Government and Public Sector Consulting

Report to the Department of Health and Ministry of Justice

Review of Prison-Based Drug Treatment Funding

Final Report, December 2007 (Published March 2008)

PRICEWATERHOUSECOOPERS

Contents

Acknowledgements

We would like to thank the members of the Steering Group, Expert Panel, and all those who took part in focus groups and interviews as part of this Review. (Please see Appendix 2 for details of participants.)

Executive Summary

Introduction

There are over 81,000 people in prison (annual turnover estimated to be 135,000 per annum), with over half of these thought to be misusing drugs according to interviews with senior prison staff. A subset of this group is defined as 'Problem Drug Users' (PDUs) i.e. those with a heroin or crack addiction according to the Home Office definition. Prison-based drug treatment caters for all types of drug misuse. The Secretary of State for Health and the Home Secretary agreed to an urgent review of how existing resources for drug treatment in prisons could be used more effectively. (The Home Secretary's responsibilities for prisons/probation passed subsequently to the Ministry of Justice.)

PricewaterhouseCoopers LLP (PwC) was appointed to undertake the review. The scope is described below.

Scope:	Therefore to examine:
• The extent to which the present drug services provided for substance misusers in prison meet their treatment and reducing reoffending needs throughout their time in custody and in preparation for release. • What options exist for ensuring all prisons are able to provide the minimum required standard of care for prisoners who need drug treatment • What realistic, achievable and measurable outcomes could be set for the provision of drug treatment in prisons • How current funding and arrangements for commissioning and delivery of prison drug treatment could be improved to ensure the provision of minimum standards within all prisons and maximise positive outcomes within existing resources • Arrangements for the performance management of drug treatment within prisons and at a partnership, regional and national level.	• The extent to which current service models, funding and commissioning arrangements are fit for purpose • Whether addressing any identified deficits in current provision is essential (in terms of need and the legal requirements placed on PCTs and the prison service) or merely desirable (in terms of best practice) • What range of existing service models appear to work best in terms of quality and cost-effectiveness • Is any realignment of budget and target setting mechanisms necessary, and if so what would best support the use of these service models and any other recommendations arising from this review. • What would be the optimum commissioning arrangements to ensure that services are coordinated and complementary and fit with NHS commissioning requirements and the new commissioning environment of NOMS • How greater consistency and continuity between prison and community based provision can be achieved.

It was agreed that the review would include the mainstream estate and high security prisons, prisons for young offenders (aged 18-21 years), and women's prisons, but exclude juvenile offender services (for those aged 15-17 years) since treatment arrangements are the responsibility of the Youth Justice Board and fall outside of the National Offender Management Service (NOMS) drug treatment remit. Welsh prisons were also excluded except in relation to arrangements for prisoner transfers, since NHS Wales / the Welsh Assembly were not signatories to the review.

1. Approach

PwC began its work at the end of August 2007 and submitted the final report on 12th December 2007 as required. The team reported to a joint Steering Group, and also consulted a panel of experts identified by Department of Health (DH) and Ministry of Justice (MoJ). During the course of our work we produced a number of outputs which were shared with the Steering Group and experts who met or were consulted at a

number of pre-agreed points.

The work undertaken comprised:

- A review of documentary and research evidence and description of current service provision and commissioning arrangements to ensure the review team understood the complexities involved prior to making recommendations. .

- An extensive stakeholder consultation exercise:

  – At national level we held interviews and group discussions with forty people identified with the Steering Group and designed to provide an overview of the issues from a variety of angles;

  – At regional level we held focus groups and interviews with a range of stakeholders in five prison areas selected with the Steering Group to provide a range of perspectives (Kent and Sussex, London, West Midlands, North West, and Yorkshire and Humberside).

  – At local level we visited eleven prisons across the five areas, and two high security prisons, meeting with a cross-section of prisoners, prison staff and senior management. We also held focus groups with ex-prisoners in three locations, and held telephone interviews with a range of local stakeholders including families and carers, primary care trusts, and the Probation Service.

  – A report of themes and findings was presented to the Steering Group and experts.

- The development of an economic framework, from a review of the literature from academic and government sources, to assess the costs and benefits from drug treatment for prisoners in relation to the economy, health, social and criminal justice systems. The results were fed into the wider project to guide the selection of commissioning, process and prioritisation options fro drug treatment programmes in prisons.

- An analysis of the additional or incremental costs that a PDU incurs over their lifetime in comparison to the average person. This indicates the potential savings, therefore, if intervention were immediately effective in reducing or eliminating problem drug use. Figures are provided for males and females at different ages.

- Production of a final report.

2. Summary of findings

2.1 Strategic planning and commissioning

The government is currently revising its overarching drugs strategy. There is a NOMS drugs strategy, and an offender health strategy is currently out for consultation. However, we identified the need for a more focussed strategy for dealing with prisoners and offenders with problem drug use which balances the objectives and priorities of the Department of Health (DH), Ministry of Justice (MoJ) and Home Office (HO) and which sets out a framework for commissioning and performance. Commissioning arrangements are complex, with multiple agencies involved at regional and local level. There is no one body or individual holding overall responsibility and accountability for the treatment of drug users in prisons. Information systems and funding streams are not joined up, and there are constraints on how funding can be used to meet needs and achieve desired policy outcomes.

Our analysis indicates the need for a single, more focussed national strategy covering prisoner and offender related drug treatment of all types in both prison and the community. The strategy will need to clarify and prioritise the required outcomes, and introduce revised commissioning arrangements to facilitate the coordination of drug treatment services and ensure that best practice is followed. Funding streams should be reviewed to see if simplification or unification would better support effective commissioning. A national performance framework is needed which will require fit for purpose information and ideally a single information system. The Public Service Agreement published in 2007 forms the basis for this strategy.

Table: Drug treatment commissioning arrangements in the community and in prison

	Funding stream	Commissioning responsibility	Performance management	Funding (£m)	
				2006/7	2007/8
Prison-based services (main estate)					
CARATs	NOMS	NOMS	Area Manager/ NDPDU	25.7m*	25.7m*
Intensive psycho-social drug treatment progs	NOMS	NOMS	Area Manager / NDPDU	19.4m	19.4m
Clinical (non IDTS)	DH	PCTs (public prisons) NOMS (private prisons)	Strategic Health Authority NOMS	11.3m	11.3m
IDTS – clinical	DH	PCTs & DATs	IDTS Regional Steering Groups	11.2m	12.7m
IDTS – non-clinical	NOMS	NOMS	NDPDU (feeding performance management information through to regional IDTS groups)	5m	6m
Community-based treatment services					
Tier 1,2,3, 4 (Clinical and psycho-social interventions)	PTB/mainstream funds (PCT and Local Authority (social services) budgets)	DAT partnerships/PCTs/ Social Services	NTA /Strategic Health Authority / Government Offices/ROMS	PTB**: 385m Mainstream: 200m **Total: £585m**	PTB:398m Mainstream: 200m **Total: £598m**
DIP delivery of enhanced Tier 2 level interventions including case management, prescribing (for tier 3) by CJIT staff	Home Office	DAT partnerships	NTA through quarterly reviews	178m***	149m***

* Excluding IDTS costs

** PTB = Pooled Treatment Budget

*** The figures for DIP funding indicate the total sum, only a proportion of which is directly spent on case management and treatment oriented interventions.

2.2 Service provision

With regard to service provision there has been considerable investment in case management and psychosocial provision over the past 10 years, including the development of pathways of care, and improved contract management. These services are valued by prisoners and demand exceeds supply. However, we found evidence of a lack of continuous joined up care within prisons. Variation in the volume and type of service, as well as different clinical practices causes difficulties in providing continuity and consistency of care both within and between prisons. We found evidence of a lack of effective targeting of programmes due in part to perverse incentives caused by Key Performance Targets (KPTs).

Furthermore, there has been a lack of research to provide evidence of efficacy of some of the case management and psychosocial programmes. Performance management has focused on volume of activity rather than quality and outcomes, so it is difficult to demonstrate value. In contrast there has been much

less investment in clinical services (clinical assessment, detoxification and maintenance prescribing) until the last few years, but there is more research evidence to demonstrate efficacy. There is a need for more research evaluating care pathways and combinations of treatments.

Whilst there is a paucity of research showing effectiveness, what is known is that drug treatment should be focused on polydrug use rather than having programmes tailored to specific drugs. Better outcomes are reported for clients receiving a combination of treatments, and time in treatment and treatment completion are associated with better outcomes. Aftercare support including access to wraparound services is also important (e.g. access to education, housing and related support, debt management services and employment preparation). There is research evidence concerning effectiveness, both in terms of health outcomes and in reducing re-offending for pharmacological treatment of opiate addiction through detoxification and maintenance prescribing, which should be supplemented with psychosocial treatment.

With regard to the use of resources we conclude that where these are limited, an effective strategy for provision needs to be based on existing evidence of what works. Programmes that are proven to work in prisons should be prioritised, whilst those where there is evidence of no effect should be withdrawn. However, there are a number of programmes where the effectiveness is uncertain; in this case it is there is a pressing need to observe their effects on outcomes, and maintain close performance management as it is likely that their success is as dependent on the way in which they are delivered as the actual intervention itself.

3. Provision options

In relation to provision we provide an outline of what we consider must be done to provide a minimum standard of care for all prisoners, based on what is humane, and on current evidence of efficacy. We also outline services with a good evidence base which should be provided when resources are available, and services that could also be provided but for which there needs to be pragmatic research to establish their efficacy (that is introduced cautiously, on a pilot basis with careful monitoring of outcomes).

We recommend the principle of 'allocative efficiency' whereby resources are realigned to ensure first that a minimum standard of care is delivered to all before resources are spent on the other services. Building on the above we also propose a notional revised care pathway to demonstrate what services a prisoner might receive at different stages during their prison stay.

Delivery of the minimum standard of care in all prisons is not likely to be possible within existing funding, so we have outlined a number of areas where we believe existing resources could be freed up, together with an approach to prioritising longer-term psychosocial treatments for maximum impact on the individual and society, based on lifetime cost savings in relation to areas such as morbidity, lost economic output, criminal justice costs and social costs. We suggest this could be used to guide the commissioning process at the strategic level, and in supporting professional judgement at the front-line when allocating scarce resources to individual prisoners.

4. Commissioning options

In relation to commissioning we describe the 8 key functions (see figure below) that make up a best practice commissioning cycle. We then describe how commissioning arrangements for prison and community treatments compare against this.

Having put a number of options for commissioning to the Steering Group and experts, showing which commissioning functions might be undertaken at national, regional and local level, we agreed with them two fundamental foundations for a revised commissioning structure:

- The need for a National Strategy Group (NSG) for prisoner and offender drug treatment combining DH, MoJ and HO membership; and

- A strong regional performance management function to apply national strategy.

We agreed with the NSG that provided these are in place and operating effectively, the exact configuration of commissioning is less important.

5. Proposed next steps

a) Establishing a National Prisoner and Offender Drug Strategy Group. The early tasks of this group, would be to establish the membership and terms of reference, and commission a series of projects to include the following:

b) Articulating and agreeing the key outcomes for prisoners and on release; Demonstrate how the partner organisations will work together to successfully deliver those outcomes; Identify measures (key performance targets) which will help the partner organisations to understand how their performance contributes to the achievement of the outcomes and: Set out how current activities (initiatives) align with the key outcomes and design others to fill gaps. Initiatives would include:

c) Establishing a set of National Minimum Standards and conducting a gap analysis to establish what is feasible within current resources, and to develop a plan for implementing the standards over the next 2-5 years.

d) Identifying opportunities for achieving efficiency savings to invest in services. These may include, disinvestment in services not falling within the national minimum standards and provider development. A detailed business case should be produced to fully appraise the extent to which funds can be released, followed by consultation to ensure the potential impact of withdrawal and changes are fully understood before final agreement and implementation. The complexities in changing systems should not be underestimated. For example, existing contracts and TUPE requirements can make implementation a long term initiative.

e) Examining the case for prioritising prisoners and offenders using the proposed economic framework. This assesses the impact on the individual and wider society of successful drug treatment for specific segments of the drug-misusing prisoner and offender population as an aid to commissioning at a strategic level, and to support professional judgement when allocating resources to an individual. The approach should be consulted on in localities, which may have different priorities.

f) Developing the commissioning model at national, regional and local level. This would commence with a consideration of the roles for example of the Regional Partnership Board, support structures and skills required to support each level. A capability and capacity review and formal assessment by region would then be required, followed by an appraisal of the costs and value for money of adopting the local or regional commissioning model we proposed, and consultation on this. Governance structures and reporting arrangements will then need to be agreed.

g) Developing a single health and a single criminal justice funding stream. In best practice commissioning, funding should follow commissioning; consequently the level at which these funding streams are aligned or merged will depend on whether a local or regional commissioning model is adopted. Funds should be merged to meet specific commissioning objectives.

h) Agreeing how information sharing will be achieved to support both performance management and case management. The lack of a shared system, and the high costs and long lead in times to any future system, should not hold up progress in information sharing (i.e. it should not be on the critical path to improvement). Measures should be taken immediately to facilitate practical information sharing for example by issuing read-only rights to staff needing access to information on the same person, with suitable protocols for confidentiality.

