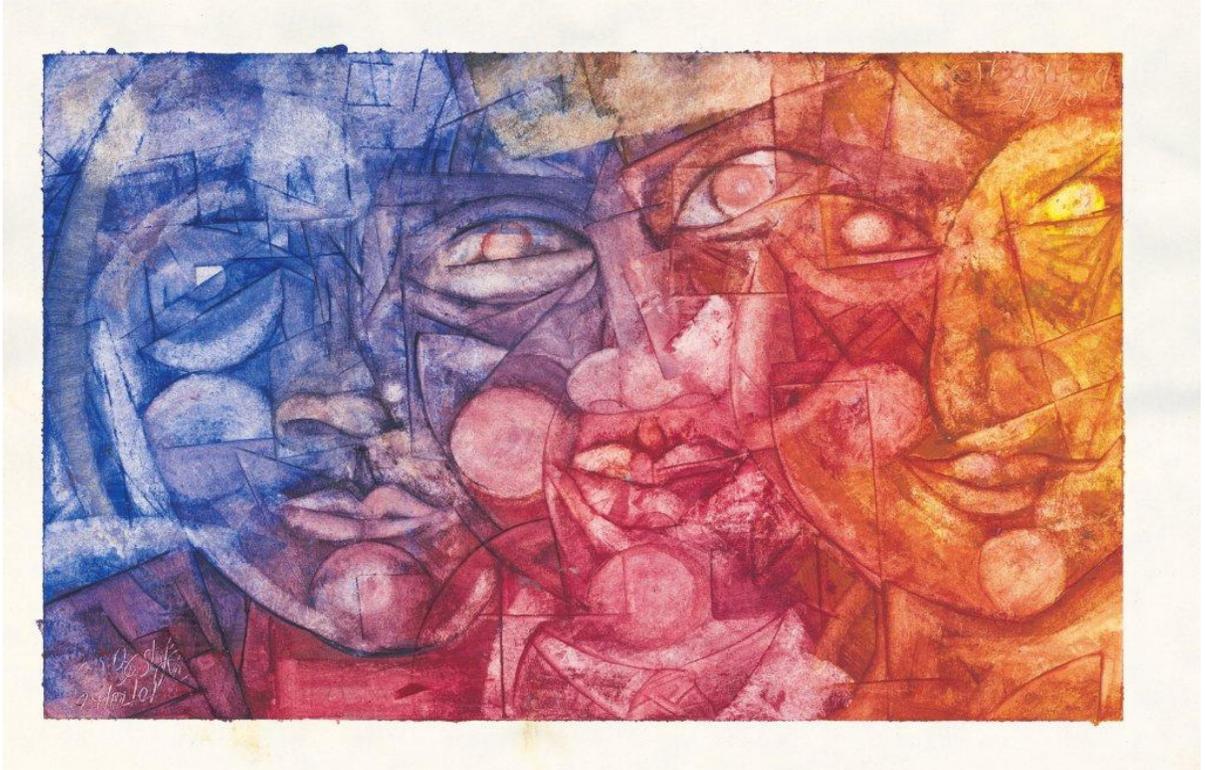


THE PATEL REPORT

PRISON DRUG TREATMENT STRATEGY REVIEW GROUP



**A REPORT BY PROFESSOR LORD PATEL OF BRADFORD OBE
CHAIR OF THE PRISON DRUG TREATMENT STRATEGY
REVIEW GROUP**

Reducing Drug-Related Crime and Rehabilitating Offenders

*Recovery and rehabilitation for drug users in prison and on
release: recommendations for action*

~ improving quality ~ increasing innovation ~ achieving efficiencies ~

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- Denise White - Chief Executive, Derbyshire Probation Trust
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Cover design

The artwork is by Christopher Bashford (1957 –2002). Christopher experienced severe mental health problems as a consequence of drug use and spent several periods in prison. Throughout his life Christopher was an exceptional artist and this picture, which was painted in 2001 while he was living in a hostel for the homeless is called ‘The Good the Bad and the Beautiful’.

FOREWORD BY LORD PATEL



I was asked to take on the role of Chair, and to establish the Prison Drug Treatment Strategy Review Group, to carry out a review of drug treatment and interventions in prisons and for people on release from prisons in England.

I have worked for many years, as a practitioner, manager and policy maker in tackling drug use and was aware of the additional complexities involved in tackling drug use in prisons. However, it was important for me to understand the real practical issues and barriers to effective drug treatment and interventions in prisons. I therefore undertook a series of visits to prisons and talked to staff at all levels, commissioners, providers and most importantly to prisoners themselves, in order to gain a personal understanding of the key issues for this review.

This review was different to many Government reviews in that it was not based on my work or observations alone, but on the work of a diverse group of people with knowledge, expertise and experience on drug treatment and interventions in prisons.

I want to acknowledge the importance of this diverse group of people who have worked together over many months to achieve consensus and produce constructive recommendations in a complex area.

This review was also different in that Government officials were invited to all the meetings as observers and the Review Group work programme was carried out with the full support of the Ministry of Justice, Department of Health, Home Office and National Treatment Agency for Substance Misuse. The review represents the commitment of external organisations and Government to work together and make a positive impact on the lives of drug users in prison and on release.

I especially want to thank the large number of service users and carers who engaged in our consultation process or communicated their views via our website. I am in no doubt from the responses that we received that drug users, ex-drug users and their families do have an appetite to be more actively involved and we need to create many more opportunities for them to do so.

I recognise that since work began on the review that we all face a tightening financial climate. I believe, however, we still have an opportunity to achieve the cultural and system change needed to engage drug users and the communities within which they reside, in effective drug treatment while in prison; to maximise their prospects for recovery and reintegration on release into the community; and, get value for money by increasing innovation, raising standards and quality, achieving efficiencies and improving cost effectiveness.

Making recommendations are only the first stage - implementation is key.

We have an opportunity for effective implementation through the work programme being developed within the Coalition's programme for Government across the fields of criminal justice, health and drugs.

I would propose to Government that implementation is not done in isolation across Government, but once again with the active involvement of external organisations and particularly with service users and carers.

This, I believe is the way to raise the levels of ambition about what can be achieved and to harness the full potential of drug users to actively engage with and assume responsibility for their own recovery.

A handwritten signature in black ink, appearing to be 'Lord Patel', written in a cursive style with a horizontal line underneath.

Professor Lord Patel of Bradford OBE

EXECUTIVE SUMMARY AND RECOMMENDATIONS

INTRODUCTION

1. The Prison Drug Treatment Strategy Review Group (henceforth known as the Review Group), chaired by Professor Lord Patel of Bradford OBE, is an independent expert group commissioned to take a fresh look at drug treatment in prisons.
2. The review commenced in April 2009 and the Review Group's remit was to focus on drug treatment and interventions for people in prison, people moving between prisons and the continuity of care for people on release from prison.
3. There is a wider range of issues, including mental health problems, alcohol issues and treatment, drug treatment in the community, the criminal justice system, and rehabilitation issues (housing, employment, skills and education), which have an impact on this scope. While these issues are not the primary focus of this review, they have been considered by the Review Group, as appropriate. It is important to note that the cross-Government Health and Criminal Justice Programme are taking forward the specific issues pertaining to mental health problems and alcohol issues in prison. The Review Group established links with this programme via Government officials.
4. The review focuses on adults (18 years old plus); therefore, young people under the age of 18 years are not covered within this review.
5. This report outlines the evidence gathered and work carried out by the Review Group and summarises their conclusions and recommendations.
6. The recommendations are focused on prisons and the drug treatment sector in England. The Review Group established links with the Welsh Assembly Government to ensure that the continuity of care for drug users on release from prisons, moving between England and Wales, was taken into consideration.
7. These recommendations have been sent to Ministers in the Ministry of Justice, Department of Health and the Home Office, and have been submitted as a response to the new drug strategy consultation.

THE NEED FOR REFORM

“Looking back 10 years ago there was very little help available. There is more help now but still not nearly enough” (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

8. Existing drug treatment funding, commissioning and delivery systems in prisons have been subject to increasing criticism. While the current systems have helped to deliver an increase in drug treatment in prisons, they are complex and characterised by a multitude of funding streams, commissioning and process targets. This has

resulted in a fragmented system with the risk of a 'one-size-fits-all' approach, with limited choices in the type of treatment and broader social support available.

