its funding allocations. Health needs within a prison population depend on a range of factors, including gender, age and churn in prisoners. Each of the seven NHSE regions commissions prison-level health needs assessments. However, the scope, coverage and frequency of assessments, including coverage of drug treatment and recovery, vary, so cannot reliably be used to inform trends in changing needs or understand differences between prisons. Instead, NHSE allocates funding to regional commissioners based on historic contract values, adjusted by an annual NHSE funding uplift and efficiency reduction (paragraphs 1.16 and 2.14, and Figure 4).

12 There is significant regional variation in NHSE spending on substance misuse treatment. We found that in 2024-25, the London region spent around 72% more per prisoner than the East of England on substance misuse treatment. NHSE has not investigated this variation. It does estimate the annual cost per prisoner of all health services, which ranges from £5,000 to £12,000 depending on each prison's function, location, and prisoner demographics (paragraph 2.14 and Figure 9).

How effectively resources have been used

13 HMPPS has sought to reduce the quantity of drugs getting into prisons, but has been too slow in responding to urgent threats, leaving some prisons vulnerable. HMPPS seeks to disrupt conveyance routes for drugs using a range of physical solutions such as enhanced scanning and window grilles as well as counter-corruption measures. But prison governors we spoke to told us that they do not have sufficient resources to respond to threats in an agile way. We identified examples of broken security equipment not being repaired and work to improve window security taking several years. Maintenance work must balance competing priorities such as maximising use of cells and undertaking security improvements, which can make it difficult to respond to urgent threats. In 2025-26, HMPPS committed around £40 million of investment to high-risk prisons for security measures, such as window grilles and netting, to counter ingress from drones (paragraphs 2.11 and 3.3 to 3.6).

14 Factors such as the physical constraints of prison buildings, prison maintenance backlogs and lack of staff training reduce the effectiveness of HMPPS's actions to prevent drugs from entering prisons.

- The physical design, age and poor condition of some prisons make them vulnerable to drug ingress, particularly older prisons and listed buildings. For example, it can be hard to implement enhanced gate security if the physical space is not well suited. The maintenance backlog across the prison estate has also doubled from £0.9 billion to £1.8 billion between February 2020 and September 2024 (paragraphs 3.4 and 3.5).
- MoJ has identified staff shortages, lack of training, and retention as main barriers to reducing ingress of drugs into prison. For example, an internal audit report found that 40% of sampled prisons did not hold complete and accurate training records for using technology such as X-ray body scanners, and around a third of prisons could not evidence that they had carried out quality assurance of searches (paragraph 3.7).
- There are technological, regulatory, legal and health constraints limiting prisons' ability to detect new drugs, use body scanners on individuals, or test legally privileged mail for the presence of drugs (paragraphs 1.10 and 3.9).

15 HMPPS's evaluations of its initiatives to reduce demand for drugs are starting to provide insights into what works. HMPPS has a long-term programme for evaluating the interventions funded by the drug strategy. Two major initiatives are Incentivised Substance Free Living (ISFL), drug-free living areas offering enhanced privileges for abstinence; and Drug Recovery Wings, designed for people dependent on illicit drugs who wish to receive treatment. In 2024, a process evaluation of the ISFL initiative noted significant variation between the three prisons under review in the scheme's implementation, including how they selected prisoners to participate and how they dealt with positive drug tests. A review of Drug Recovery Wings found that, while there was evidence of positive change, the scheme had not been implemented as intended. Overall, HMPPS does not yet know whether its interventions have achieved good value for money or been prioritised where they will have most impact. However, it is aware of differences in implementation and intends to explore which characteristics are most effective (paragraphs 3.12, 3.13, 3.15 and 3.16, and Figure 13).

16 NHSE commissioners have limited evidence to demonstrate that drug treatment services are improving or providing best value for money. There is a shallow market for healthcare and drug treatment provision in prisons, meaning in some cases competition for providers is limited. Commissioners can set local performance measures and thresholds appropriate to the prison. NHSE told us that it has a robust contract management process to address instances of poor performance, and regional commissioners hold regular contract review meetings with providers. We reviewed a sample of records from contract review meetings and found they varied in scope and coverage. NHSE shared an example of commissioners taking robust steps requiring providers to make service improvements in response to coroners' reports following deaths in custody. We did not find much similar evidence of action triggered by routine contract monitoring, for example where prison staff had expressed dissatisfaction with the provider's performance. NHSE told us that commissioners do require improvement actions where necessary from concerns raised informally, although it accepted there was little supporting documentation (paragraphs 3.17 and 3.18).