Figure: Best Practice Commissioning

Plan Stage

Assess needs – through a systematic process that assesses and translates the needs of a resident population.

Describe services and gap analysis – Reviewing and defining the gaps of services through the perspective of areas of overuse, misuse or under use.

Deciding priorities **–** Using the available evidence of cost effectiveness and a robust ethical framework. Prioritise areas for commissioning.

Risk Management – Assessing the key risks facing the Commissioner and deciding on the strategy to manage it.

Strategic Options – Examine and appraise the options available to deliver the Commissioning priorities.

Execution Stage

Contract implementation – designing service specifications and contracts to put these strategic commissioning intentions into action.

Provider development – shape and support provider developments or introduce new providers to deliver the services required.

Performance Management Stage

Managing performance – monitor and manage the performance of providers against their contracts, especially against KPTs.

1

1 Introduction

There are over 81,000 people in prison (annual turnover estimated to be 135,000 per annum), with over half of these thought to be misusing drugs according to interviews with senior prison staff. A subset of this group are defined as 'Problem Drug Users'(PDUs) i.e. those with a heroin or crack addiction according to the Home Office definition. Prison-based drug treatment caters for all types of drug misuse, both for PDUs and for those misusing other drugs. PDUs tend to come into contact with the criminal justice system through committing crime in order to fund their drug habit. Dependence on heroin and/or crack cocaine is a chronic relapsing condition which can last a life-time. Consequently, although a custodial sentence provides an opportunity to treat the addiction, services should be provided end to end with continuity of care between community and prison. This is particularly important given high rates of suicide of PDUs on entry to prison, and of accidental overdose and death on release, as well as the potential to reoffend in order to fund a continuing drug habit.

Prison overcrowding, the consequent movement or 'churn' of prisoners between prisons, and the availability of illicit drugs within prison present challenges to providing a coherent drug treatment service in prison. Furthermore, the prison population is set to grow, and new policy initiatives, such as the introduction of indeterminate public protection (IPP) sentences, place further pressure on prisons. Such offenders cannot be released until they can prove they have addressed their offending behaviour within prison and thus reduced their risk to society.

A note on terminology: Throughout the report we use the term 'prisoner' to include those who are on remand and those who have been sentenced. Where we use the term 'offender' this relates only to those who have already been sentenced and can include offenders in prison or on community sentences. These terms are not applied consistently in the literature or in common parlance.

Over the past ten years there has been a significant increase in funding for drug treatments in prison. Case management and a range of accredited psycho-social programmes have been introduced in prisons to treat drug dependence, prior to which there was no real provision of this sort to treat drug addiction in a custodial setting. Responsibility for prisoners' healthcare, including the "clinical" aspects of drug treatment, transferred from the Prison Service to the Department of Health from April 2003. This led to a split between the commissioning and funding of interventions for drug treatment.

The process of devolving responsibility to NHS Primary Care Trusts (PCTs) was completed by April 2006, and is reported to have led to improved general healthcare in line with that provided in the community for those with long-term conditions such as asthma and diabetes. However, clinical practice in relation to drug misuse has been patchy, leading to clinical negligence claims being made by prisoners both before and after devolution of responsibility to PCTs. Clinical and psychosocial provision is also poorly joined up.

The Integrated Drug Treatment System (IDTS) went live in October 2007. It seeks to improve the volume and quality of drug treatment with a particular emphasis on the first 28 days in custody which reflects best practice and is better integrated with the community services to which most drug misusing prisoners will return. To date, 53 prison/PCT partnerships have received funding for enhanced clinical services during 2007/8 (out of a total of 149) and 29 have also received funding for enhanced case management and psychosocial care. However due to budgetary restrictions there are no plans as yet to roll out IDTS to all establishments, and across the prison service demand for both clinical and psychosocial services continues to outstrip supply.

Consequently, the Secretary of State for Health and the then Home Secretary agreed to an urgent review of the use of existing resources for drug treatment in prisons. The Home Secretary's responsibilities for

prisons/probation passed subsequently to the Ministry of Justice. There are considerable challenges to improving the delivery of services, including the diverse means through which drug treatment in prison and in the community is currently commissioned and delivered, and the wide range of interests and views on the subject.

PricewaterhouseCoopers LLP (PwC) was appointed to undertake the review. The objective of this review is to explore how existing resources can be utilised more effectively to ensure that services for people in prison meet their assessed needs matched to time spent in prison and that there is better integration between prison and community based treatment to ensure continuity of care for those entering and leaving the prison system. The scope of the review, as defined within the invitation to tender is given below:

Scope:	**Therefore to examine:**
• The extent to which the present drug services provided for substance misusers in prison meet their treatment and reducing reoffending needs throughout their time in custody and in preparation for release. • What options exist for ensuring all prisons are able to provide the minimum required standard of care for prisoners who need drug treatment • What realistic, achievable and measurable outcomes could be set for the provision of drug treatment in prisons • How current funding and arrangements for commissioning and delivery of prison drug treatment could be improved to ensure the provision of minimum standards within all prisons and maximise positive outcomes within existing resources • Arrangements for the performance management of drug treatment within prisons and at a partnership, regional and national level.	• The extent to which current service models, funding and commissioning arrangements are fit for purpose • Whether addressing any identified deficits in current provision is essential (in terms of need and the legal requirements placed on PCTs and the prison service) or merely desirable (in terms of best practice) • What range of existing service models appear to work best in terms of quality and cost-effectiveness • Is any realignment of budget and target setting mechanisms necessary, and if so what would best support the use of these service models and any other recommendations arising from this review. • What would be the optimum commissioning arrangements to ensure that services are coordinated and complementary and fit with NHS commissioning requirements and the new commissioning environment of NOMS • How greater consistency and continuity between prison and community based provision can be achieved.

Further to this it was agreed that the review would include the mainstream estate and high security prisons, prisons for young offenders (aged 18-21 years), and women's prisons, but exclude juvenile offender services (aged 15-17 years) since treatment arrangements are the responsibility of the Youth Justice Board and fall outside of the National Offender Management Service's (NOMS) drug treatment remit. Whilst the Prison Service covers both England and Wales, DH covers England only, with health services in Wales being structured differently. NHS Wales / the Welsh Assembly had not signed up to the review, so PwC's report relates to England only, although we comment on the arrangements for prisoners transferred between prisons in England and prisons in Wales.

PwC began its work at the end of August 2007 and has undertaken a review of documentary and research evidence, an extensive stakeholder consultation exercise at national, regional and local level, developed an economic framework and conducted an options appraisal. The team reported to a Steering Group, and also consulted a panel of experts identified by DH and MoJ. During the course of our work we have produced a number of outputs which have been previously discussed with the Steering Group and experts, and which are included as appendices to this report.

This is the final report, in which we present a number of options for the commissioning and provision of prison-based drug treatment, in each case emphasising ways of strengthening partnership working which is vital to the successful treatment of PDUs. We would like to thank the Steering Group, Expert Panel, and all those who provided information, ideas and data during the stakeholder consultation (see Appendix 2 for list of those involved).

The review has been undertaken concurrently with a revision of the National Drug Strategy (NDS), which is led by the Home Office with the Ministry of Justice and other Government departments contributing. A further important development is the announcement in October 2007 of a new Public Sector Agreement (PSA 25) to 'Reduce the harm caused by alcohol and drugs'. Delivery of PSA 25 will be monitored through

five performance indicators which will be used to drive a reduction in harm to communities as a result of associated crime, disorder and anti-social behaviour.

The indicators will be supported by indicators housed within other PSAs that are crucial to reducing these harms. Within health and social care services, for example, the focus will be upon social inclusion with enhanced access and assertive outreach and retention within care. The PSA, together with the current revision of the National Drug Strategy, provides the policy context within which the recommendations of this report can be taken forward.

In a further development announced on 5th December 2007, three 'Titan' prisons, each holding 2,500 prisoners, are to be created, and by 2014 the total number of places in prisons in England and Wales will have risen to 96,000. This may provide opportunities to develop different ways of delivering drug treatment in prison, which we touch upon in the rest of the report.

2 Summary of findings

(See Appendix 1 for a summary of the issues presented in this section).

Strategic planning and commissioning

An examination of current planning and commissioning arrangements for prison-based drug treatment revealed that there is no overall strategy for dealing with prisoners and offenders with drug problems which balances the objectives and priorities of the Department of Health (DH), Ministry of Justice (MoJ) and Home Office (HO) and which sets out a framework for commissioning and performance.

As Table 1 below shows, commissioning arrangements are complex, with multiple agencies involved at regional and local level – however there is no one body or individual holding overall responsibility and accountability. There is a lack of formal authority to make decisions on commissioning priorities across the whole service pathway (from community, through prison and back into the community). Information systems are also fragmented (sometimes worsened by missing or lost records) which limits information sharing of the sort that is required to support commissioning decisions. Funding streams are fragmented and consequently there is lack of flexibility in how funding can be used to meet needs and achieve desired policy outcomes. There is no systematic approach to priority-setting given the resources available, nor is there agreement on whether reoffending or health outcomes take precedence.

Several different outcomes are used to assess drug treatment effectiveness. They tend to be grouped into three main categories:

- Drug misusing behaviour.
- Social functioning, including criminal behaviour.
- Health, both physical and mental including risk behaviours.

Given limited resources, any strategy needs to be clear on the nature and priority of these outcomes in order to direct resources to their achievement. For example, if reduced reoffending by PDUs is the primary desired outcome, the case can be made for targeting further services on those most likely to reoffend. However, if the prevention of self-harm and of transmission of blood-borne viruses is the primary desired outcome, the case can be made for targeting further services on those most likely to self-harm regardless of impact on reoffending. In line with the lack of clarity of outcomes, the key performance targets (KPTs) used to manage the performance of drug treatment providers are based on volume of activity and not on quality and outcome which limits their usefulness. The recent Public Service Agreement (PSA), led by the Home Office and also covering MoJ and DH, gives a strong guide that the primary focus is on reducing re-offending rates:

PSA 25: to **reduce the harm caused by Alcohol and Drugs** which will drive further improvement in the level of effective treatment for drug users, for the first time extending this to focus on alcohol misuse, thereby reducing the harm to communities as a result of associated crime, disorder and anti-social behaviour.

Table 1: Drug treatment commissioning arrangements in the community and in prison

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* Excluding IDTS costs

** PTB = Pooled Treatment Budget

*** The figures for DIP funding indicate the total sum, only a proportion of which is directly spent on case management and treatment oriented interventions.

Entry to and release from prison are high risk for PDUs. Drug-dependent prisoners are approximately twice as likely to commit suicide in the first week in custody as those who are non-dependent. Release from prison carries a risk of relapse as a person returns to their old social networks, and 1 in 200 (0.5%) of injecting drug users entering prison will overdose and die on release due to reduced tolerance to opiates. Therefore, any strategy needs to span community and prison provision, remove barriers to coordination on entry to and release from prison, and incentivise coordination through a performance management framework.

With the exception of clinical research, there has been a lack of research commissioned to examine which treatments and combinations of treatments are most effective in achieving health and reoffending outcomes for PDUs, and which represent best value for money (see also below). Consequently there is no agreement on the scale of need and unmet need for different types of service. Nevertheless there is a growing recognition that prison drug treatment needs to move away from a 'one size fits all' model to a more

personalised service that matches individual needs to treatment options. Drug misusing prisoners are not a homogenous group. Age, ethnicity and gender have all been found to have a significant impact not only on drug misusing behaviour but also on responsiveness during induction into drug treatment and effectiveness once in treatment (see Appendix 3). The recent NICE guidance on drug misuse (July 2007) provides some helpful indications which we have used in defining the options presented later in this report. However, it also brings into relief the gaps in evidence for treatments or interventions which has a strong face validity and are popular with prisoners, but for which there is ambiguity about effectiveness, and lack of supporting performance data to measure impact on outcomes. It is hard to justify continued investment in some of these interventions without further research and improved performance measures based on outcomes.

Our analysis indicates the need for a national strategy that clarifies and prioritises outcomes; revision of commissioning arrangements to facilitate coordination of drug treatment services within and outside prison and ensure best practice is followed; simplification or unification of funding streams; and a national performance framework supported ideally by a single information system, or by protocols to ensure effective information sharing.

It was beyond the remit of this review to examine the commissioning and provision of community services except in relation to transition arrangements into and out of prison. However, it is vital that the strategy covers drug treatment both in the community and in prison to ensure continuity of care. This was strongly supported by Steering Group members and experts involved in the review, and relates equally to commissioning and funding arrangements, the performance framework and supporting information systems, and the commissioning of research into treatment effectiveness.