9. The Price Waterhouse Coopers (PWC) report specifically identified:
 - The lack of a clear, unified inter-departmental strategy across Government;
 - Fragmented organisational arrangements for funding, commissioning, performance management and delivery of services in prisons;
 - The lack of a clear evidence-base for some services currently offered in prisons; and,
 - Inefficiencies and gaps in services.
10. The criminal justice system presents an opportunity and a challenge when addressing a wide range of clinical and social care needs of drug users. We know that getting drug users in prison to engage in treatment can have a positive impact.
11. We recognise that the continuity of care of drug treatment for people entering prisons, moving between prisons and on release is a complicated issue due to the nature of the prison environment – a rising prison population resulting in a strain on limited staffing resources, disrupted regimes and some prisoners being placed further from home.
12. However, there is now a strong call amongst drug users and carers for greater continuity of drug treatment both within and between prisons. And there is a very clearly articulated need for much greater support and help on release especially with respect to appropriate housing, having enough money, having something meaningful to do and greater integration and co-ordination with community services.
13. We have been concerned that the progress required to make the kind of system changes necessary to address the criticisms raised has been slow.
14. However, since the inception of this review, there has been a substantial change in the political landscape. The Coalition's programme has indicated a keenness to re-look at issues with regard to drug use, crime and rehabilitation and the NHS White Paper, *Equity and excellence: Liberating the NHS*, has already announced fundamental changes to the commissioning system.
15. With further changes likely to be announced within the new drug strategy, the Ministry of Justice Green Paper, 'Engaging Communities in Criminal Justice', etc. we now have an opportunity to achieve the cultural and system change needed to engage drug users and the communities within which they reside in effective drug treatment while in prison, and to maximise their prospects for recovery and reintegration on release into the community.

16. Our recommendations are intended to be in step with this changing political landscape - e.g. streamlined commissioning systems and a move towards outcomes. We seek to raise the levels of ambition about what can be achieved and to challenge the reluctance to recognise and harness the full potential of drug users to actively engage with and assume responsibility for their own recovery, including a renewed focus on abstinence as a clear goal.

ECONOMIC CONSTRAINTS

17. There can be no doubt that developing effective drug treatment and interventions in prisons and continuity of care on release in the context of tightening resources will be demanding - drug users' priorities may become low ranking in a difficult economic climate.

18. Within a tight fiscal context, local partnerships, commissioners and prison governors will have to make tough choices about where to target investment for the future and have a determination to get value for money from every pound spent by increasing innovation, raising standards and quality, achieving efficiencies and improving cost effectiveness.

19. Equally, economic constraints can have the potential to be catalysts for change. Improvements can come from making changes in current practice and refocusing efforts and resources, including better working practices in terms of commissioning and delivery to allow the frontline more capacity to innovate.

20. Therefore, we have worked on the basis that our recommendations should not need additional money to implement them, but would need to address:

- Improving the quality of drug treatment for people in prison and on release from prison, through the development of clear standards and outcomes.
- Increasing innovation – in terms of service delivery, commissioning and partnership working - to contribute to a reduction in re-offending and reduced mortality from accidental drugs overdose or chronic health problems such as blood borne viruses.
- Achieving efficiencies and improving cost effectiveness within the drug treatment system in prison and for people on release from prison.

21. Achieving the above will require genuine collaboration cross-Government and co-ordinated commissioning between local prisons and their community partners if effective drug treatment and interventions in prisons and continuity of care on release is to be established as a fundamental part of the work of the whole prison establishment and an integral part of local commissioning partnerships.

REVIEW GROUP APPROACH AND KEY PRINCIPLES

22. Our review and recommendations have been strengthened by a thorough review of the evidence base for drug treatment in prisons incorporating over 160 high quality peer reviewed papers, and a service user and carer consultation based on 553 responses.
23. Our aim is not to ‘reinvent the wheel’ but to build on the successes of preceding strategies, research and reviews. Accordingly, we have taken into consideration a wide range of key work programmes and reviews, including the Bradley Report, the Drug Interventions Programme review and the National Offender Management Service (NOMS) review of accredited substance misuse interventions. Research on efficiency savings and value for money on drug treatment in the community and in prisons was also considered.
24. We believe that the goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency. For some this can be achieved immediately, but others will need a period of drug-assisted treatment with prescribed medication first so their overall health can be improved, which will enable them to work, participate in training or support their families. They can then be supported in trying to achieve abstinence.

*“The worst experience was being detoxed without any warning or consultation”
(Service user forum - Review Group Service User and Carer Consultation)*

25. We believe that an integrated care pathway, from the community into prisons and visa versa, and a balanced treatment system are vital to ensure that individuals get access to the types of treatment that is appropriate to their changing needs and circumstances. Local commissioners need to be able to choose from a broad spectrum of treatment options in both prisons and the community including prescribing and residential rehabilitation.
26. Treatment alone can only go so far and we need to be more ambitious in helping drug users to make lasting changes, to maintain their recovery and ensure that there is help and support from outside the treatment system – family and friends, peer support/mutual aid networks, access to housing, and education and employment opportunities.
27. Hence, our work during this review has been underpinned by the following key principles:
 - Continuity of care as people pass through, in and out of the prison system is the critical issue.
 - Drug users in prison should have access to drug treatment and health and social care provision equivalent to those provided in the community and appropriate to a prison environment.

- Drug users released from prison should be offered on-going rehabilitation and support on their return to the community and be encouraged to maintain their contact with community substance misuse services, as appropriate.
- Existing finite resources should be used more effectively.
- The range of services provided should be appropriate, supported by best available evidence and ensure an equivalence of national standards of care across the country.
- The needs of particular groups, e.g. transitional issues of the 18-21 year old prison population, women, Black and minority ethnic groups, people with dual diagnosis (mental health and substance use problems) must be considered.
- It is vital that the service users 'voice' is heard and their experiences are taken into account.

KEY ISSUES FOR CHANGE

28. We believe an effective and balanced drug treatment and interventions system would contribute to a range of criminal justice and health outcomes, including:

- Reducing drug related offending and re-offending
- Reducing drug use in prison
- Community safety
- Individual drug user's health and social functioning
- Lower public health risks from blood borne viruses and overdose

29. In developing our recommendations, there was a wide range of issues that this review could potentially focus on. However, to attempt to tackle all issues could result in a diluted approach that fails to have any impact at all.

30. Therefore, we have chosen to focus on challenging and making improvements in the key areas outlined below. We believe making changes in these areas would have the most significant impact and deliver improvements in the outcomes and experiences of drug users in prison and on release:

- **More decentralisation around commissioning enabling a more autonomous and accountable system:** Decision-making should be focused at a local level, and more responsibility given to local partnerships, commissioners, prison governors and users and carers. Maximising local ownership will sustain and improve outcomes in terms of both re-offending and reduction of harm to the individual, their families and their communities. Local areas require greater autonomy and flexibility to deliver better services by focusing on increasing the access and quality of drug interventions, matched to individual needs, and on reducing bureaucracy.

- **Clear outcomes to improve efficiency and effectiveness of commissioning:** The development of an outcomes framework for assessing and managing performance at a local level, which is focused on recovery, is crucial. This will ensure that the services that are commissioned are needs based; delivered to high standards and achieve best value for money; and, realise any efficiency savings by removing duplication and reinvesting in improvements to services.
- **Needs based treatment and interventions:** It is vital that drug treatment and interventions are matched to individual need and appropriate to individuals at the time that they are within the criminal justice system i.e. making sure that the right people, get the right intervention, at the right time. All available evidence must be used to make sure we are creating an integrated care pathway between prisons and community services that supports the treatment and interventions that are most effective, targeted at the right users with abstinence-based treatment for some, drug-replacement over time for others.
- **Improving access to reintegration pathways and provision:** Integrated care pathways can help to ensure that there is a focus on reintegration and appropriate support services at an early a stage as possible, to begin to address the broad range of issues around recovery and reintegration presented by people with drug problems in prison and on release.
- **Integrated partnership working:** To create an integrated care pathway and integrated services by improving partnership working between criminal justice, health and social care organisations, enabling effective health, social care and criminal justice outcomes.
- **Improving capacity and capability:** To have an informed and effective workforce to deliver services for drug users in prison with health and social care needs, making sure that they are able to work confidently across organisational boundaries, by equipping them with the right skills and knowledge to share information and take co-ordinated action that supports the continuity of care.
- **Diversity and equity of access to services:** Encourage the development of skills, awareness and knowledge in relation to issues of diversity with respect to drug use. This would include those relating to diversity of the workforce in prison and probation so that they can deliver quality drug services to the full diverse range of the population being served and firmly embed this into the working culture of the criminal justice system. This is vital to ensure that all offenders – irrespective of race, gender, disability, age, sexual orientation, religion or belief – will secure the same access to health and social care services, appropriate to their needs and in line with standards set for the rest of the population.
- **Breaking barriers** - Government Departments need to work closely with external organisations and partners to ensure joined up national thinking across institutional boundaries; to help break down any barriers to local partnership working; establish shared objectives; and, facilitate integrated care pathways

between local agencies. This cross-boundary work should also continuously consider improvements in value for money.