17 Capacity pressures and a lack of alignment between performance metrics for prison and health staff are hindering effective joint working. NHSE regional commissioners report to NHSE nationally where prison operational pressures are adversely affecting healthcare delivery. In February 2025, NHSE commissioners reported serious pressure on healthcare delivery in 35 prisons, of which 14 were "very likely to result in harm to patients". In 2024-25, NHSE recorded nearly 160,000 substance misuse appointments as 'Did Not Attend' (DNA), around 35% of all appointments. This can be for a variety of reasons, including the prisoner choosing not to attend, but has the potential for negative impacts on people's health and wellbeing, the efficient use of health and prison staff resources, and the prison regime. Moreover, DHSC data show that in 2024-25, 24% of prisoners with potential substance misuse needs waited over three weeks for a triage assessment, following reception screening, although the reasons for this are not recorded. Prison governors' performance is currently assessed on metrics such as education and purposeful activity rather than on facilitating prisoner access to drug treatment services, which can lead to a risk that these may be seen as lower priority. Conversely, some prison governors told us they lacked an adequate mechanism for engaging with health service performance, including what they believed to be underperformance (paragraphs 1.17, 3.18, 3.21 to 3.23 and 3.26).

Conclusion

18 Illicit drugs in prison pose significant challenges to successful offender rehabilitation, prisoners' physical and mental health, the safety of staff and prisoners, and the stability of the prison environment. Tackling drug harms in prison involves restricting the supply of drugs into prison and supporting people in prison to reduce their drug misuse, both through drug treatment and recovery services and by creating a prison environment that incentivises sustainable drug-free living. This works best where there is good liaison between HMPPS and health services, with a shared understanding of need and well-aligned incentives for staff to support prisoners' treatment and recovery. However, in a context of wider pressures on prison capacity, prison staff reported they lacked the influence needed to improve health-related services, while NHS staff did not always feel sufficiently involved in decisions on prison operations and were reliant on prison staff to enable those services to be delivered safely.

19 It is impractical to calculate a precise cost of tackling drug harms in prisons, making it impossible to assess overall value for money of drug treatment and recovery. However, HMPPS significantly underspent budgets intended for security improvements and initiatives to support prisoners. We also heard prison staff voice their frustration at the slow pace of urgent repairs and improvements. Meanwhile, our estimate is that drug treatment funding has decreased in real terms. Better performance information, continued willingness to innovate, continued learning from robust evaluation and, above all, a renewed commitment to cross-government partnership working will be essential for the government to direct resources to where they will have greatest impact.

Recommendations

a To reduce drug availability and get better value for money from spending on drug treatment, HMPPS should respond with more urgency to identified security weaknesses at specific prisons, including broken windows or inadequate window grilles that currently allow drone access into prisons, specifically by:

- allowing senior operational leaders to bid for responsive security investment to ensure available funds can be used; and
- reviewing the maintenance contract to increase responsiveness and flexibility where there are urgent security-based works.

b There are many factors influencing drug supply and use in prisons, but HMPPS and NHSE require better information on prevalence and need to prioritise funding.

- HMPPS should consider how it might use its drug testing resources to best effect, to get optimal information on prevalence and treatment need from the range of available drug testing options (including individual testing options and wastewater testing). It should use these resources to inform operational decisions, monitor and compare prison performance, and influence decisions on security and health treatment.
- MoJ and HMPPS should share 'under the influence' data more consistently within and across prisons, and with DHSC and NHSE. All the partner organisations should use this information to understand changes in the prevalence of drug misuse, assess risks, and measure the impact of 'under the influence' instances on other services.

c To enable health commissioners to ensure they are getting value for money from drug treatment and recovery services they are paying for, the commissioners should:

- refocus health needs assessments (HNAs) to inform commissioning and funding allocation decisions. These HNAs should include a specific focus on drug treatment and recovery needs of local populations;
- refine standardised costing formulae to benchmark the cost of drug misuse services that takes account of different needs in different prisons, including the prevalence and type of drugs, and variation in prison population (such as age, gender and churn); and
- include costed key performance indicators in contracts that test whether providers are delivering value for money for those services.

d As DHSC redesigns responsibilities for health in prisons, HMPPS and relevant health bodies should renew and strengthen partnership arrangements, both nationally and locally. These should support better alignment of incentives to shared goals on health-related interventions, for more effective performance management and partnership working, including increased information sharing.

e HMPPS and NHSE should draw on robust evaluation to understand what works and encourage best practice.

- HMPPS should conduct a programme of evaluations of the relative success of security measures to restrict ingress of drugs. It should use the findings of this work to support evidence-led training and development for staff.
- HMPPS and NHSE should continue their programme of evaluations of measures to tackle drug misuse, including drug strategy investment funding such as Incentivised Substance Free Living. They should draw on the findings of this work to improve understanding about factors supporting and detracting from successful implementation, and take these factors forward in any further rollout of schemes to tackle drug misuse in prisons.