Service provision

Whatever structural changes are made, strategic planning and commissioning decisions need to be based on evidence of what treatments, packages of treatments and treatment pathways are most effective for PDUs with diverse needs. Service provision comprises case management (including assessment and care planning), clinical services, and psychosocial services. There has been considerable investment in case management and psychosocial provision over the past 10 years, including the development of pathways of care, and improved contract management. These services are valued by prisoners and demand exceeds supply. However, there has been a lack of research to provide evidence of efficacy of some of these services, and performance management has focused on volume of activity rather than quality and outcome, so it is difficult to demonstrate value. In contrast there has been much less investment in clinical services (clinical assessment, detoxification and maintenance prescribing) until the last few years and there is more research evidence to demonstrate efficacy. We summarise the research evidence below, and then report on feedback provided by prison and treatment staff, and drug-misusing prisoners.

Evidence on treatment effectiveness

(See Appendix 3 for a review of research evidence and references. This has been supplemented by discussion with the panel of experts.)

Many prisoners are poly-drug users and abuse a cocktail of drugs, including opiates and stimulants. There is also a distinct racial and socio-economic component to drug choice and black and ethnic minority prisoners tend to favour stimulants over opiates. Experts consulted as part of this review all appeared to support a poly-drug approach as being most effective, therefore, rather than drug-specific approaches and programmes.

Case management

For prisoners with sufficient time in custody, CARATS construct a care plan following a comprehensive substance misuse assessment, which plans future interventions including structured one to one work, group work, and referral to short and longer-term programmes. Little research has been commissioned to examine the efficacy of CARATS teams that provide case management (assessment, care planning, review, transition and release planning and handover). Since performance data focuses on quantity of activity rather than quality and outcome, it is difficult to prove its effectiveness.

However, the rationale for having a case management function as part of drug treatment is strong and given that drug addiction is a chronic relapsing condition with complex interventions required, it is difficult to know how services could be delivered without case management and associated assessment. It is important, therefore, that case managers have the skills to support prisoners with a wide range of complex needs, and

have a range of services available when constructing care plans.

Clinical treatment

Currently, no pharmacological treatments have demonstrated success in treating either cocaine or amphetamine dependence. As a result, the Department of Health makes no recommendation about the pharmacological treatment of stimulant dependence and instead advocates the provision of a 28-day psychosocial programme for stimulant misusers. NICE guidelines on drug misuse similarly recommend a range of psychosocial interventions over pharmacological interventions, ranging from brief motivational interventions to contingency management and self-help. Consequently, clinical treatment focuses on opiate addiction.

Historically, detoxification is the most preferred method of clinical management of opiate withdrawal in prisons. Evidence suggests that detoxification is not effective as a means of achieving long term abstinence as a stand-alone intervention and is more effective when offered with a combination of other interventions such as maintenance prescribing and psychosocial support. A clear detoxification delivery plan exists for prisons but it is not delivered consistently and is often poorly managed leading to some recent clinical negligence claims by prisoners.

Replacement therapies, such as Methadone Maintenance Treatment (MMT) for prisoners and offenders have been found to produce positive outcomes in terms of both drug misusing behaviour and criminal behaviour. Buprenorphine has also been shown to have similar outcomes to MMT. Issues that need to be considered when prescribing maintenance therapy to prisoners is both the length of sentence and the availability of community throughcare to support the regime upon release from prison. Clinical staff also need to be trained specifically in maintenance therapy. Historically, UK prisons have not consistently offered opioid maintenance. Even where it has been offered, the means by which it is delivered has been inconsistent between prisons and prisoners. This is changing however, and opioid maintenance is a key part of the IDTS programme. Like detoxification, maintenance prescribing has been found to be most effective when combined with psychosocial interventions.

Psychosocial interventions

Both opiate and stimulant users are believed to benefit from psychosocial programmes, although the evidence base supporting these interventions is relatively weak. There are three main types of psychosocial intervention within prisons:

- CARATS workers are able to provide one to one and group-work in addition to case management;
- Short courses designed for prisoners with low to medium levels of dependency;
- Longer-term or ‘intensive’ drug treatment programmes.

Little research has been commissioned to examine the efficacy of the 28 day psychosocial intervention package offered by CARATS for PDUs. Similarly little research has been commissioned to examine the efficacy of short-term programmes (SDP and P-ASRO) which provide 20 sessions over a period of 4-6 weeks for prisoners with low to medium levels of dependency, and focus on harm-minimisation.

There is more research evidence of the efficacy of the longer-term programmes of which there are three main types: cognitive behavioural therapy (CBT), 12-step programmes and therapeutic communities. Whereas CBT and 12 step programmes refer to a range of intervention techniques, TCs in particular provide a therapeutic environment in which participants live together and receive a variety of treatment modalities, which can include both 12 step and CBT intervention types. All three have been shown to produce positive outcomes and are equally suitable for prisoners using different drugs and poly-drug users. TCs have received the most attention. There is some concern about the quality of research on these long term programmes and the impact of selection bias on findings and applicability to the UK prison population.

Since CBT, 12-step and therapeutic communities are all abstinence-based, experts stressed the importance of the timing of such interventions at the right time for the individual, when they are ready to be and remain abstinent. This will occur at different times for different individuals, and again emphasises the importance of skilled case management to determine appropriate timing. Also, NICE (2007) provides guidance on when particular programmes should be used – ie CBT should not be routinely offered to people presenting with

cannabis or stimulant misuse or those receiving opioid maintenance. However CBT *is* appropriate for the treatment of co-morbid depression and anxiety disorders for those with cannabis and stimulant problems, those who are abstinent or are stabilised on opioids.

Cross-cutting themes

Looking at the research as a whole, there are a number of cross-cutting themes. The literature offers no gold standard of drug treatment intervention but that there are different treatment effects in different settings. However better outcomes are reported for clients who receive a combination of treatment programmes eg methadone maintenance and psychosocial interventions. Time in treatment and treatment completion are associated with better treatment outcomes, and better outcomes are reported for clients receiving aftercare support after completing a programme or course of treatment, such as ready access to a CARATS worker, together with wraparound services such as education, housing and related support, debt management, and employment preparation.

Prison drug treatment services are structured around care pathways, where clients potentially receive a multitude of concurrent interventions eg MMT, CARATs support, as well as mental health inreach support, and education services. However, the research that has been undertaken evaluates specific interventions in isolation from the wider care process, making it difficult to assess how effective care pathways are. Similarly little is known about the possible cumulative effects of multiple treatments, and how different treatment episodes may interact or interfere with one another.

Special consideration is needed when devising care plans for women, black and ethnic minority prisoners and prisoners with accompanying mental health problems. Some of the evidence has shown that these groups tend to have difficulty accessing treatment. The competency of staff in developing therapeutic alliances and providing motivational interventions is an important aspect of treatment. Many PDUs have spent years in their addiction phase and have developed a variety of associated problems including health, social and offending related aspects. Those in prison have arguably the most severe problems which will be multi-faceted in nature and therefore the responses need to be equally complex and flexible to address individual situations.

Feedback from stakeholders

(See appendix 4 for a summary of feedback from stakeholders.)

Drug treatment benefits and success factors

From the staff and prisoner perspective, a number of benefits were perceived to arise from the delivery of drug treatment such as an increased awareness of the impact of drugs on health and behaviour and the acceptance of the need to change, health benefits, and improved self-esteem. It was seen as most successful when a holistic approach is taken to health needs, and wider needs such as accommodation, employment and ongoing support on release. Other success factors were:

- Care plan and treatment tailored to the needs of the prisoner
- Frequent contact with and access to CARAT staff
- Enthusiastic, non-judgemental, approachable staff (clinical, psychosocial and prison)
- Multidisciplinary teamwork in delivering programmes including prison officers
- Prisoners acting as peer supporters
- Throughcare and aftercare in place after a programme ends.

Clinical services, and treatment for opiate vs stimulant users

Prisoners commented on the variation in detoxification treatment times in different prisons, and on the attitude of some clinical staff which can impact negatively on their self-esteem. There was a feeling that those people abusing opiates got more treatment than stimulant users due to pharmacological treatment focusing on opiate addiction (for valid reasons), and the perception (we believe borne out in practice) that they were given priority over other drug misusers for the limited number of places on longer-term intervention programmes, based on the more severe consequences of self-harm (overdose, blood-borne infections etc).

CARATS and care planning

Prisoners valued contact with CARATS staff. CARATS staff were reported to be readily available in some prisons (not necessarily those visited during this review), whilst in others prisoners perceived CARATS to be scarce, with some saying they waited weeks to see a worker. A lack of treatment rooms led to a lack of privacy when staff were discussing user needs. In addition, there were reported to be a lack of offices to allow for clinical and psychosocial staff to be collocated and form teams.

With regard to care planning, due to staff shortages, the availability of places on suitable programmes, short sentences, and the churn of prisoners between prisons, such continuity can be difficult to achieve. Where prisoners are able to get on to a programme, some of those interviewed felt there was little to support them on completion either in terms of access to a CARATS worker, or wraparound services to keep them occupied and build a positive future.

Service variability and coordination

The variability in the type and volume of clinical and psychosocial treatments provided in different prisons was reported to present particular problems in continuity when prisoners transferred between prisons. This is a particular problem for women and young prisoners since there are fewer prisons.

Within prisons, because clinical and psychosocial services are funded, commissioned and provided separately, this can lead to poor coordination and teamwork in spite of the intention to provide coordinated care. The Integrated Drug Treatment System (IDTS) is a new pathway, designed to introduce a coordinated package of clinical and psychosocial care during the first 28 days on entry to prison and this will help to integrate clinical and psychosocial assessment and provision and throughcare into the community. It is too early to judge whether IDTS has or will be successful although there is strong support from all stakeholder groups for the principles of IDTS. However, fewer than half of all prisons currently have IDTS and there is currently no funding to extend implementation to the others.

Transition

With regard to transition between community and prison, these services are funded and commissioned separately, and provided by separate teams; CJITs or 'DIP teams' in the community; CARATS in prison. The teams use different assessment tools. The Drug Intervention Record is designed to enable key information to be exchanged between teams when a person enters and leaves prison, however this is in a paper-based form and we found evidence of forms being lost or arriving too late so that work is duplicated. There is no electronic information system which is currently used to assist information sharing. We found examples of effective, well-managed transition arrangements between community and prison and out again, although these were rare.

Prisoners and prison and programme staff commented on the need to avoid Friday night releases which make continuity of care difficult as the community team is not set up to respond to them, as does the unplanned release of remand prisoners which is beyond the control of prisons and treatment providers. They emphasised the need for support from CJITS and the Probation Service, especially in the immediate period after release, and for the involvement of peer supporters post-release and engagement with family, partners and close friends. Where IDTS is being implemented additional CARATS resource has been included to assist with transition planning, although the impact on community services of IDTS in terms of larger numbers of prisoners being released on methadone maintenance is unknown.

Wales

We were asked to examine issues arising for Welsh prisoners being accommodated in English prisons. North Wales has no prisons and South Wales has no full Category B prisons. Consequently these prisoners go to English prisons, mainly in the south of the country. The Area Drug Coordinator for Wales was not aware of any transition issues unique to Welsh prisoners in English prisons. He felt that the issues, such as short notification of release date to CJITs, and the slow transfer of information between teams, were the same for Welsh prisoners moving backwards and forwards across the border, as they were for prisoners elsewhere.

Coordination with alcohol, mental health, and wraparound services

Alcohol and mental health services are also funded commissioned and provided separately from drug treatment (through PCTs). With regard to mental health, there is a particular challenge to coordinate

services for those drug misusers at high risk of suicide or self-harm. Wraparound services such as employment preparation, housing advice and debt management (through prisons) are also provided separately. A prisoner may be receiving several programmes (eg a psychosocial programme, other behaviour package, and mental health inreach) with potential duplication of effort.

Tailoring, targeting and performance indicators

In order to access a short or longer-term DTP, prisoners must be assessed by the CARATS worker as needing it. They may then wait for a place, and/or be moved to another prison providing a suitable programme. However, the stakeholder interviews conducted during this review indicated that in spite of staff effort, treatment is not necessarily tailored to the needs of the prisoner, or targeted at those most in need. Rather, it may be based on what is available at the time in each prison.

Key performance targets are based on volume of activity rather than quality or outcome and some staff taking part in the reveiw, under pressure to reach output based key performance targets (KPTs), reported selecting programme users based on their availability to complete the programme rather than on severity of dependence and timeliness for the individual. For example, the Prison Service should achieve 5,923 drug treatment programme completions (2006/7), and CARATS should ensure 52,499 prisoners receive a completed substance misuse triage assessment (2006/7). There was strong support from all stakeholders for the introduction of KPTs based on quality and outcomes.

High security prisons

As well as looking at the main prison estate, we visited two prisons and spoke to the national offender health lead and area drug coordinator for high security prisons. High security prisons appear to have many of the same problems as those in the main estate. We were told that it can be difficult to recruit CARATS staff due to the 12 week wait for additional security clearance after someone has been offered a job. We understand the process has recently been reduced to 6 weeks although the additional work presents a pressure to the service. One longer-term CBT programme is offered which is specific to high security prisons (FOCUS). Like similar programmes in the main estate the course appears to be valued, but there may be little aftercare available. More worryingly, one of the prisons visited currently had no detoxification service available, and reported difficulty in getting the PCT to make the resources available.