31. It is important to note that all our recommendations are interlinked and so need to be viewed in an integrated way. For example, the commissioning and outcomes recommendations are complementary and both are necessary – without clear outcomes, effective commissioning standards cannot be established and the commissioning of effective care pathways covering drug treatment and interventions, continuity of care provision and mainstream reintegration/recovery services (housing, employment) are essential in helping drug users to make lasting changes.

32. A summary of our recommendations are outlined below.

SUMMARY OF THE REVIEW GROUP'S RECOMMENDATIONS

<p>RECOMMENDATION 1: CROSS-GOVERNMENT STRATEGY</p> <p><i>Achieve efficiencies and improve cost effectiveness by developing (for the first time in England) a unified cross-Government drug treatment and interventions strategy for people in prisons, moving between prisons and on release</i></p>	<p>We recommend that any new Government drug strategy covers not only community-based drug treatment but, for the first time in England, includes a streamlined, unified cross-Government drug treatment and interventions strategy for people in prisons, moving between prisons and on release.</p> <p>This cross-Government strategy should be based on:</p> <ul style="list-style-type: none"> • The twin aims of reducing drug-related crime caused by re-offending and improving the health and rehabilitation of offenders. • An integrated approach between Government Departments with a renewed focus on abstinence as a clear goal. • A revised streamlined commissioning system and a new outcomes model that focuses on the outcomes that matter i.e. a stable place to live, a job, positive mental health and well-being. • A robust evidence-base, including evidence of cost-effectiveness. • Making more effective use of existing residential rehabilitation services - offenders who have become drug-free and need secure and safe accommodation on release should have access to these services to support their ongoing recovery and abstinence. • Reintegration/resettlement options – in both employment and housing terms, as an integral part of the building blocks to maximise recovery. • Active involvement of drug users, their families and local communities. <p>A unified prisons drug treatment and interventions strategy should also incorporate the elements outlined in the recommendations below.</p>
<p>RECOMMENDATION 2: ESTABLISHING OUTCOMES</p> <p><i>Shift focus and resources towards reducing re-offending outcomes and better health outcomes, through a national health and criminal justice outcomes model</i></p>	<p>We recommend that the Government adopt the first cross-Government outcomes model for drug treatment and interventions in prisons with the twin aims of reducing re-offending and improving health and rehabilitation. This outcome model focuses on 4 main themes:</p> <ul style="list-style-type: none"> • Reduced drug use • Reduced re-offending • Improved health & social functioning • Increased employment and enhanced workforce skills <p>This outcomes model can provide a benchmark for the quality of services provided that would support commissioners and providers to evidence, assess and improve the quality of service provision.</p>

	<p>This model can use existing sources of data and, with a performance assurance framework, could replace all current NOMS drug treatment key performance targets and the Prison Health and Performance and Quality Indicator for drug treatment, thereby reducing the burdens and duplication within the existing system.</p>
<p>RECOMMENDATION 3: STREAMLINED COMMISSIONING SYSTEMS</p> <p><i>Shift focus and resources to develop a streamlined, autonomous and accountable commissioning system that is coherent, cost-effective and enables more effective decision-making by local commissioners and partnerships</i></p>	<p>We recommend moving away from the current complex commissioning systems, characterised by a multitude of funding streams and process targets, which have resulted in a fragmented system with the risk of a ‘one-size-fits-all’ approach, with limited choices in the type of treatment and broader social support available.</p> <p>We recommend moving to a streamlined effective and efficient commissioning system that is reflective of consensus on evidence and good practice and clearly aligned with outcomes. It is proposed that for the first time in England, the majority of drug funds be jointly commissioned at a local level - this includes NOMS CARATs funding. This would mean that local health commissioners, potentially within new consortia of GP practices, and local drug partnerships including local authorities, local Directors of Public Health, prison governors, etc. would share the responsibility for commissioning drug treatment both in prisons and on release and would have a collective responsibility to ensure effective joint commissioning and to align/pool budgets to obtain the best outcomes, efficiencies and value for money. Some commissioning at a national level may still be needed, for example, to ensure the needs of the women estate and under 21-year-old offenders are addressed and, under this proposed system, services can be commissioned based on needs, at whichever level (national, regional or local) is appropriate for the intervention.</p> <p>We are aware that even as our work programme and recommendations were being completed major changes to commissioning systems within the NHS were being announced. Our proposed model, however, is aligned with the Coalition’s programme approach for a more autonomous and accountable system and with the NHS White Paper, <i>Equity and excellence: Liberating the NHS</i>, around GP commissioning consortia, which focuses on the patient’s needs – i.e. ensuring that patients get the right treatment, at the right place, at the right time.</p> <p>There is no detail yet about what will happen to local drugs partnerships and where the commissioning of drug treatment will fit. However, these changes to local commissioning systems reinforce the need for collaboration and joint commission to ensure that the needs of drug user in prison and on release are met against a clear strategy that is reflective of consensus on evidence and good practice, and clearly aligned with outcomes.</p> <p>Therefore, we recommend that the Government consider putting in place this revised commissioning system by 2011/12.</p>

<p>RECOMMENDATION 4: SERVICE DELIVERY</p> <p><i>Refocus and increase ambition, quality and innovation in service delivery through an updated national drug treatment and interventions framework that covers both community and prisons to:</i></p> <ul style="list-style-type: none"> • <i>increase the numbers of drug users who are able to achieve recovery from dependency and sustain this for the longer-term; and,</i> • <i>contribute to a reduction in re-offending and reduced mortality from suicide, accidental drug overdose, blood borne viruses and other chronic health problems</i> 	<p>Helping people get off drugs for good must be a crucial ambition for the new drug strategy and for the drug treatment and interventions system both in the community and in prisons.</p> <p>Delivering optimal systems of care that are evidence-based and supported by a range of choices and different pathways that promote reintegration and recovery is a vital challenge in developing a truly effective and balanced treatment system.</p> <p>Therefore, we recommend the Government agree to an updated national framework that for the first time in England:</p> <ul style="list-style-type: none"> • Outlines the ambition to maximize drug users prospects for recovery (i.e. becoming free of dependency) • Spans drug treatment both in the community and in prison • Outlines an appropriate ‘menu of services’ including medical treatment, psychosocial interventions, harm minimisation and broader social care that promotes resettlement and recovery • Ensures that the service user and their recovery are at the heart of all commissioning and service delivery <p>An effective outcomes framework and commissioning system will require access to a range of treatment and intervention services that are able to meet the varied, and at times, complex needs of drug users. Therefore, it is vital that any ‘menu of services’ must cover both drug treatment in the community and in prisons to avoid creating further silos and to enable genuine joint commissioning.</p> <p>The appropriate place to develop a clear ‘menu’ of evidence-based, effective and cost-effective services would be within a new national framework that spans drug treatment in the community and in prison to ensure consistency and continuity of care as people are released from prison. This should be an early aim of the new drug strategy.</p>
<p>RECOMMENDATION 5: SERVICE USER AND CARER ENGAGEMENT</p> <p><i>Increase social capital by identifying ‘Recovery Champions’ in the community and prisons to reduce poor social cohesion in local communities and support the creation and expansion of volunteering, co-operatives, charities and social enterprise</i></p>	<p>A drug treatment system that promotes achieving abstinence needs a robust, realistic narrative of recovery that is meaningful to the drug-users and their families, and endorses ‘Recovery Champions’, peer support and mentoring groups.</p> <p>Therefore, we recommend that commissioners and local partners focus on increasing the social capital through the identification of Recovery Champions and appropriate community groups - local councillors, business people; families and friends of users; ex-drug users. We need to make more effective use of people who understand the problems of dependency; those who want to understand more; and those who may have resources to help make recovery a more realistic option.</p> <p>All offenders, irrespective of race, gender, disability, age, ethnicity, religion and sexual orientation should be able to secure the same</p>