Private prisons

We held one interview with a private prison Controller to ascertain whether there were any lessons to be learned from their experience. From that limited encounter we could identify little distinction between the private prison and the main estate. They were also encountering difficulties in engaging the PCT to access funding for detox services. One difference was that the Controller felt they had good links with the community since they had a relatively large CARATS team. Each CARATS worker held a caseload for a particular area from which prisoners are received (eg North Wales), so were able to establish links with the DIP teams and rehab workers to facilitate release planning.

Other gaps in provision

- Adequate staff support to address mental health issues within the prison based population (mentioned by prison clinical staff),
- Need to address health needs of users in a holistic way e.g. full screening as a means of getting them to take responsibility for their wellbeing,
- Non-English speakers and those with literacy problems thought to have unequal access to treatment,
- Post release planning issues, particularly in relation to housing assistance.

Although beyond the scope of this review, consistent feedback also pointed towards the need for an (accredited) alcohol treatment programme. This was reiterated by a range of stakeholders including prisoners. Two women serving life sentences in Holloway for example had set up their own support network through Alcohol Concern and had been deeply frustrated about the lack of provision prior to that.

Conclusion

Our analysis indicates the need for a national strategy covering drug treatment of all types in both prison and

the community. It will need to clarify and prioritise the required outcomes; and introduce revised commissioning arrangements to facilitate coordination of drug treatment services and ensure best practice is followed. Funding streams need to be simplified or unified to support effective commissioning, and a national performance framework is required, which will require fit for purpose information, and ideally a single information system.

Where there are limited resources, an effective strategy for provision needs to be based on evidence of what works. Programmes that are proven to work in prisons should clearly be prioritised, whilst those where there is evidence of no effect should be withdrawn. However, there are a number of programmes where the effectiveness is uncertain; in this case it is not justifiable to invest large amounts of resources on the provision of these services, but instead introduce them cautiously, observing their effects on outcomes, and maintaining close performance management as it is likely that their success is as dependent on the way in which they are delivered as the actual intervention itself.

There is research evidence demonstrating the effectiveness of the pharmacological treatment of opiate addiction through detoxification and maintenance prescribing, which should be supplemented with psychosocial treatment. There is also research evidence of the efficacy of psychosocial treatment for stimulant users and for long-term psychosocial programmes for both opiate and stimulant users and poly-drug users. More research is needed into CARATS, short-term programmes, and the cumulative impact of a variety of services provided along a pathway. Drug treatment should be focused on polydrug use rather than having programmes tailored to specific drugs.

Services were appreciated by prisoners although demand for each type of services outstrips supply. Although pathways of care have been designed, we found evidence of a lack of continuous joined up care within prisons, and the variation in the volume and type of service, as well as different clinical practices causing difficulties in providing continuity and consistency of care both within and between prisons. We found evidence of a lack of effective targeting of programmes due in part to perverse incentives caused by KPTs based on volume of activity rather than outcome.

In the next two sections we provide options for the way forward. We start with service provision, since this will inform the choice of commissioning structure and the way in which diverse funding streams might be aligned or merged.

3 Implications for service provision

Introduction

In this section we address three key questions:

- What **must** be done to provide a minimum standard of care for all PDUs in all prisons? Within this group we include services where failure to provide care would be considered inhumane, and where there is already a strong evidence base of efficacy in relation to reduced self-harm, and reduced re-offending.
- What **should** be provided in addition? We include services with some evidence base, which could be provided on a prioritised basis where resources are available.
- What **could** be provided? We include services where the evidence base is as yet weak or non-existent (as opposed to evidence of ineffectiveness) and where investment must be linked to careful analysis of impact and ongoing delivery.

The principle in applying the above is that if people are unable to receive the minimum standard of care because resources are being spent on services in the 'should' or 'could' category, there is a clear implication that resources should be shifted. In commissioning terms this is 'allocative efficiency'.

When more evidence becomes available of the efficacy of a treatment or programme, it should move up from could to should, and should to must.

Dependence on heroin and/or crack cocaine is a chronic relapsing condition which can last a life-time. Although a custodial sentence provides an opportunity to treat the addiction, services should be provided end to end, with coordination between community and prison. Therefore, a prison sentence is not always the right time to offer a full gamut of interventions - it may however be a critical time to offer someone help. Effective assessment and case management can help determine this.

Services should be tailored to the needs of the individual which includes providing the right treatment at the right time and in the right place to be effective.

Sources of information and options: The options below are based on the review of research evidence, stakeholder feedback including that from the Steering Group and Expert Panel, and examples of good practice and innovation encountered during fieldwork.

What must be done to provide a minimum standard of care for all PDUs in all prisons?

What might minimum standards comprise?

Defining a set of minimum standards will be an early task for a national strategy group. However, using the evidence available to us, the advice of various experts (sometimes conflicting) and applying the principles of humane treatment and services with a strong evidence base, we suggest the following be considered:

- The need to provide the same 'front end' on arrival in prison for all prisoners - to assess, stabilise and prevent self-harm. The IDTS model indicates this should last for the first month.

- All to receive a holistic assessment of needs and a matching care plan.
- The care plan should aim to be holistic including psychosocial inputs and preferably also wraparound services, alcohol and MH inputs.
- The NICE guidelines for detoxification should be implemented, and rapid access maintenance prescribing made available in all prisons, which should remain available to those prisoners who continue to inject while in prison. The latter will also allow prisoners on maintenance programmes to be moved more easily between prisons
- Measures to reduce the transmission of blood-borne viruses, such as screening and vaccination.
- The minimum psychosocial input should be ongoing case management, with particular attention on the period leading up to release, and to an effective handover and follow-through into the community. The level of input may vary with the severity of addiction and complexity of the prisoner's needs.

The danger of litigation from prisoners on indeterminate public protection sentences has been raised as a concern. This issue is covered under 'prioritisation' in a later section.

Issues and implications

The minimum standards suggested above imply greater expenditure on clinical treatment facilities, replacement therapies and training, and the introduction of an out of hours and weekend service, to ensure prescribing can be provided to prisoners released during these times.

They also imply an increase in the numbers of CARATS staff, with the possibility of introducing morning and evening shifts to increase operating hours and therefore availability. The skill level of CARATS staff needs to be raised to ensure they can provide effective case management to PDUs with diverse and complex needs. The KPT for CARATS needs to change from a numerical target for assessment, to a set of indicators that monitor the quality and timeliness of case management tasks. A minimum benchmark for CARATS is needed eg X workers per 100 PDUs based on an agreed caseload. However, apart from the short interventions outlined in the NICE guidance, there seems to be little evidence to support the use of resources in CARATS workers offering any more psychosocial input.

Does this imply that IDTS in its current form should be implemented in every prison? Issues to consider are:

- The model only went live in October 2007 and has yet to be evaluated.
- To implement it in all prisons is not achievable within current funding judging from costing estimates provided by DH and MoJ for the clinical and psychosocial elements in 2006/7 and 2007/8.
- Some stakeholders have indicated to us that IDTS encompasses what should be happening anyway and also that the funding for IDTS could go further if IDTS allocations were to be adjusted to take account of existing resources.
- IDTS is a short-term intervention and does not address the needs of prisoners on longer-term sentences. It is also perceived by some to benefit opiate users more than stimulant users.

Continuity of care on entry to and release from prison would be facilitated by DIP and CARATS teams being commissioned as one combined service. This could also improve productivity and value for money and would be facilitated by the merging of criminal justice budgets across prison and community. Indeed it is understood that those involved in revising the National Drug Strategy are examining the possibility of merging the DIP budget (£150m) with the prisons and DRR budgets.

A more radical solution would be to commission highly skilled drug treatment teams under strong leadership, able to cater for a variable population across community and prison. This would need to encompass CJITs, CARATS and clinical functions under a strong leadership. The benefits would be continuity of care; ability to tackle the range of needs including opiates, stimulants, alcohol and incorporating or liaising with mental health inreach services.

What should be provided in addition to the minimum standards, when resources are available?

We include here services with some evidence, albeit usually generated in very different settings to UK prisons. According to the evidence presented in section 2, these comprise:

- Longer-term DTPs (12-step, CBT and services delivered in a TC) which have been shown to provide benefits, and are suitable for all including those with poly-drug use.
- Of these CBT *is* appropriate for the treatment of co morbid depression and anxiety disorders for those with cannabis and stimulant problems, those who are abstinent or are stabilised on opioids.
- The NICE guidance (2007) recommends the use of behavioural family/couples therapy work and contingency management.
- Training of clinical staff and mainstream uniformed staff within prison to address issues of empathy and support raised by prisoners who took part in the consultation exercise. Such training is already available in IDTS prisons.

Rehab hostels: The greater use of rehabilitation hostels are indicated to be effective in preventing relapse and self-harm in the NICE guidelines (July 2007). These could be used both for those released from prison as a step-down facility, where intensive work on housing, family work, and preparation for employment can also take place. A PDU might also be more easily released early with a tag if they were to go to a hostel.

Issues to consider

These DTPs are expensive and places need to be allocated to those who are ready to benefit. Since they are abstinence-based, prisoners need to be ready to be abstinent and to continue being abstinent. It may be that a prisoner will not reach this point whilst in prison, and may not be ready until post-release. Consequently these DTPs need to be delivered in both prison and community settings, for instance in rehab hostels.

The DTPs also need to be followed by aftercare in order to maximise their effectiveness. If aftercare cannot be provided, the impact on the prisoner reduces in the months that follow which represents poor value for money, although prisoners may benefit greatly at the time. For this reason, the availability of aftercare and time to release (so that they can use it as a platform for recovery) are also important factors in allocating places.

Clustering of prisons, whereby services are provided to serve a combined prison population could help to reduce the cost of providing the longer-term DTPs. This is already operating in Sheppey, and less formally in regions like Yorkshire where transport links between the main cities and prisons are good. London local prisons also tend to have arrangements with particular prisons elsewhere. Clustering would need to work across PCT, LA and Probation Trust (PT) boundaries. The newly announced Titan prisons, which we understand will have a number of separate blocks, also provide an important opportunity to provide a continuous pathway of care.

When faced with prioritising prisoners to receive scarce places on programmes, an ethical framework for prioritisation would help to support professional judgement. We propose a means of prioritising prisoners later in the report.

What could also be made available?

We include services where the evidence base is as yet weak (as opposed to evidence of ineffectiveness). Once good or strong evidence is available, such treatments would move into the ‘should’ or ‘must’ categories. According to the evidence presented in section 2, these comprise:

- The CARATS element of the IDTS programme.
- Short-term programmes – SDP and PASRO.
- The introduction of needle exchange in prison is a controversial issue. However, we understand it is

common practice in parts of Europe. We understand that those people who inject in prison share injecting equipment more often and with more people than they do in the community.

- Drug free prisons: Reducing drug supply in prisons is a major issue and mandatory and voluntary drug testing incurs significant expenditure. Not all prisons could be drug free but there could be voluntary facilities which had higher security and more extensive personal search requirements.

Issues to consider

More research is needed into the efficacy of the short-term programmes (SDP and P-ASRO). A review of the literature on the benefits and practicality of introducing needle exchange within prison is also needed, together with an examination of prisons which already provide this service.

The creation of drug free prisons is an expensive option and was not considered to be practical in the current resource climate. However, the recently announced creation of 3 new Titan prisons, which we understand will comprise separate blocks within a shared compound with shared services, presents an ideal opportunity to consider building designs and operational arrangements that would facilitate the creation of environments that can be kept genuinely drug-free.

Option for notional revised care pathway within prison

Using the services outlined in the previous pages a notional new care pathway is proposed below. Further consultation should be undertaken to refine such a pathway, and its introduction is unlikely to be possible within current resources. It would require, for example, more CARATS staff to undertake case management/key working, and more wraparound services during the middle of the sentence. If resources were increased, or significant realignment to take place, it would also take time to put in place.

Entry to prison: A combined DIP and CARATS service would assist with continuity of care on entering (and release from) prison. The teams would use the same assessment tools and share information using a common information system. In Wales DIP workers offered to give CARATS read-only access to their data systems which they could access via the internet. This had proved relatively easy to implement.

First 28 days: As described under 'minimum standards' above, all prisoners would receive the same core services on arrival to stabilise them and prevent self-harm. Based on the IDTS model, this will include assessment, clinical inputs to stabilise the prisoner and provide maintenance prescribing or a detoxification pathway, measures to reduce the transmission of blood-borne viruses, and a care plan. As a minimum this requires that rapid access maintenance prescribing be available in all prisons. Where resources are available behavioural family/couples therapy work and contingency management should also be provided.

Mid-sentence: During the middle of the sentence for those with sentences over a month, the care plan would include access to peer support, CARATS and clinical inputs, working in coordination with other prison services (education, employment, debt management, mental health). Methadone maintenance would continue for prisoners who continue to inject in prison, but with careful management and review.

For those PDUs ready to be abstinent, they should have access to a range of intensive DTPs. These include the 12 step programme for those with severe dependence both to opiates and/or stimulants; CBT for opioid dependence or co-morbidity, and therapeutic communities for all those with significant drug misuse problems as indicated in the NICE guidelines (July 2007). However, in the absence of aftercare to support a prisoner on completion of a DTP, placing a prisoner on such a programme should be reviewed in the context of scarce resources.

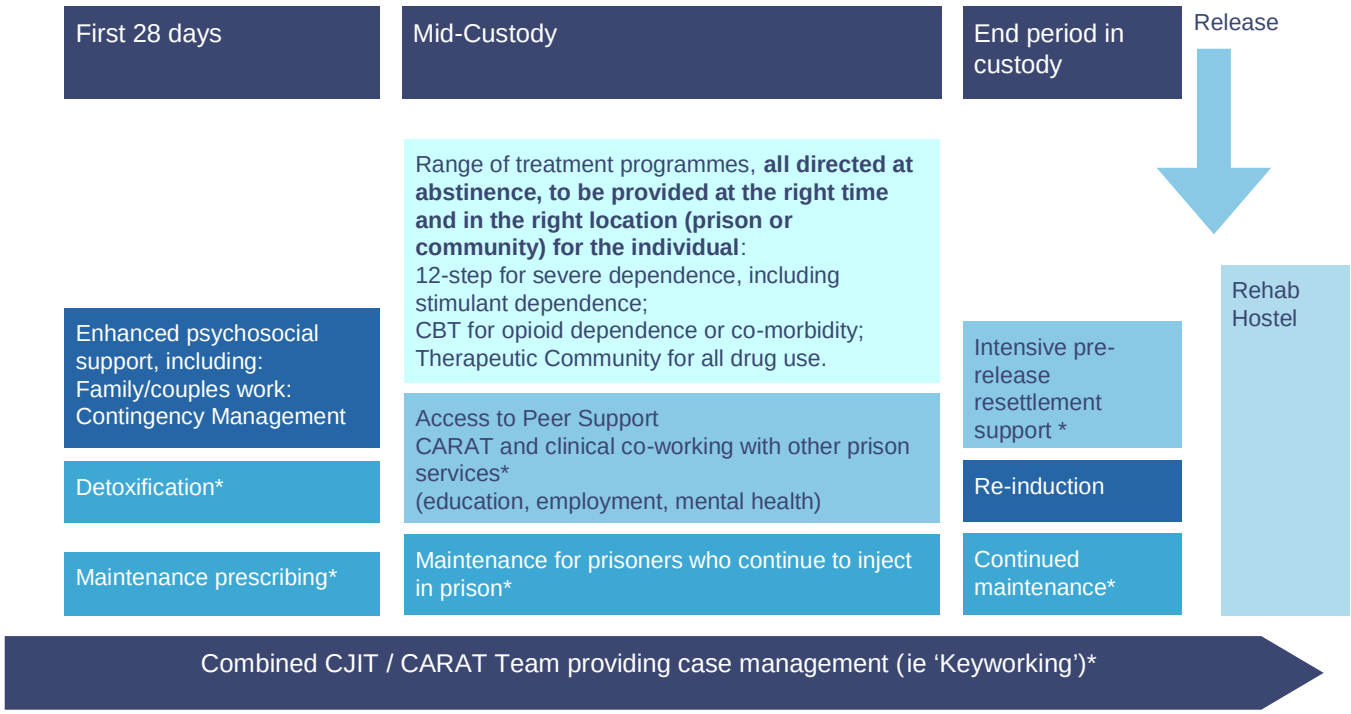
End period in custody: All prisoners must receive intensive pre-release support from CARATS and wraparound services designed to ease their transition into the community, ensure continuity of care and prevent relapse. Retoxification is an option, based on professional judgement for those PDUs deemed likely to relapse on release in order to prevent accidental overdose and death.

Release: Where resources are available, prisoners who were deemed to benefit should be released to a rehabilitation hostel post-release in order to prevent relapse and self-harm, as indicated in the NICE guidelines (July 2007). Intensive work on housing, family work, and preparation for employment can take place at this stage.

Figure 1 below shows how the pathway might work.

Figure 1: Notional Prison Drug Treatment System

(* denotes minimum standard)



How could resources be freed up within the existing system to help pay for minimum standards for all?

It is beyond the scope of this review to provide detailed costings of the impact of the suggested changes above. However, we outline here some areas where we think resources could be freed up.

Follow the principle that if people cannot receive the minimum standard of care because resources are being spent on services in the 'should' or 'could' category, there is a clear implication that resources should be shifted. In commissioning terms this is 'allocative efficiency'.

In those prisons where IDTS is being implemented, explore the possibility of reducing IDTS funding to take account of pre-existing resources in order to support the achievement of minimum standards for all PDUs in all prisons.

CJITs and CARATS teams report a lack of capacity to conduct effective transitional handovers, although cultural factors may also be present. The two teams use different assessment forms, and the Drug Intervention Record designed to enable information to be passed from one to the other is paper-based and may get lost. These problems could be overcome by the creation of joint CJIT/CARATS teams, or teams that also include clinical staff. Based on experience in other sectors, a productivity gain of 10% minimum could be expected, for example through eliminating duplication of effort. It would also potentially make it easier to keep track of remand prisoners with unplanned releases.

The creation of a single criminal justice funding stream combining prison psychosocial and DIP funding would facilitate this and provide a more efficient basis for co-commissioning generally. As previously stated, the inclusion also of clinical treatment funding for prisons and community provision would create yet more efficiencies.

Contract specifications focused on outcomes, and tighter performance management of providers is required in order to hold account for the delivery of the terms of the contract.

The involvement of providers in the strategic commissioning process is good practice and has many benefits for commissioners. Our work with local authorities indicates that providers may be prepared to reduce prices (without compromising quality) if they have more certainty about future commissioning intentions, and longer-term contracts. It is also important to introduce contestability to ensure best value for money.

Incorporating drug treatment messages into other programmes provided within prison as an alternative to some of the work of CARATS group work, and the short-term DTPs (SDP and P-ASRO). There is also a need to rationalise and coordinate existing programmes to ensure there is no duplication of effort eg drug, alcohol, mental health, education programmes.

Mandatory drug testing (MDT) was not part of this review; however it was felt appropriate that we would comment if we found any evidence of an impact on drug treatment. Our analysis of the views of national and regional stakeholders indicated support for anonymised testing to provide an indication of the level and type of illicit drugs that were being taken by prisoners (which would aid the planning and commissioning of services). However, staff and prisoners generally felt that MDT should not be used to monitor the behaviour of individuals since it was open to manipulation (with clean urine often being used as a currency), and other problems such as recreational users of cannabis moving to opiate use to avoid detection.

We suggest that longer-term DTPs (12-step, CBT and use of TCs) should be used where resources are available. Given that sufficient resources may not be available to treat all those prisoners who are ready for such programmes, we propose below a method for supporting professional judgement in prioritising prisoners.

Option for prioritising longer-term intensive psychosocial treatments

Context

Early in the review, we explored with the Steering Group and Expert Panel the segmentation of the prison population via a number of characteristics such as age and gender. There was a general acceptance among Steering Group members, experts and others interviewed of the need for some form of prioritisation in relation to the more expensive interventions, such as intensive CARATS monitoring and review, the 12 step programme, and therapeutic communities. We were advised that segmentation might be the basis for that, but that it should not be used until after the first 28 days in custody. We propose below an approach to prioritisation based on segments of the population used within an economic model that considers a range of impacts of drug treatment on the individual and society.

Prioritisation model

We propose the introduction of a rational prioritisation model based on government policy and the outcomes required. At present, desired outcomes include reducing reoffending, reducing health problems (accidental death, suicide, transmission of blood-borne viruses), and improving future life chances (employment, earnings).

The choice of indicators has been determined by the evidence base which identifies groups who require particular attention, together with the development of an economic model which looked at the expected costs and benefits to society, the individual and the state from certain areas of costs.

The prisoner characteristics identified through the evidence review (see Appendix 3), our early work on segmentation, and an initial broad brush economic impact assessment were discussed with the Steering Group and with later on with the regional workshops. Among PDUs the prioritisation groups are:

- Young (eg 18-21) – less likely to already have long-term damage and have more potentially positive years in front of them; however, they are often harder to treat as they are further from the personal consequences of their actions.

- Older (eg 30+) – more likely to accept treatment as they are closer to the personal costs of their addiction; however, they have a higher likelihood of existing long-term problems and fewer years of potential positive activity.

- Short-term prisoners for acquisitive crime including PPOs and prisoners on remand – these prisoners are among the most common causers of social costs (through their criminal activities), have frequent contact with the authorities but often pass through the criminal justice system fairly quickly (matter of months rather than years).

- Women – women have different treatment needs than males especially with regard to the role of relationships and children with regard to their treatment needs. The impact of their drug abuse on their children is also likely to have significant costs for both their children and for society.

- Those co-dependent on alcohol – alcohol abusers continue to face many of the health, social, criminal

justice and economic output costs that illegal drug abusers face. Indeed, evidence from the NTORS study suggests that when drug abusers reduce their drug taking, they may compensate by increasing alcohol consumption, though this evidence was for all drug abusers and not only those with a heavy alcohol dependence.

- IPPs – these prisoners may face difficulties in meeting their release criteria if they are not offered programmes to address their drug problems. Failure to provide courses in a reasonable time frame may have legal consequences if they are not considered to have been fairly treated.

The only prisoners excluded from the above groups are men in their twenties who have been convicted of more serious crimes. Furthermore the groups are not mutually exclusive - a person may be young, female and a PPO. We are not suggesting that individuals in each of these categories are automatically prioritised (see under 'Potential uses of the model below).

The potential cost savings over the course of a lifetime were estimated in relation to:

- Excess mortality costs
- Excess morbidity costs
- Direct health costs
- Lost economic output
- Costs to the criminal justice system
- Social costs
- Intergenerational costs.

All these costs have been calculated in present value terms by using a 3.5% discount rate. In each case where a choice of variable was presented, the more conservative options was selected (eg lowest pay band). This biases the model outputs as underestimates of the true costs.

We were able to estimate the costs only on the basis of age and gender due to the availability of data. The findings were that cost savings *if the intervention were immediately effective* were estimated as:

- 21 year old male £736,000
- 30 year old male £560,000
- 21 year old female £737,000.

The economic framework is written up in Appendix 5, and an explanation of the model and calculations used above are included in Appendix 6. This approach can be adapted as Government policy changes, but serves, alongside other evidence, to promote a review of the level of resourcing provided for drug treatments.

Potential uses of the model

There are two potential uses of this approach:

a) To assist in strategic needs analysis to guide planning and commissioning decisions;

b) To support staff in using their professional judgement in allocating scarce resources in such a way as to best achieve desired outcomes for the individual and society. Here the approach would be built into an assessment tool by way of a points system. A person's risk rating would be higher the more categories they fall into.

As the evidence base develops, the weightings attached to different groups could be changed.

Conclusion

In this section we have provided an outline of what must be done to provide a minimum standard of care to all prisoners, based on what is humane, and on current evidence of efficacy. We also outline services with a good evidence base which should be provided when resources are available, and services that could also be provided but for which there needs to be more research to establish its efficacy. We recommend the use of 'allocative efficiency' whereby resources are realigned to ensure first that a minimum standard of care is delivered to all before resources are spent on other services. Building on the above, we also propose a notional revised care pathway.

Delivery of the minimum standard of care in all prisons is not likely to be possible within existing funding so we have outlined a number of areas where we believe existing resources could be freed up, together with an approach to prioritising longer-term psychosocial treatments for maximum impact on the individual and society, based on lifetime cost savings in relation to areas such as morbidity, lost economic output, criminal justice costs and social costs. We suggest that this could be used to guide the commissioning process at a strategic level, and in supporting professional judgement at the front-line when allocating scarce resources to individual prisoners.

4 Commissioning, Funding and Performance management

Introduction

This review was also tasked with examining the extent to which current commissioning arrangements are fit for purpose and if not, given the service objectives, what should be the preferred commissioning model. In previous sections we have concluded that a national strategy is required to guide the commissioning and provision of drug treatment to span both community and prison, and one that clarifies and prioritises outcomes. Accompanying the strategy should be a national commissioning framework to facilitate the coordination of drug treatment services and to ensure that best practice is followed, together with the simplification or unification of funding streams. A national performance framework is then required, supported ideally by a single information system, or by protocols to ensure effective information sharing. Finally we highlight areas where further research is required to demonstrate the efficacy of particular services, and combinations of services.

The section on provision indicates the range and balance of services that must be provided for prisoners and offenders as a national minimum standard of care; and those that should also be provided where resources are available. These options themselves have implications for the way in which commissioning and funding streams need to be structured. For example, we make the case for a combined CJIT/CARATS service to help ensure continuity of care on entry to and release from prison. This will be facilitated by a single budget and a single commissioning body to cover community and prison psychosocial services.