	<p>access to drug treatment services as the rest of the population. At a local level, active engagement with users and their families can help tackle the unmet treatment needs and barriers to treatment, including the needs of young people, women drug users, Black or ethnic or other minority communities, sex workers or parents with dependent children. Recovery Champions would need to reflect this diversity.</p> <p>In order to move away from centralisation and ‘big’ government to creating a ‘Big Society’, Recovery Champions, community groups and the families of drug users can play an important role in articulating ambition, championing routes to recovery and challenging partnerships and services to retain a recovery focus – both prior to release and on release. People who have personal experience of problematic drug use and who have achieved successful recovery, and feel ready to volunteer and support others, should be encouraged to become involved in peer support, mentoring groups and other community groups, and talking about what made their recovery a reality e.g. access to housing and jobs.</p> <p>Increasing social capital is important not only to those who are recovering from substance misuse, but is significant from a community perspective. The role of social capital is important in keeping drug dealers from infiltrating into neighbourhoods - illegal markets tend to flourish in areas where there is poor social cohesion, resulting in difficulties regulating nuisance and problematic behaviours; increasing social capital can support the well-being of drug users and their families and minimize nuisance factors.</p>
<p>RECOMMENDATION 6: ESTABLISHING LINKS TO WIDER CRIMINAL JUSTICE AND HEALTH AND SOCIAL CARE SYSTEM</p> <p><i>Increase efficiencies and improve cost effectiveness by ensuring drug treatment and interventions strategy in prisons is not developed in isolation but linked to other relevant initiatives and strategies as they develop</i></p>	<p>Government Departments need to work closely with external organisations and partners to ensure joined up national thinking across institutional boundaries; to help break down any barriers to local partnership working; establish shared objectives; and, facilitate integrated care pathways between local agencies. This cross-boundary work should also continuously consider improvements in value for money.</p> <p>Therefore, it is vital that any drug treatment and intervention strategies in the community and in prisons are not developed in isolation but linked to other relevant initiatives and strategies as they emerge.</p> <p>However, past reports by the National Audit Office, the Committee of Public Accounts and others have identified failures in the delivery of public services that could have been avoided.</p> <p>A 2009 National Audit Office (NAO) report found many instances where major programmes and projects have been either frustrated, or severely hampered, by failure to take on board lessons from their own past experiences or those of others. The main barriers experienced by departments are silo structures, ineffective mechanisms to support learning, a high turnover within the workforce and a lack of time for learning.</p>

	<p>To achieve value for money in public services, Government Departments need to learn from success and failure, and to improve their capacity to learn from each other. The NAO report found that Departments often found cross-Departmental networks and communities of practice most valuable to supporting learning.</p> <p>Therefore, to avoid fragmentation of approach and to increase efficiencies and improve cost effectiveness, we recommend that efforts must be made to effectively link drug treatment issues with a range of criminal justice, health and social care issues, which are currently under development, including:</p> <ul style="list-style-type: none">• Green Paper on rehabilitation• NHS White Paper, <i>Equity and excellence: Liberating the NHS</i>• Review of sentencing policy - ensuring that sentencing for drug use helps offenders come off drugs.• Exploring drug rehabilitation prisons• Implementation of the Prisoners' Earnings Act 1996• New Mental Health strategy
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1. SETTING THE SCENE - THE CHALLENGE

INTRODUCTION

1.1 In order to develop our recommendations, we needed to have a good overall understanding of the current position around drug treatment and interventions in prisons, so we reviewed and examined a number of critical areas, specifically:

- The scale of the challenge
- Drug treatment need
- The current approaches and the views of service users and carers
- The evidence base

1.2 The results of these various pieces of work are outlined below.

THE SCALE OF THE CHALLENGE

1.3 It is clear that while the criminal justice system presents an opportunity to address a wide range of clinical and social care needs of drug users, the scale of the challenge cannot be underestimated.

1.4 Many drug users will need repeated treatments before they finally overcome their dependence, whilst others are 'lost' when transferred between local treatment services and prisons, and vice versa. Some of the current fragmented organisational arrangements, as outlined in the Price Waterhouse Coopers report, can result in organisations and community services finding it difficult to match treatment to individual need at the right time.

1.5 Moreover, given the environment in which prison treatment is provided, there are specific challenges to be considered in developing good quality drug treatment and interventions services in prisons:

- **Prison population** – According to the Prison Service, there are 136 adult prisons in England and Wales with more than 84,000 people in prison. Around 26 per cent of male prisoners and 29 per cent of female prisoners are from Black and minority ethnic groups, with a majority serving longer sentences than their white counterparts. In 2008, the prison system received 134,000 new admissions or receptions (60 per cent increase on prison numbers since 1995), a great many of whom have complex problems including:
 - 10 per cent of the overall prison population have a serious mental health problem;
 - 69 per cent of those who enter prison have taken drugs within the previous 12 months;

- Of these, 40 per cent report injecting drug use within the 28 days preceding imprisonment; and,
 - Someone received into a prison who is drug dependent is twice as likely to commit suicide in the first week of imprisonment as a non-dependent prisoner.
- **High volume and frequency of movement of prisoners** - A busy remand prison can see upwards of ten new drug dependent prisoners per night i.e. over 3,000 new drug dependent prisoners a year. Many of these prisoners will move to other prisons within weeks or even days of arrival, and many will be transferred to a third or even fourth prison during a single prison sentence.

“When arriving from a transfer sometimes you only get to see a nurse and have to wait to see a doctor in the morning and as meds do not travel with you this causes immense discomfort” (Service user forum - Review Group Service User and Carer Consultation)

- **Polydrug use is common among offenders entering custody** - People arrive in prison co-dependent on any combination of alcohol, opiates, stimulants and benzodiazepines.

“There is more visible support for heroin but is this at the expense of alcohol and others?” (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- **Dual diagnosis or the co-existence of mental health and substance use problems** - Dual diagnosis has become far more common in both the community and within prisons. A 2008 study looking at prison mental health in-reach services suggested that dual diagnosis should be regarded as the norm, rather than the exception. A 2003 study showed that:
 - 74.5 per cent of users of drug services and 85.5 per cent of users of alcohol services experienced mental health problems; and
 - 44 per cent of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels in the past year.

Despite the recognised high prevalence of dual diagnosis among offenders with mental health problems, the Bradley Report found that services are not well organised to meet this need. In fact, services are currently organised in such a way as to positively disadvantage those needing to access services for both mental health and substance use/alcohol problems.

"I don't feel my mental health needs have been addressed, I've now self harmed for 18 months cutting my arms/wrists, hanging myself and taking overdose. I still self harm and I feel nobody cares. I've had no counselling at all and I got bullied and the suicide liaison officer rewarded one of the bullies."
(Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- **Social exclusion issues, including people from Black and minority ethnic backgrounds being over-represented in the prison population** - Many prisoners have a history of social exclusion, including high levels of family, educational and health disadvantage, and poor prospects in the labour market. People from Black and minority ethnic backgrounds are over-represented in almost all these dimensions of social exclusion. A 2002 report from the Social Exclusion Unit demonstrated that it is no coincidence that people from some Black and minority ethnic backgrounds are over-represented in the prison population.
- **Specific needs of women** - The Corston Report described the effect of prison sentences on women's lives. Women are often in prison for very short sentences, and often on remand. However, prison regimes were not properly geared up for women prisoners and Prison Service practice was focused on incarcerating men. Treating men and women equally in prison did not produce equal outcomes. A woman-centred approach to regimes was necessary and could turn women's lives around and help them to develop much needed self-esteem and life skills. Since the Corston Report, there has been progress towards gender specific standards and staff training, including the abolition of routine strip-searching in prisons from April 2009.

"The women felt strongly about being re-housed away from their original home address in decent accommodation which would help to give a feeling of 'a fresh start' and make a move away from old habits. This can often be hampered by the requirement of some housing associations to have a family connection in order to live in a particular area." (Service user forum - Review Group Service User and Carer Consultation)

- **Many drug users lead chaotic lives and experience a range of issues with housing, employment education and health that need to be addressed** - A 2008 UK Drug Policy Commission report stated that up to 80 per cent of drug users are unemployed and most employers would refuse to employ even an abstinent recovered drug user, let alone one who is still in treatment. The report highlighted the importance of being realistic about the time required before many drug users will be in a position to participate in the job market. The physical and mental health problems experienced by drug users may also impact on their ability to achieve and sustain employment and these need to be recognised and adequately addressed. This will have implications for benefit regime procedures and other support mechanisms. The report also stated that there is a need for improved provision of a range of suitable

accommodation to facilitate recovery and rehabilitation. Housing agencies in particular need to be more closely involved in local drug partnerships and there is a need for identification and sharing of good practice in provision.

"You can do all of the work in prison only to be left with nowhere to live, leaving you to go to a hostel which is full of drugs. We need more help in resettlement." (Service user forum - Review Group Service User and Carer Consultation)

- **Release from prison is a critical time** – A 2005 study from Farrell and Marsden found that, in the week following release, prisoners are 37 times more likely to die of a drug overdose than other members of the public due to diminished opioid tolerance. Women are 69 times more likely to do so.

"I mean for me I found it quite daunting because I didn't know when I was going. I was woken up at five in the morning and told to get my stuff because I was leaving and that was it and I was put on the street with a bag." (Service user forum - Review Group Service User and Carer Consultation)

Moreover, a 2010 study from Stover and Michels highlighted that *"coercive abstinence in prison may be followed by relapse immediately after release, often resulting in overdose, drug emergencies and death"*. This study on prison deaths confirms the increased risk of drug-related death in the first two weeks on release from prison. Importantly, it also shows that the risk persists through to weeks three and four though, as expected, it tapers off as time passes. The high death rates demonstrated in this study is a reminder of the real risk that prisoners, particularly newly detoxed ones, face on release.

- **Support for prisoners on release** - In a Home Office review of the Drug Interventions Programme help with housing was rated as the most important issue to drug-using offenders. More emphasis was also needed on developing life skills to help prevent relapse into drug use and offending, and a lot of importance was placed on crisis support, peer support and daytime activities to help make the transition to a normal life. This review stated that current thinking about service delivery has not recognised the importance of these factors. The Corston Report highlighted the specific needs of women prisoners on release, particularly those on short sentences. A woman in prison for a month could lose her home and see her children taken into care. Following release, the fact that her children were in care could lead to problems obtaining housing and this, in turn, could lead to problems getting her children back.
- **Multi-agency working needs strengthening:** Partnership working is still too reliant on persuasion and goodwill despite the strengthening of governance structures. Multi-agency working is an area for further development particularly in respect of working with prison, police and probation and wider agencies such as housing.

Security Issues

- 1.6 For drug treatment and interventions staff working in prisons, the challenges are compounded by the routine movement of prisoners and the security imperative, which limits access to prisons, and the sudden lowering of mood consistent with the occurrence of imprisonment and drug withdrawal.

“...the Screws are so understaffed, when the CARAT team come on the wing and the Screws are like, ‘No we’re not unlocking anybody because we haven’t got the staff to supervise you’. You can see the CARAT team arguing with them saying, ‘We have to see these people to give them some support and help them for when they get out’. But the Screws are saying, ‘We haven’t got the staff to unlock them and supervise you doing this work’. I only saw them once and that was on my second day there, then I didn’t see them after that in the whole six months I was there.” (Service user forum - Review Group Service User and Carer Consultation)

- 1.7 The Blakey Review specifically considered security issues and measures to disrupt the supply of drugs into prison. The review made 10 recommendations on how to improve the effectiveness of the Prison Service’s measures for disrupting the supply of illegal drugs into prison, which were accepted by Government.
- 1.8 This complex backdrop makes prisons a uniquely complicated drug treatment setting and highlights the difficulties in establishing integrated care pathways and a comprehensive drug treatment and interventions system within prisons and for people on release.

Continuity of care for drug users moving between England and Wales

- 1.9 In Wales, all health and community safety issues and funding have been devolved and are now the responsibility of the Welsh Assembly Government, including the provision of drug treatment in the community and in prisons.
- 1.10 This means that there are some differences in the types of drug treatment provision available, waiting times for treatment, etc. in prisons and in the community in England and Wales. This can create difficulties around ensuring effective continuity of care for drug users moving between drug treatment services in England and Wales.

DRUG TREATMENT NEED

- 1.11 We found that there is an incomplete picture of drug treatment need. Historically, need has been determined on a local basis, so we were reliant on epidemiological surveys to provide central estimates of treatment need.
- 1.12 Epidemiological data indicates that on average 55 per cent of prisoners report a serious drug problem on arrival, with 80 per cent reporting some misuse and around 7 per cent of prisoners reporting severe alcohol dependency. These

figures are derived from an Office for National Statistics report. This report followed a large psychiatric survey of morbidity among prisoners in 1997, which indicated that levels of drug dependency for males was between 43 per cent and 51 per cent and for females between 41 per cent and 54 per cent.

- 1.13 Other surveys have corroborated this estimate. A survey carried out by the Home Office in 2003 indicated that up to 60 per cent of female prisoners had a drug problem.
- 1.14 Despite the considerable investment in prison drug treatment in recent years, it is estimated that there remains a significant unmet treatment need.

CURRENT APPROACHES AND THE VIEWS OF SERVICE USERS AND CARERS

- 1.15 A variety of initiatives and programmes have established drug treatment and intervention services both in prisons and in the community to address the wide range of issues presented by drug users. Overall, this appears to have had a positive impact, for example:
- Funding for prison drug treatment has increased year on year and is now over 15 times that of 1997 – with record numbers engaging in treatment.
 - In this time drug use in prisons, as measured by random mandatory drug tests, has decreased by 68 per cent.
 - There has been a significant decline in adult re-offending since 2000, and figures show a fall of 13 per cent between 2005 and 2006.
 - Since the development of the Drug Interventions Programme (DIP) in 2002, to provide a route out of crime and into treatment, recorded acquisitive crime – of which drug-related crime makes a significant contribution – has fallen by almost a third.
 - Record numbers continue to be engaged in drug treatment in the community, including drug-using offenders - 207,580 were in treatment in 2008/09; and 24,656 successfully completed their treatment free of dependence, which is a 35 per cent increase on the previous year's figures and almost double the rate of a few years ago.
- 1.16 In order to gain a full picture of the impact of the current approaches, we not only reviewed the range of drug treatment and interventions available but also carried out a service user and carer consultation process and asked their views on the best and the worst aspects of the current system and the changes they would like to see.

- 1.17 This review was carried out in a very short space of time and the results exceeded expectations - responses were received from 553 drug users, ex-drug users and carers and included responses from service user forums held in prisons and service user groups in the community.
- 1.18 The full report on the service user and carer consultation can be found in Appendix A.
- 1.19 One of the overall themes to emerge is that people need to feel they have choices. This is as important when deciding about treatment and interventions options and in choosing their own route to recovery i.e. working toward abstinence. The reality of supported self-change is vital in a recovery focused treatment system in order to raise aspirations and create opportunities for further self-change and personal development.

“The drug treatment in prison has improved due to the fact that no-one likes to be forced to stop like they did a year ago and before. So now when we get released, we can still be on scripts if we choose that we are not ready to stop. Us prisoners basically have more choices now.” (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- 1.20 Carers identified themselves as the major support for someone leaving prison and yet they often felt left out of the treatment process. Carers recognised that improvements had taken place but wanted to receive more information early on in treatment and to be more involved prior to release. Early involvement was felt to be especially important with respect to younger offenders.

“In general, better information sharing and dialogue with families would facilitate a smoother release process and make the family feel more engaged in an issue they invariably have a large stake in.” (Carer forum - Review Group Service User and Carer Consultation)

- 1.21 The current range of drug treatment and interventions available in prisons and for people on release are briefly outlined below, along with views from users and carers.

Clinical Drug Treatment Services

- 1.22 An range of clinical services, funded by the Department of Health, are available in prisons to:
- Provide clinical management of drug use problems through detoxification and/or maintenance prescribing programmes.
 - Address the associated wider health issues, which arise from drug use, such as blood borne viruses, deep vein thromboses, abscesses and dental disease.