The key questions: What outcomes is prison drug treatment there to achieve, and how can services be funded, commissioned and delivered most effectively to ensure there is clear accountability for and continuity of care for drug misusers in the criminal justice system? Commissioning has a further objective to facilitate the delivery of the recently developed PSA target:

- PSA 25: to **reduce the harm caused by Alcohol and Drugs** which will drive further improvement in the level of effective treatment for drug users. For the first time this will be extended to focus on alcohol misuse, thereby reducing the harm to communities as a result of associated crime, disorder and anti-social behaviour.

The process that we went through is as follows. We gathered stakeholder views on current commissioning arrangements, facilitated a discussion on best practice commissioning and what tasks could best be undertaken at a national, regional or local level, put forward a number of options for discussion by the Steering Group and experts and took account of proposals and comments received from individual Steering Group members and experts.

Commissioning is a strategic process for assessing the needs of a population, in developing services or providers to meet those needs if required, contracting [including monitoring and performance managing] services and undertaking a range of strategic efforts to meet a population's needs. Stakeholders emphasised the need to build on existing structures and networks as far as possible, and to ensure fit to the direction of travel in NOMS and DH with regard to commissioning. The principle of a commissioner – provider split is generally accepted.

Current arrangements

The current commissioning arrangements for drug treatment services within prisons and outside in the community involve various organisations and incur a mix of regional and local commissioning arrangements. Table 1 in section 1 demonstrates the myriad arrangements. Clinical services are commissioned locally through PCTs who since 2005 have been responsible for clinical treatment both in custody and in the community. Guidelines for clinical services are set by the National Treatment Agency (NTA) although NTA does not have strategic responsibility for drug treatment in prisons. The psycho-social services in prisons are commissioned by Governors but often in partnership working with DATs and other agencies. Services in high security prisons are commissioned centrally by NOMS.

Current funding arrangements are complex. There are multiple funding streams (see Table 1 in Section 1). Different departments fund different drug treatment services both in prison and the community. This creates a barrier to partnership working, potentially stifling innovations that cross boundaries. It represents an inefficient way of providing joined up services.

There are pooled treatment budget (PTB) mechanisms already in existence covering drug treatment in the community but excluding DIP funding. A recent change means that the PTB can now be used to invest in drug treatment within prisons provided they enter data on NDTMS which is a step forward although there is concern that unmet demand for treatment in prisons could potentially threaten services in the community.

Stakeholders wanted there to be fewer or possibly a single funding stream which could be used more flexibly to support the whole of a prisoner's drug treatment needs both inside and outside prison. Conditions could be set on the use of the funding for example to support partnership working in order to maximise positive outcomes.

What is Best Practice Commissioning?

In evaluating the most appropriate commissioning arrangements for drug treatment services in prison, it is important to understand what is expected role of a commissioner and the best practice features that make up a "best in the class" commissioning function.

Drawing from evidence from international experts, academic reviews and experience from other sectors, PwC has evaluated the commissioning requirements against a Commissioning function model that describes what "best in the class" commissioners actually do to deliver the desired outputs of appropriate treatment and value for money. The eight commissioning functions are shown and summarised in Figure 1 below. The functions do not have to be delivered at one single level, and some can be delivered at different levels. Indeed, it is worth remembering the adage that commissioners are generally either too large, or too small; choices about commissioning need to be based on a series of judgements.

It should be noted here that the involvement of providers in the strategic commissioning process is good practice and has many benefits for commissioners. Providers should be involved in the strategic needs assessment to harness valuable market intelligence, ideas and innovation. The sharing of information on likely commissioning intentions with all providers including potential new ones on an equal basis will give advance warning of shifts in policy and purchasing decisions so that providers can respond accordingly, ensuring the required volume and range of services is in place in a timely manner, and ensuring contestability. Contracts should specify quality standards (from national performance framework) and outcomes and leave a degree of flexibility on delivery.

Figure 2: Best Practice Commissioning

Plan Stage

Assess needs – through a systematic process that assesses and translates the needs of a resident population.

Describe services and gap analysis – Reviewing and defining the gaps of services through the perspective of areas of overuse, misuse or under use.

Deciding priorities **–** Using the available evidence of cost effectiveness and a robust ethical framework. Prioritise areas for commissioning.

Risk Management – Assessing the key risks facing the Commissioner and deciding on the strategy to manage it.

Strategic Options – Examine and appraise the options available to deliver the Commissioning priorities.

Execution Stage

Contract implementation – designing service specifications and contracts to put these strategic commissioning intentions into action.

Provider development – shape and support provider developments or introduce new providers to deliver the services required.

Performance Management Stage

Managing performance – monitor and manage the performance of providers against their contracts, especially against KPIs.

Evaluation of the Commissioning Function Requirement

As part of evaluating the commissioning options, we assessed the requirements against the best practice model functions and tested this out in a workshop session with the steering group. The key questions examined were:

- What level is best placed to undertake the commissioning function (national, regional or local PCT)?
- What is the likely availability of skills and expertise?
- What are the optimum arrangements to deliver the national multi-factorial policy objectives and commission services that address a spectrum of prisoner needs both in and outside the prison pathway?

The key conclusions of each function are summarised in Table 2 below.

Table 2: PwC interpretation of Steering Group discussion on 31st October 2007

Commissioning Function	Current Position	Recommended Approach
Strategic Needs Assessment Assessing needs through a systematic process that assesses and translates the needs of a resident population.	• NTA provides health needs assessment analysis around community services, and we understand NOMS is developing a needs assessment tool for use in prisons.. • Ad hoc research analysis undertaken by DH – no systematic analysis undertaken as part of a commissioning cycle.	• Should be undertaken at the appropriate population planning level. • Requires a national needs assessment tool methodology to ensure consistency. • Needs to be integrated with the community based needs assessment work undertaken by NTA. • Proposed that it has a national and regional function
Review services and gap analysis Review current services and models in relation to outcomes/costs – include areas of under use, overuse and misuse.	• With IDTS beginning to introduce a service and gap analysis assessment as part of the 2008/09 planning cycle.	• Need for a co-ordinated assessment of service provision compared to needs profile across both prison and community. • Suggests that this is better undertaken on a regional level to reflect the regional population churn. • Information needs to be collated for national perspective in order to inform overall DH, NOMS and HO planning.
Manage risk e.g. population risks, policy changes and policy shifts.	• Limited activity at present around undertaking a systematic horizon scanning assessment • Stakeholders commented on the need to clarity accountability and responsibility.	• Needs a national and regional perspective to undertake horizon scanning across various factors. The impact on commissioning or treatment programmes e.g. of drug taking habits – requires multi-departmental inputs. • Requires new skill sets, in particular, actuarial skills
Decide priorities – uses Available evidence for cost effectiveness and ethical framework which must be agreed by stakeholders	• Current priority setting processes are not transparent • Limited involvement of stakeholders	• This commissioning task needs a collaborative approach across national policy departments to agree the top priorities. • Need to develop national knowledge management based at what is best practice to be used by all regional commissioners. • Preferred approach is that decision making around priorities should be at a regional level within a national framework based on a clear strategic vision with outcomes.

Commissioning Function	Current Position	Recommended Approach
Strategic Options Brings together all available information including best practice, economic appraisals, stakeholder views to define best model to deliver agreed and measurable outcomes.	• No one agency/organisation currently undertakes this role with the right set of information. • Stakeholders highlighted many issues in relation to achieving continuity of care between prisons and the community.	• A national good practice database would assist commissioning activity • If you commence to commission prison services as an integral part of community service provision, then this commissioning function should be part of a regional commissioner's remit.
Contract implementation Puts best service models into action through robust contracting arrangements to deliver measurable quality outcomes and values.	• This requires a commercial process and the requisite skills. NOMS' DST develops service specifications and service contracts are managed by prison area drug coordinators. • Stakeholders highlighted that variability and the large number of DATS doesn't lend itself to consistent contracting.	• Requires commercial skills to be provided at. a national level. But implementation should be a regional activity.
Provider Development Promote improvements and encourage introduction of new providers and provide reform.	• Undertaken by national support team around third sector • No systematic approach linked to a regular commissioning cycle. • Stakeholder enjoyment – highlighted the desire for regional stakeholders to get actively involved in shaping provider services.	• Required at national and regional level, to cater for both national providers and more regional or local ones.
Manage Performance Systematic performance review of services and contracts.	• Fragmented approach across organisations • Problems highlighted in relation to existing performance management arrangements within particular regions and prisons.	• Requires a national performance framework within a regional commissioning approach. • But requires regional and local authority input, and systems in place to deliver effective operational management.

Overall, this assessment indicates that decision-making and performance management warrants local stakeholder involvement. However, the majority of the functional activities that represent good practice commissioning would be cost-effectively provided by establishing a regional collaborative commissioning approach. We concluded that a regional model is the most appropriate way forward, working within a national framework of minimum service standards and a cross departmental strategy that balances the various objectives and priorities. Some of the commissioning functions clearly would be better undertaken with the use of a national approach and specialist commissioning function. A key issue raised in the work is the extent to which the prison population needs can be planned for on a regional or national basis. The scale of prisoner transfers could imply that forecasting and planning needs to be on a national basis. However stakeholders indicated that in most regions prisoner transfers are maintained within a regional network of prisons (except for example London). Taking a year on year trend, the mix of prisoners is relatively reliable to predict and subsequently use as a planning basis.

The assessment clearly shows that commissioning activity does not necessary best fit into a complete national and regional commissioning approach.

Stakeholder Views

Many of the stakeholders consulted emphasised the need to build upon the existing regional drug partnership networks or forums established around both prison and community based treatment programmes, but that they would need to be given the authority through joint commissioning arrangements that enables decisions on resource prioritisation across the full service spectrum for prisoners and offenders with drug problems. The desire for an integrated commissioning approach across both community and prison based services was raised by nearly all stakeholders.

The key gaps in the current commissioning arrangements highlighted by many were:

- Absence of an overall cross departmental strategy for dealing with prisoners and offenders with drug problems, which balances the objectives and priorities, and sets out a framework for commissioning.
- Lack of formal authority to make decisions on commissioning priorities across the whole drug service pathways and joined up treatment and care interventions for prisoners moving from prison to prison - real joint commissioning with authority and responsibility.
- Lack of systematic approach to priority setting given the resources available.
- The ability of individual PCTs with one or two exceptions to build up sufficient expertise to commission prison based treatment services and in particular shape and reform the future supply side. Also difficulties in making the improvement of service provision in prisons a priority given the existing PCT commissioner structure and the many other agendas facing PCTs.
- Lack of focus on attempting to join up service commissioning to address the service gaps and duplication associated with community teams and prison based teams.
- Focus on provider performance management that is based on activity based output measures rather than a balance of outcome measures. .

Options for a revised commissioning model

All of the tasks within the best practice commissioning cycle do not need to be undertaken by one body or at one level. However there does need to be a coherent structure to link the tasks. Following discussion and review with the Steering Group and experts, consensus was reached on the following that needs to be built into any future commissioning arrangements:

A joint national strategy group for offender drug treatment involving DH, MoJ and the HO; together with:

- Establishment of Regional Partnership Boards for prisoner and offender drug treatment that would undertake a performance management role holding local joint commissioners to account in the delivery of their commissioning plans; and
- Development of an integrated commissioning model for both prison and community based drug treatment programmes, with clinical commissioning remaining the responsibility of PCTs.

Provided the national strategic and regional performance management functions are in place and operating well, it is less important which option for day-to-day commissioning is chosen. We outline below the remit of a joint national strategy group and of Regional Partnership Boards. We then discuss two options for commissioning.