- Provide clinical management to drug users with serious mental health problems (dual diagnosis).
- 1.23 The Department of Health were committed to ensuring that prison clinical drug treatment was brought to a minimum standard across all English prisons by 2011. In 2009/10, £39.7 million was allocated for primary care trusts (PCTs) to commission clinical drug treatment services on behalf of prison/PCT partnerships and from April 2010, clinical drug treatment funding was available for all adult (over 18 years of age) in English prisons.
- 1.24 Increased funding for clinical drug treatment has resulted in an increase from 40,000 people on detoxification and prescribing programmes in prisons in 2001/02 to 59,000 people in 2007/08. By 2009/10, a total of 60,067 prisoners had received a clinical drug intervention. Of these, 36,323 received detoxification and 23,744 received a maintenance prescription for opioid dependency of either methadone or buprenorphine.

Service Users and Carers' Views:

- Drug users recognise that drug treatment has improved and many saw this as being significant.
- The factors that drug users report as being good include speed of access, being able to exercise choice and having continuity of treatment both on entering prison and during transfer within the prison estate.

"They give you what you need and the doctor listens to you and he will give you what you're more comfortable with subutex or methadone." (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- Drug users also rate good clinical treatment as having an impact on reducing the need to use illicit drugs in prison and reducing bullying and debt.

"Means we don't buy illegal drugs in jail, so we all have money for canteen, etc. also puts people off bringing in drugs as they struggle to sell them." (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- Different categories of prison, however, varied in access to detoxification or maintenance and the availability of certain programmes. Fewer drug users had experience of Category A prisons but amongst those who had, they more generally reported the experience of drug treatment as being negative.

"Only been in Cat A and it's not good they treat everybody as if they're still on the street and lying and cheating to get what they can to get high when they really just want to feel calm and sleep at night!" (Prison questionnaire respondent ☒ Review Group Service User and Carer Consultation)

- Transfers were felt to result in unmet needs when the new prison has a different regime that restricts choice about what medication or programme is being followed. This was also said to affect care on release adversely.

“I was on a detoxification and I got shipped to another prison and then that particular prison didn’t allow people there who were on medication for the high amount I was on. So I had to stay there for two days without anything and they sent me back.” (Service users forum - Review Group Service User and Carer Consultation)

Dual Diagnosis

- 1.25 Responsibility for dual diagnosis, by its nature, overlaps a number of the health and social care services provided in prisons, including primary mental health services, secondary mental health services, drug treatment services, chaplaincy and peer support groups. Prisons vary in the way in which the functions of mental health and substance use interventions are divided between these respective departments.
- 1.26 Improved services for prisoners who have a dual diagnosis of mental health and substance use problems is a recommendation under the Bradley Review and work is underway to improve the management of dual diagnosis among offenders, through the cross-Government Health and Criminal Justice Programme, specifically:
- In response to the need identified by Her Majesty's Inspectorate of Prisons for more coordinated care for people in prisons with dual diagnosis, the Department of Health and Ministry of Justice issued joint guidance in 2009 for prison commissioners, service providers and practitioners on the management of dual diagnosis within prisons. This work incorporates the instruction from the mental health Care Programme Approach policy that individuals with dual diagnosis should have their care coordinated within the Care Programme Approach process. This is the first published national guidance for any prison system in the world.
 - A partnership dual diagnosis training project was initiated in March 2009 that involves the Department of Health, Skills for Health and the Pan-London Lifelong Learning Network. The project is producing a national higher education accredited set of dual diagnosis training modules for staff working in prisons. These modules will be available for inclusion in higher education courses across England and Wales for any practitioner working in any part of the criminal justice sector. The module will also be approved under the Bologna agreement for the whole of Europe, the first dual diagnosis course to be so accredited for any patient group or setting.

Service Users and Carers' Views:

- One of the biggest problems cited by people as not being met was mental health problems.
- Drug users cited lack of awareness and knowledge about dual diagnosis, poor medical responses, including long waiting times to see a mental health professional and differences across all categories of prison.

"I am on anti-depressants and I have still not been seen by a member of the mental health team to assess my health. They seem to want to throw tablets at us to shut us up." (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

"I suffer with bad depression but wasn't given anything for it just placed on the hospital wing. No one seemed to address my mental health needs, if you're on methadone they won't give you anything else, that's what the doctor told me." (Community questionnaire respondent - Review Group Service User and Carer Consultation)

Drug Related Deaths

- 1.27 Farrell and Marsden found that in the week following release, prisoners are 37 times more likely to die of drug overdose than other members of the public, due to diminished opioid tolerance. Women are 69 times more likely to do so.
- 1.28 A 2010 study by Stover and Michels highlighted that *"coercive abstinence in prison may be followed by relapse immediately after release, often resulting in overdose, drug emergencies and death"*. The high death rates demonstrated in this study is a reminder of the real risk that prisoners, particularly newly detoxed ones, face on release.
- 1.29 There is no doubt that these death rates are likely to be significantly reduced by the provision and continuation of substitution treatment, so FP10 MDA prescriptions to prisoners were piloted in eight prisons and now being fully rolled out.

Service Users and Carers' Views:

- Continuity of prescriptions on release i.e. access to a prescription on the day of release was highlighted as important.
- However, the need for ID or a formal letter was cited as a block to gaining a prescription from a GP in the community.

“Sometimes when you get out of jail you have to wait a few days before you can start your script up again ‘cos sometimes it takes a while to get in touch with the jail or whatever excuse they’ve got. But if you get out and you’ve got your script waiting for you, then it might be alright, ‘cos if you haven’t, you’ve got to go out and do whatever you have to do to make the money and then buy the heroin to substitute.”
(Service user forum - Review Group Service User and Carer Consultation)

Harm Minimisation Approaches

- 1.30 In 2001, a universal prison hepatitis B vaccination programme was established. English prisons are now the health setting that immunises the greatest number of injecting drug users per annum.
- 1.31 A number of health promotion initiatives for the prevention of blood borne viruses have been developed including a DVD *“Hepatitis C: inside and out”*.
- 1.32 In 2007/2008 a series of policy and programme initiatives in prisons in England & Wales were established to prevent and control blood borne viruses including the distribution of disinfecting tablets in prison.

Service Users and Carers’ Views:

- In spite of the above, harm minimisation was generally thought to be lacking, in particular with respect to sharing of needles and razors.

“There are a lot of problems with needles in prison, people making them from anything they find (pens for example) or stealing them from clinical waste bins. There are people who already have an abscess who are continuing to inject in prison.” (Service user forum - Review Group Service User and Carer Consultation)

Psychosocial Interventions

- 1.33 The Ministry of Justice funds psychosocial drug services in prison, comprising of CARAT services, including IDTS (£33.9m in 2009/10) and Accredited Drug Treatment programmes (£22.2m in 2009/10). Details on these programmes are briefly summarised below.

CARAT (Counselling, Assessment, Referral, Advice, Throughcare) Services

- 1.34 CARAT services have been available in all adult and young offender prisons in England and Wales since 1999. CARATs provide psychosocial support and advice to drug users by assessing the nature and extent of their problematic drug use before providing, or referring to, a range of psychosocial interventions. The service is designed to address the needs of low, moderate and severe drug users and to act as a gateway or link to other services within prisons and the community through the following key provisions:

- Access, referral & throughcare
- Assessment
- Key working
- Care planning and reviewing
- Structured psychosocial intervention

Accredited Drug Treatment Programmes

1.35 Prisons run a variety of rehabilitation programmes for drug users. The programmes are designed to reduce the risk of re-offending through alleviating prisoners' substance use problems. There are three types of programme, based on different therapeutic approaches:

- **Cognitive behavioural therapy (CBT)** - Examples of prison CBT programmes include P-ASRO (Prison-Addressing Substance Related Offending), which is a low/medium intensity programme that runs in 39 male prisons (a gender specific P-ASRO for Women is available at Low Newton) and Short Duration Programmes available in 43 prisons across the estate.
- **12-step programme** - The 12-step approach works on the assumption that addiction is a life-long illness that can be controlled but not necessarily completely cured. The 12-step programme is available in twelve prisons. The programmes are high intensity for highly dependent individuals and last for 15-18 weeks.
- **Structured therapeutic community (TC)** - TCs are based on hierarchical treatment and aims to teach new behaviours, attitudes and values, reinforced through peer and TC support. It is available for adult prisoners with a medium or high risk of reconviction and level of dependence on drugs. There are currently four TCs across the prison estate.