National Prisoner and Offender Drug Strategy Group

A national prisoner and offender drug strategy group (NSG) for drug treatment would include representation from DH, MoJ and the HO. Its role would be to produce and maintain:

- An integrated prisoner and offender drug treatment strategy
- A set of national minimum standards setting out what must be provided in each prison working with community case management and providers
- A resource allocation model
- A commissioning and performance management framework
- Model contracts

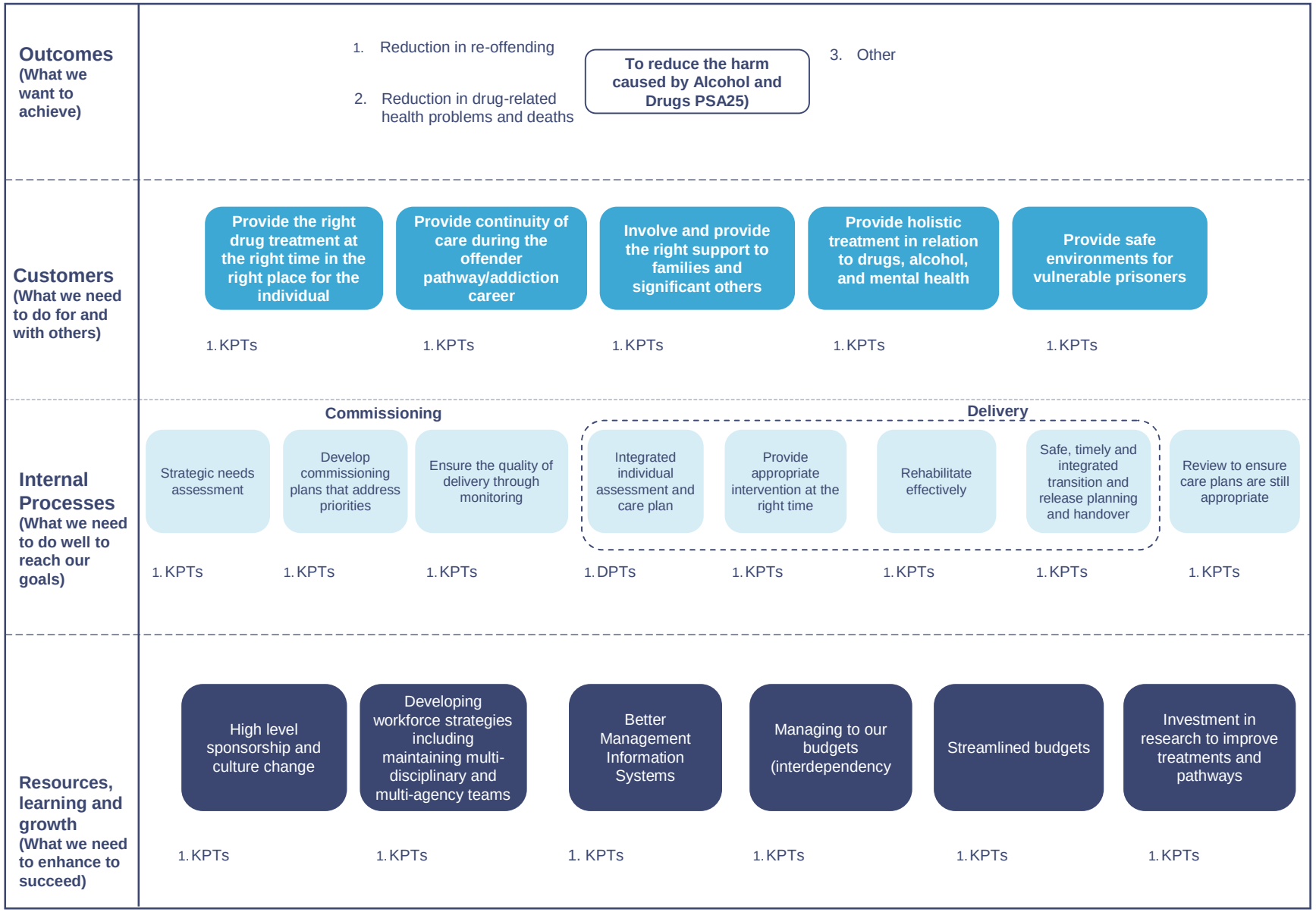
In addition we would recommend that the NSG would play a role in:

- Undertaking provider development (for national providers)
- Commissioning research to support the development of services and pathways over time.

The NSG would be supported by a national strategic commissioning team with the skills to undertake the above.

An early task of the NSG would be to jointly examine the various commissioning strategies, objectives and performance measures of each Department pertaining to prisoner and offender drug treatment. One way of doing this is to use a balanced scorecard approach, which helps to identify and describe the shared strategic intentions for prisoner and offender drug treatment across prisons and the community, and outline the mechanisms by which the partner organisations can work towards achieving these, and know when they have done so. The first step is to work together to develop a strategy map, which is then supported by an index of key performance targets which ultimately develops into a performance framework. An example of what such a scorecard might look like is given in Figure 3. Please note that this has been drawn up merely to illustrate the sorts of elements that might go into such a strategy and does not represent recommended content.

Figure 3: Example Strategy Map



Regional Performance Management Function

Responsibility for performance management would be vested in a Regional Partnership Board (RPB), supported by a Regional Joint Performance Team, and hosted and led by either the NTA or the ROM for the region. It would include representation from Regional Offender Management, the National Treatment Agency regional manager, the SHA, and the Government Office. Its role would be to apply the performance management framework above, to hold commissioners to account, and to report to the NSG. It must have the authority to enforce its judgements. There is potential to link this function to one of the existing regional groups providing it could dedicate sufficient attention to the task.

The RPB would need to have clear leadership. The Steering Group indicated that a new role be created to allow the leadership to focus solely on prisoner and offender drug treatment eg a Regional Prisoner and Offender Drug Treatment Manager (RPODTM). It was probably less important who they worked for (it could be NTA, SHA or ROM) than to ensure they work to a multi-disciplinary agreed regional performance plan, based on the national strategy, and delivery of the national minimum standards.

The RPODTM would require a team with the requisite skills (eg data analysts) and powers to collate data and manage performance.

Option: a joint performance framework is needed to clearly reflect priority of outcomes (e.g. reoffending, health). The performance framework should include key performance targets based on quality and outcome rather than volume of activity. Each key element of case management should have a KPT (assessment, care planning, review, transfer or release), and KPTs should be used to incentivise continuity of care and partnership working.

We have not provided a set of proposed new KPTs as these would need to be the result of joint strategic planning – however the above approach will help devise them. One example however is:

Example of a KPT based on volume of activity: Across the prison service CARATS must ensure 52,499 prisoners receive a completed substance misuse triage assessment.	KPT based on quality and outcome: Triage assessment to be undertaken within X period of arrival in prison; All prisoners to be registered with a GP prior in their home locality prior to release from prison.

Commissioning options:

We provide below two options.

Option 1: Local commissioning by DATs under PCT leadership of all prison and community-based drug treatment; including clinical and case management services (CJITS and CARATS) and psychosocial programmes (Figure 4)

Option 2: Establishment of a regional commissioning function to commission more specialist programmes such as psychosocial drug treatment services or to undertake specific parts of the commissioning function on behalf of local commissioning groups (Figure 5)

These options are described below:

Option 1: Local Joint Commissioning model approach

We would envisage that this commissioning model would build upon the existing Drug Action Team (DAT) commissioning role but in order to coordinate with wraparound and other services, a representative of the ROM would need to be included if they are not already. This local joint commissioning team would be hosted by the PCT but would co-opt local expertise where available from other agencies to undertake the full range of commissioning activities as outlined in Figure 4. The Commissioning role would be shaped by the proposed national strategy group and supporting national commissioning team. These local joint commissioners would be responsible for:

- commissioning clinical services in prison and community; and
- commissioning case management and psychosocial as well as wraparound services in the community (DIP and other services) and prisons (this includes intensive long-term drug treatment programmes).

In terms of funding streams we would recommend that these local joint commissioning bodies (hosted by local PCTs) receive two funding streams:

- An integrated clinical services budget is established to support the reduction of self harm and reduced transmission of blood-borne viruses. This would cover detoxification, maintenance, and other healthcare services targeted specifically on drug misuse among prisoners and offenders in the community.

- An integrated non-clinical budget to support the joining up and reducing re-offending objectives. This would cover case management and psychosocial programmes both in prison and the community and the funding of 'step-down' rehab hostels. It is understood that those involved in revising the National Drug Strategy are examining the possibility of merging the DIP budget (£150m) with the prisons and DRR budgets so this option is a real possibility.

This option envisages that each PCT in conjunction with DATS would establish a commissioning function to undertake the following commissioning activities:

- All Planning activities as outlined in the commissioning cycle with the exception of risk management support activities

- Execution of commissioning plans around establishing local contracts and developing providers

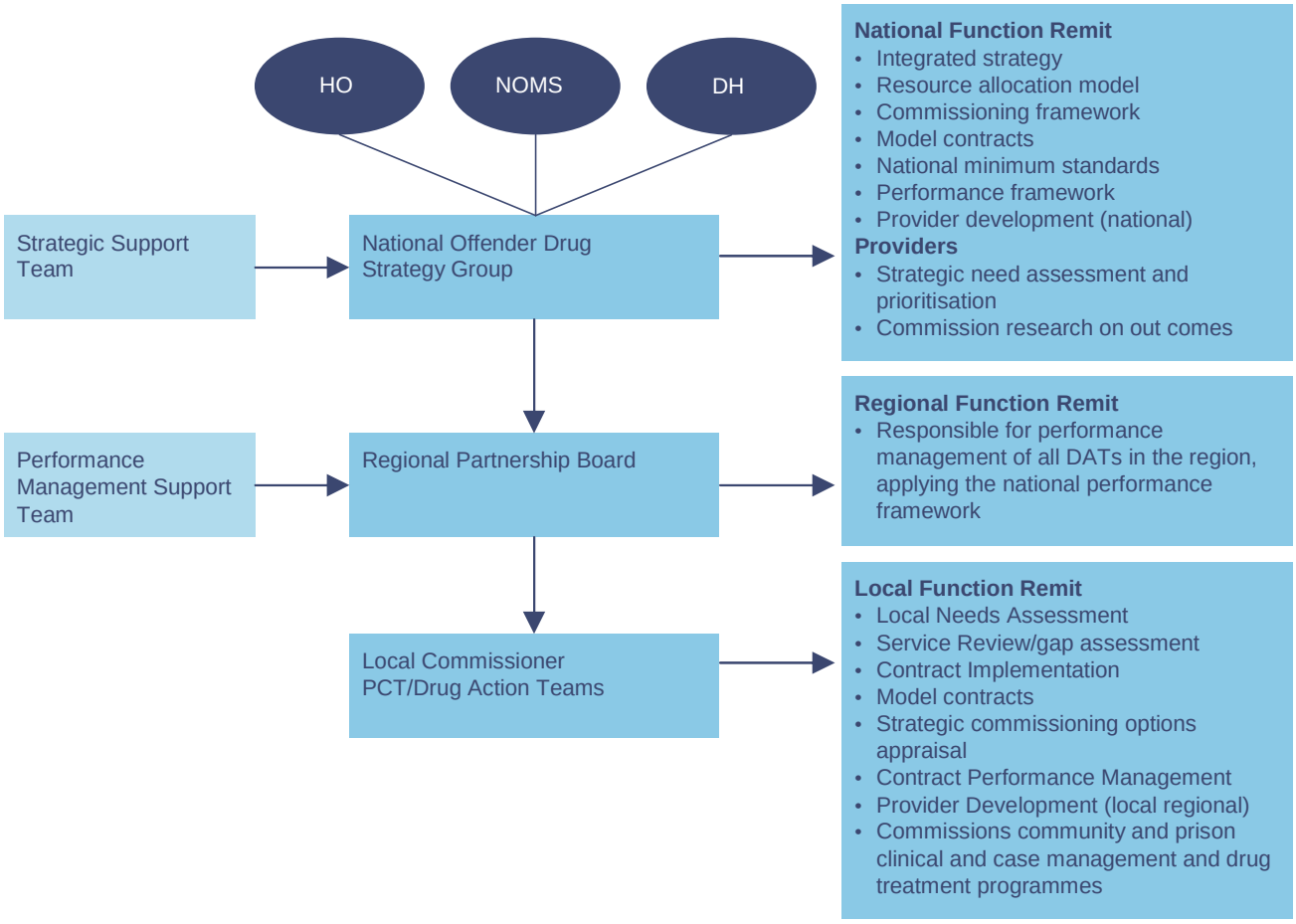
- Performance management of contracts.

The performance of the local joint commissioners against a national performance framework would be undertaken by the proposed Regional Partnership Boards with inputs from national commissioning team support.

The drawback of this commissioning model is the scale of potential duplication in commissioning support functions to undertake the full role. Health sector experience highlighted by the recent State of Nation 2007 Report indicates that there is a lack of expertise and capability at a local level across the board to deliver best practice commissioning. Evidence in the Report indicates that PCTs are not yet in a position to fully understand local health needs, and to translate these effectively into the commissioning of services. This is particularly the case for relatively small segments of the local population such as drug misusers in prison. The capability of local DATs in conjunction with PCTs to undertake an effective provider development and performance management role is currently limited.

Overall this option will require a considerable investment in commissioning capability across the full range of local PCTs and DATS if the potential gains of joint commissioning are to be realised. This scale of investment may represent between 3 to 5% of the commissioning investment in order to provide an effective commissioning function. There is a significant risk, even with a national commissioning function capability around the planning and specific execution activities, that the quality and capability of commissioning may still be very variable within this organisational model.