1.36 Referral to these programmes is through CARATs, based on risk and need. The different approaches allow the individual to be directed towards the treatment that is most suited to the severity of their problem and fits with their personal characteristics and circumstances. Some of the CBT programmes are suitable for people who are stabilised on methadone prescribing as part of the process of working towards abstinence, while the 12-step and TC models require participants to be entirely drug-free before commencing the programme.

Service Users and Carers' Views:

- In terms of psychosocial interventions, the factors which are rated as being good include the quality of relationships, ease of access and experiencing a transformation in which drug users describe their life as having being 'turned around'.

“It helps me to focus on turning my life around. It stops me from wanting to use drugs in the prison and I can learn to control my addiction problems and move forward in life. I think it is the best way forward in tackling drugs and it motivates yourself to change your life style.” (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- CARATs are very well regarded but drug users reported having difficulties in access in some prisons and waiting long periods.

“CARATs really explained things to you, help you, advise you and they do really listen to you and do care what your life is about.” (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

“In most prisons it just takes too long to get to see a CARAT worker that would be my main concern (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- Intensive courses and programmes including 12-step were very highly valued but drug users reported difficulties in access resulting from waiting times, lack of capacity and differences across the prison estate.

“It’s given me the chance to get my life back on track and to live clean and sober. I can now see a future for myself and all I have to do is keep going to my meetings and work my recovery daily.” (Service user forum - Review Group Service User and Carer Consultation)

Voluntary/Compact-Based Drug Testing

- 1.37 Compact-based drug testing is intended to provide an incentive for people in prisons to stay drug free – either because they are recovering from drug dependence or because they wish to continue receiving particular privileges, such as a release on temporary licence or a more desirable job within the prison. They provide a level of assurance to staff that people are sticking to the terms of their compact, but this would also be considered in light of other factors such as their general behaviour, drug finds or mandatory drug tests.

Integrated Drug Treatment System for Prisons (IDTS)

- 1.38 IDTS was introduced in 2006 with the aim of enhancing clinical interventions for drug users in prison, reducing duplication in assessments, improving integration between healthcare and CARAT services, and reinforcing continuity of care between prisons and the community. The development of IDTS has resulted in considerable investment in clinical drug treatment, case management and psychosocial provision, including the development of pathways of care and improved contract management.

Service Users and Carers' Views:

- In terms of continuity of care, drug users' experience is very varied and this reflects the fact that there are clearly different levels and quality of service. For example, one aspect of the lack of continuity of care concerned the differences between different categories of prison, which ranged from having no treatment to being treated very well.
- Lack of choice features prominently, especially with respect to issues beyond the person or the prison's control such as early release from court.

"It could even happen while you go to court; your space may have been taken over by the jail that you have come from and you're in the middle of a detox programme, you get shifted out to another jail and you have to start all over again, back to square one. You have to contact a doctor again and all that kind of stuff." (Service user forum - Review Group Service User and Carer Consultation)

- Concerns were raised about poor relationships with prison officers and between officers and drug treatment workers. These poor relationships are often characterised by security and staffing issues.

"It's just that battle between CARAT workers and the Screws...you hear them 'Oh them bloody CARAT workers are here again'...They see them as interference." (Service user forum -- Review Group Service User and Carer Consultation)

- People with substance problems other than heroin stated that their needs were often unmet e.g. alcohol and crack use.

"The help for heroin addicts is good but I myself need help for depression, crack addiction, alcohol and cannabis and as they are not physically as bad so I don't get any help..."(Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- Experience on reception and assessments were stated as being problematic, especially when the person entered prison on a Friday night and could not be assessed adequately until Monday morning.

"Say you've landed on a Friday and it has gone passed the times for the chemist to check, you've got all weekend then until Monday until they arrive before it is found out. So if you say well actually I'm on this medication or that medication they don't give it you." (Service user forum - Review Group Service User and Carer Consultation)

- Drug users reported having to undertake repeat assessments and finding it difficult to keep stating their needs.

Drug Interventions Programme (DIP)

- 1.39 Drug users released from prison requiring assistance for drug problems can access DIP services, which are made up of multi-disciplinary teams, known as Criminal Justice Intervention Teams (CJITs). The CJIT allocates a worker following an assessment process. This can occur at any point in the criminal justice system or on leaving treatment. Where a CJIT client is remanded into custody, CARATs take responsibility for managing drug treatment whilst the person is in prison and liaise with the CJIT in preparing release plans at the end of the sentence.
- 1.40 Research shows that offending levels can fall following contact with DIP, which has made drug users face tough choices about their drug use and need for treatment.

Service Users and Carers' Views:

- Drug users identified lack of, or poor, care planning on release as a factor that could influence their progress.
- More integrated care planning and greater joined up services between prisons and the community, including end-to-end management, were cited as improvements that drug users would like to see.

"It would be nice to get picked up by your drug worker so you don't end up getting drugs on the way home". (Service user forum - Review Group Service User and Carer Consultation)

"Someone to meet you from either the local DIP teams or a trusted person to make sure you are not going to slip straight back to your old habits". (Service user forum - Review Group Service User and Carer Consultation)

Drug Rehabilitation Requirements

- 1.41 From April 2005, the Drug Rehabilitation Requirement (DRR) has gradually replaced the Drug Treatment and Testing Order (DTTO) as the main delivery route for drug interventions for adults within community sentencing. The DRR is targeted at drug users who commit acquisitive crime to fund their drug habit and show a willingness to co-operate with treatment. The DRR requires the individual to undergo treatment for a specified period, to be regularly tested for drug use and to attend review hearings where the court will assess progress under the order.
- 1.42 The DRR offers courts an intensive vehicle for tackling the drug use and offending of many of the most serious and persistent drug using offenders and as such, represents a viable alternative to custody. The number of DRRs/DTTOs has increased from 4,854 DTTOs in 2001-02 to 17,642 DRRs and DTTOs in 2008/9.

The proportion of offenders successfully completing DRRs/DTTOs has increased from 28 per cent in 2003 to 47 per cent in 2008/9.

Service Users and Carers' Views:

- Having something meaningful to do, including employment, education and structured programmes, was cited as a key determinant in remaining drug free.
- Appropriate accommodation - hostels were cited as places where drug use was common and a risk to those who had been released drug free. Women in particular identified the importance of being re-housed away from their old areas as significant to their progress and remaining drug free.

"I need to go to secondary rehab so that I can keep the work that I'm doing in here. It's my last chance to stay drug free and I can't afford to waste it." (Prison questionnaire respondent - Review Group Service User and Carer Consultation)

- Many drug users cited inadequate access to funds as being a factor that would lead them back to old habits, especially offending.

"They say to you that there is a thing called a crisis loan and they don't even give you that. You're sitting there saying I've got no food in my house. When I'm in prison I get three meals a day. I'm now out of prison and I'm not eating." (Service user forum - Review Group Service User and Carer Consultation)

- 1.43 There is no doubt that progress has been made, and service users and carers acknowledged the improvements and increased access to drug treatment and interventions in prisons and on release. However, more action needs to be taken to build on current gains and to address the issues and concerns raised by service users and carers.

THE EVIDENCE BASE

- 1.44 At the start of the review, we agreed that as far as possible our recommendations should be evidence-based. Therefore, we carried out a thorough review of the evidence base for drug treatment and interventions in prisons incorporating over 160 high quality peer reviewed papers, to consider:

- The current drug treatment and interventions services provided in prisons
- An overview of evidence for effectiveness by treatment modality
- The issues that influence effectiveness and interpretation of evidence

- 1.45 This review concluded that good quality drug treatment and interventions are effective and can contribute to a reduction in re-offending and reduced mortality from accidental drugs overdose or chronic health problems such as blood borne viruses.