Figure 4: Option 1 – Local Joint Commissioning



Option 2: Development of Regional Commissioning Function hosted by a lead PCT supporting local joint commissioning arrangements across the region

This option envisages the development of a regional commissioning function to undertake the following activities:

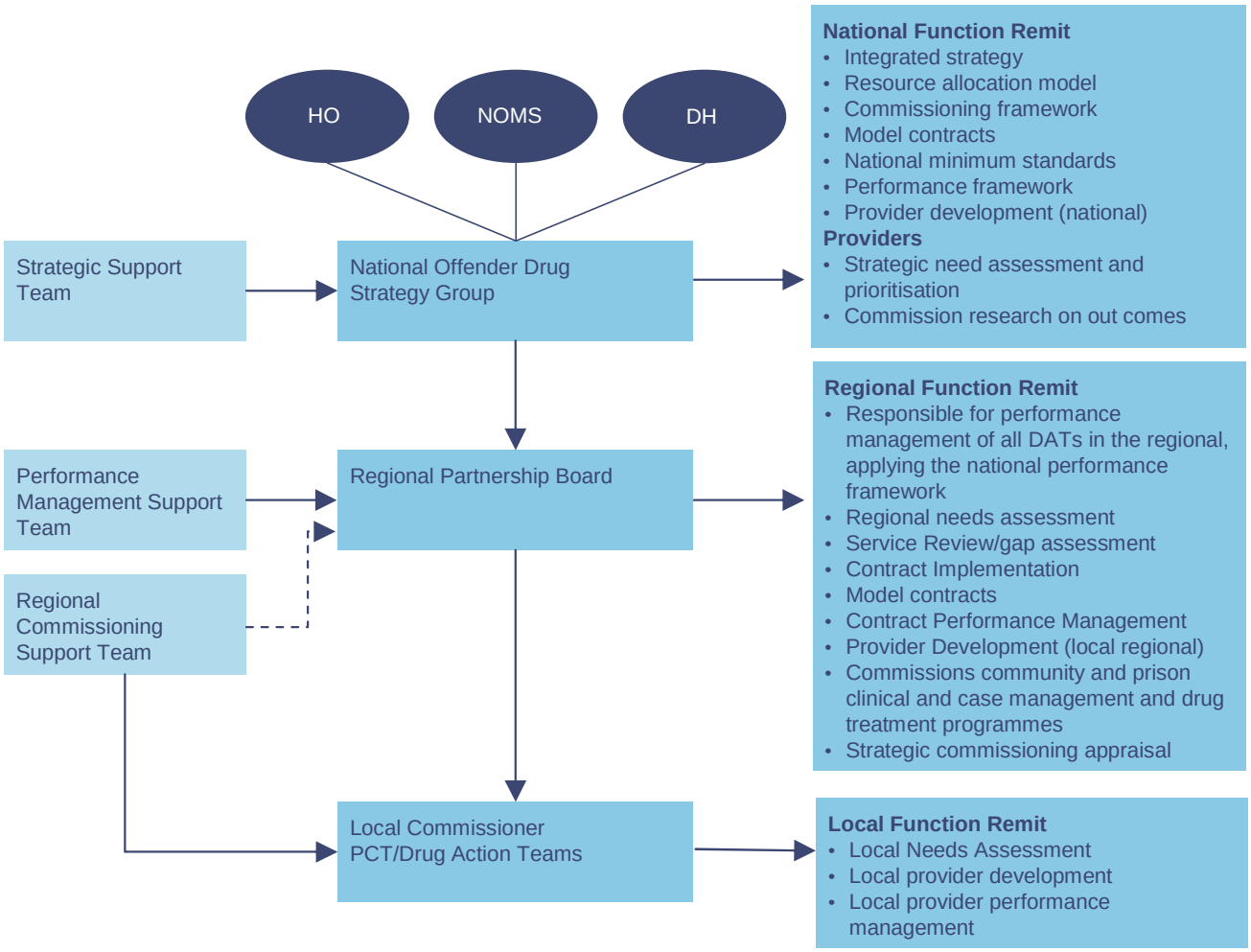
- Undertake specific parts of the commissioning function on behalf of individual PCTs or DATs. For example, as outlined in the best practice model – the planning activities such as health / social needs assessment, review of services compared to health needs, and the identification of strategic options. The provider development and performance management role could also be undertaken on a regional basis on behalf of the PCTs/DATs.

- Undertake all the commissioning activities for specific specialist or intensive programmes. For example it is recommended that intensive longer-term psychosocial programmes (CBT and 12-step) and therapeutic communities are commissioned regionally. The tasks would include shaping and agreeing regional priorities in relation to these services, addressing the transition of prisoners between prisons, and assisting with the development of prison clusters to achieve economies of scale.

- Commissioning of specific enabler projects that support the development of commissioning of drug treatment programmes across prison and in the community eg integration of assessment and information systems.

This option would still require a local priority setting, but the regional commissioning function would support local groups in the delivery of their commissioning role. The local DATs/PCTs would also have a role to play in the various planning activities, shaping the development of service specifications, and performance monitoring of local contracts.

Figure 5: Option 2 – Regional Joint Commissioning hosted by a lead PCT



Funding Streams Implications

We would advise that a similar funding stream approach would still be required with this option at a local level. There is flexibility to pool funds where agreed between health and criminal justice based on joint planning priorities and within these departmental funding streams to commission joined up treatment and psychosocial programmes.

PCTs and DATs (local authorities) would receive the funding streams from health and criminal justice and decide how much is needed to support an agreed regional commissioning infrastructure and finance regionally commissioned programmes.

The advantages of this commissioning model options are:

- Concentration of commissioning function activity associated with drug treatment programmes into a specialist number of teams where best practice commissioning competencies can be developed or procured
- Likely to represent a better value for money option around the development of commissioning function capability
- Facilitates the development of provider relationships on a manageable scale from the providers perspective where innovation of service design delivery and improved performance could be given a greater focus as a result of reducing the scale of interactions with many different commissioners

- Provides large funding streams to pool resources across health and criminal justice to develop a greater risk share approach and flexibility in the use of available resources from year to year

- Provide some greater purchasing leverage with particular regional or national providers.

The drawbacks of this approach however are around the following:

- The envisaged lower involvement of DATS and individual PCTS in the total commissioning function activity than option 1

- Synergy in the geographical boundaries between NOMs regional structure with health and other government offices

- Addressing all local nuisances in service specification when commissioned at a regional level.

These barriers can be overcome through the design of the commissioning function engagement culture with constituent stakeholders and joint working across geographical boundaries.

Recommendation

Overall, prior to deciding which option to adopt, we would recommend that the National Steering Group consults upon both options and examines the scale of investment to provide the necessary commissioning support for each option.

It should be noted that improvements in commissioning are delivered not just by introducing appropriate structures and systems, but as in other parts of the public sector, by developing the necessary competencies and capabilities of the commissioning team.

High Security

CARATS and psychosocial drug treatment programmes are currently commissioned nationally by NOMS for the high security prisons. However, since drug treatment in these prisons is essentially the same as in other prisons (clinical services, CARATs, and a limited number of psychosocial programmes), we are of the view that services could be commissioned at regional level under Option 2 above alongside services for other prisons. This would ensure consistency of approach and procurement efficiency. A precedent has been set in the commissioning of other services such as bail accommodation. We understand also that South Central lead PCT and the SE ROM are in discussion over the commissioning of prisoner and offender health services more generally, including high security and youth establishments.

Implementation – the challenges

It is important to note the challenges that organisations will face in implementing the far-reaching changes proposed. We list some of these below:

- The time and effort needed to develop a common understanding of concepts and terminology should not be underestimated.

- The requirement for different departments and organisations to change working practices, to look beyond traditional boundaries, to define clear outcomes, and develop a stronger evidence base to guide commissioning decisions, all present major challenges.

- The practical implications of changes in structure and commissioning arrangements including TUPE, contract variations, developing specifications for new services and decommissioning others, will take time.

- Introducing more joined up structures and arrangements at a time when some of the organisations involved are still going through complex internal changes adds another layer of complexity.

5 Conclusion and next steps

Conclusion

There has been investment in prison-based drug treatment services over the last 10 years leading to notable improvements in care. We have encountered many examples of excellent practice and real commitment amongst staff during this review. However drug treatment in prison and continuity of care with community provision is fragmented, with many organisations responsible for funding, commissioning and performance managing different aspects of care, but with no one body being held accountable. There is a lack of agreement on outcomes that services are there to achieve, the evidence base for some current interventions in relation to outcomes is weak, and there is a lack of meaningful performance data with which to measure progress against outcomes. Through a careful examination of documentary data, extensive stakeholder consultation, and advice from experts, we have put forward a number of options to help simplify and clarify arrangements, and improve coordination, continuity and quality of care.

With regard to the provision of services, we have provided an outline of what must be done to provide a minimum standard of care to all prisoners, based on what is humane, and on current evidence of efficacy. We also outline services with a good evidence base which should be provided when resources are available, and services that could also be provided but for which there needs to be more research to establish its efficacy. We recommend the use of 'allocative efficiency' whereby resources are realigned to ensure first that a minimum standard of care is delivered to all before resources are spent on the other services. Building on the above we also propose a notional revised care pathway.

Delivery of the minimum standard of care in all prisons is not likely to be possible within existing funding, so we have outlined a number of areas where we believe existing resources could be freed up, together with an approach to prioritising longer-term psychosocial treatments for maximum impact on the individual and society, based on lifetime cost savings in relation to areas such as morbidity, lost economic output, criminal justice costs and social costs. We suggest this could be used to guide the commissioning process at the strategic level, and in supporting professional judgement at the front-line when allocating scarce resources to individual prisoners.

In relation to commissioning we describe the eight key functions that make up a best practice commissioning cycle. We then describe how commissioning arrangements for prison and community treatments compare against this, based on a Steering Group discussion. Having put a number of options for commissioning to the Steering Group and experts, showing which commissioning functions might be undertaken at national, regional and local level, we agreed with them two fundamental foundations for a revised commissioning structure: The need for a National Strategy Group for prisoner and offender drug treatment combining DH, MoJ and HO membership; and a strong regional performance management function to apply national strategy. We agreed with the NSG that provided these are in place and operating effectively, the exact configuration of commissioning is less important.

We propose two options for commissioning, both of which combine the commissioning of prison and community, and clinical and psychosocial provision. Option 1 is based on PCTs and Drug Action Teams; and Option 2 proposes the development of a Regional Commissioning Function hosted by a lead PCT to support local joint commissioning arrangements across the region. We suggest that the latter is likely to serve the needs of prison and offender drug treatment best, given the scale of potential duplication in commissioning support functions in individual PCTs/DATs to undertake the full role, and PCTs are not yet in a position to fully understand local health needs, and to translate these effectively into the commissioning of services, particularly for relatively small segments of the local population such as drug misusers in prison. Furthermore, the capability of local DATs in conjunction with PCTs to undertake an effective provider

development and performance management role is currently limited. However, before choosing we would recommend that the National Steering Group consults upon both options and examines the scale of investment to provide the necessary commissioning support for each.

We outline some of the challenges facing departments and organisations in implementing the above changes to commissioning arrangements and provision, which are considerable and will take time.

Next Steps

We provide below an outline of the initial actions required to implement our proposals, should they be approved:

1 Establishing a National Prisoner and Offender Drug Strategy Group. The early tasks of this group, in its first 100 days, would be to establish the membership and terms of reference, and commissioning a series of projects to include the following:

2 Articulate and agree the key outcomes for prisoners and offenders in prison and in the community; Demonstrate how the partner organisations will work together to successfully deliver those outcomes; Identify measures (key performance targets) which will help the partner organisations to understand how their performance contributes to the achievement of the outcomes and: Set out how current activities (initiatives) align with the key outcomes and design others to fill gaps. Initiatives would include:

3 Establishing a set of National Minimum Standards and conducting a gap analysis to establish what is feasible within current resources, and to develop a plan for implementing the standards over the next 2-5 years. This will include build or procure plans.

4 Identifying opportunities for achieving efficiency savings to invest in services. These may include, for example, disinvestment in services not falling within the national minimum standards, and achieving productivity gains for example by merging CJIT and CARATS teams and through provider development. A detailed business case should be produced to fully appraise the extent to which funds can be released. It should then be consulted upon to ensure the potential impact of withdrawal and changes are fully understood before final agreement and implementation.

5 Examining the case for prioritising prisoners and offenders using the economic framework proposed in Section 4. This assesses the impact on the individual and wider society of successful drug treatment for specific segments of the drug-misusing prisoner and offender population as an aid to commissioning at a strategic level, and to support professional judgement when allocating resources to an individual. The approach should be consulted on in localities, which may have different priorities.

6 Developing the commissioning model at national, regional and local level. This would commence with a consideration of the roles for example of the Regional Partnership Board, support structures and skills required to support each level. A capability and capacity review and formal assessment by region would then be required, followed by an appraisal of the costs and value for money of adopting the local or regional commissioning model proposed in Section 4, and consultation on this. Governance structures and reporting arrangements will then need to be agreed.

7 Developing a single health and a single criminal justice funding stream. In best practice commissioning, funding should follow commissioning; consequently the level at which these funding streams are aligned or merged will depend on whether a local or regional commissioning model is adopted. Funds should be merged to meet specific commissioning objectives.

8 Agreeing how information sharing will be achieved to support both performance management and case management. The lack of a shared system, and the high costs and long lead in times to any future system, should not hold up progress in information sharing (i.e. it should not be on the critical path to improvement). Measures should be taken immediately to facilitate practical information sharing for example by issuing read-only rights to staff needing access to information on the same person, with suitable protocols for confidentiality.

List of Appendices

1. Summary of issues identified during the course of the review
2. List of national and regional consultees and experts
3. Evidence Review
4. Local stakeholder consultation report
5. Economic Framework
6. Economic Framework Model