- 1.46 To address the gaps around the evidence base, which are mostly around psychosocial interventions, we agreed an expert consensus on 'good-practice' and the importance of having integrated medical and psychosocial services within a menu of drug treatment services if recovery and rehabilitation of drug users are to be realised.
- 1.47 Research on efficiency savings and value for money on drug treatment and, specifically, on drug treatment and interventions in prisons was also reviewed. Prison-based treatment services can provide good value for money providing they are linked to rehabilitation and resettlement, and offer good potential for improving the life expectancy, reducing costs associated with deaths in custody, and reducing re-offending and future criminal justice system costs.
- 1.48 The evidence review was used to inform our debates and is one of a number of information-based papers produced to inform discussions. It should be read, therefore, in conjunction with other papers within the Appendices, specifically the papers on outcomes as evidence and outcomes are interrelated.
- 1.49 Full details of this evidence base review can be found in Appendix B and the impact of this and the service user and carer consultation can be found in Part 2, which outlines the recommendations of the Review Group.

CHANGES IN THE POLITICAL LANDSCAPE

- 1.50 Since the inception of this review, there has been a substantial change in the political landscape. The Coalition's programme has indicated that this Government will re-look at issues with regard to drug use, crime and rehabilitation and the NHS White Paper, *Equity and excellence: Liberating the NHS*, has already announced fundamental changes to the NHS commissioning system.
- 1.51 There is no doubt that further changes are likely to be announced within the new drug strategy, the Green Paper on rehabilitation and so forth. This provides an opportunity to achieve the cultural and system change needed to engage drug users and the communities within which they reside in effective drug treatment while in prison and to maximise their prospects for recovery and reintegration on release into the community.
- 1.52 We believe that our recommendations are in step with this changing political landscape - e.g. streamlined commission systems and a move towards outcomes.
- 1.53 And, with these recommendations, we seek to raise the levels of ambition about what can be achieved and to challenge the reluctance to recognise and harness the full potential of drug users to actively engage with and assume responsibility for their own recovery, including a renewed focus on abstinence as a clear goal.

2. THE RECOMMENDATIONS

DEVELOPMENT OF THE REVIEW GROUP'S RECOMMENDATIONS

- 2.1 The aim of this review has been to learn where there is good practice and innovative approaches and to improve and re-focus existing drug treatment and interventions systems and services in prison.
- 2.2 Therefore, the focus of our recommendations is on highlighting the potential for more effective use of resources and the gains that can be made by improving the quality of drug treatment and intervention services in prison. The recommendations are based on doing more within existing resources, reinvesting short- and long-term savings across the system, unlocked by implementing good practice more widely and supported by clear streamlined systems and evidence about what needs to be delivered.
- 2.3 We recognise that within the current economic climate it is important that any recommendations achieve greater efficiency and cost effectiveness. Any future strategy around drug treatment and interventions in prisons must be able to face tough choices about where to target resources and a determination to get value for money from every pound spent and, where possible, demonstrate a quantifiable return on investment by increasing innovation, raising standards and quality, and achieving efficiencies.
- 2.4 Therefore, we have worked on the basis that our recommendations should not need additional money to implement them, but would need to address:
- Improving the quality of drug treatment for people in prison and on release from prison, through the development of clear standards and outcomes.
 - Increasing innovation – in terms of service delivery, commissioning and partnership working - to contribute to a reduction in re-offending and reduced mortality from accidental drugs overdose or chronic health problems such as blood borne viruses.
 - Achieving efficiencies and improving cost effectiveness within the drug treatment system in prison and for people on release from prison.
- 2.5 There was a wide range of issues that this review could potentially focus on, however, to attempt to tackle all issues could result in a diluted approach that actually fails to have any impact. Therefore, we chose to focus on six key areas that we believe would have the most significant impact and deliver improvements in the outcomes and experiences of drug users in prison and on release.

- 2.6 All these recommendations are interlinked and need to be viewed in an integrated way. For example, the commissioning and outcomes recommendations are complementary and both are necessary – without clear outcomes, effective commissioning standards cannot be established and the commissioning of effective care pathways covering drug treatment and interventions, continuity of care provision and mainstream reintegration/recovery services (housing, employment) are essential in helping drug users to make lasting changes.
- 2.7 Our work programme, the key elements to be addressed and our recommendations are outlined below.

RECOMMENDATION 1: CROSS-GOVERNMENT STRATEGY

Criticisms of current system: Lack of a clear inter-departmental strategy; no agreement on priority of outcomes – health vs. re-offending, therefore, unclear what commissioning is for; variability of views between Government Departments.

Review Group Recommendation: Achieve efficiencies and improve cost effectiveness by developing (for the first time in England) a unified cross-Government drug treatment and interventions strategy that covers people in the community and in prisons, moving between prisons and on release.

- 2.8 We recommend that the proposed new drug strategy covers not only community based drug treatment but also includes a streamlined, unified cross-Government drug treatment and interventions strategy for people in prisons, moving between prisons and on release.
- 2.9 The lack of a unified cross-Government strategic approach to drug treatment and interventions within prisons and the community has created a fragmented treatment system with individual services and providers separated from one another, at times due to differing ideology and targets.
- 2.10 A unified approach to drug treatment and interventions needs to focus on recovery i.e. achieving abstinence; to situate the individual at the heart of provision; and, to encourage more inter-service partnerships, which allows greater flexibility and movement between system elements based on responsive, needs-based placement to the most appropriate service from locally available choices.
- 2.11 We recognise that effectively addressing the needs of drug users can be a challenging aspect of the management of prisoners, not only for health services but also for the prison regime. Tensions can develop, for example, between some harm reduction measures and other issues around the running of a prison (security, criminal justice and occupational health). Issues can also arise around the need to maintain confidentiality and the assurance of health and safety arrangements for prison staff.
- 2.12 Therefore, addressing drug use and achieving continuity of care will require an acceptance of practices amongst prison staff, prisoners themselves, professionals, and legal authorities, and will require a comprehensive, multi-disciplinary approach including clinical and psychosocial interventions.
- 2.13 A unified approach to drug treatment and interventions at the centre is vital to begin the process of developing these integrated local systems where all the various elements are co-coordinated, speak the same language, communicate with each other and have an agreed set of values, principles and outcomes

around achieving the goal of working towards abstinence. Therefore, a cross-Government strategy on drug treatment and interventions in prison should be based on:

- The twin aims of reducing drug-related crime caused by re-offending and improving the rehabilitation of offenders.
- An integrated approach (including integrated/streamlined care pathways) between Government Departments with a renewed focus on abstinence as a clear goal.
- A revised streamlined commissioning system and a new outcomes model that focuses on the outcomes that matter i.e. a stable place to live, a job, positive mental health and well-being.
- A robust evidence-base, including evidence of cost-effectiveness.
- Making more effective use of existing residential rehabilitation services ☒ offenders who have become drug-free and need secure and safe accommodation on release should have access to these services to support their ongoing recovery and abstinence.
- Reintegration/resettlement options – in both employment and housing terms, as an integral part of the building blocks to maximise recovery.
- Active involvement of drug users, their families and local communities.

2.14 A unified prison drug treatment and interventions strategy should also incorporate the elements outlined in the recommendations below.

RECOMMENDATION 2: ESTABLISHING AN OUTCOMES FRAMEWORK

Criticisms of current system: Lack of minimum standards for the prison setting; measures of activity currently gathered not outcomes, data on outcomes incomplete; lack of accountability, no one in overall charge in terms of performance management.

Review Group Recommendation: Shift focus and resources towards reducing re-offending outcomes and better health outcomes, through a national health and criminal justice outcomes model.

- 2.15 We carried out a thorough review of existing standards and outcomes to help us gain an understanding of the national context and the key factors shaping the drug treatment and interventions sector, which have an impact in determining outcomes for people in prison who require drug treatment. We considered a variety of issues in relation to outcomes, including:
- The wide range of literature on outcomes
 - Factors that affect outcomes in prisons
 - Government targets in the community and in prisons
 - Relevant data/information, research and surveys
- 2.16 We concluded that there are no existing outcome models appropriate for drug treatment in a prison setting.
- 2.17 We, therefore, developed the first national health and criminal justice outcomes model for drug treatment in prisons with the twin aims of reducing re-offending and improving rehabilitation. This outcome model focuses on four main themes:
- Reduced drug use
 - Reduced re-offending
 - Improved health and social functioning
 - Increased employment and enhanced workforce skills
- 2.18 This model can use existing sources of data and with a performance assurance framework could replace all current NOMS drug treatment key performance targets and the Prison Health and Performance and Quality Indicator for drug treatment, thereby reducing the burdens and duplication within the existing system.
- 2.19 We recommend that the Government adopt this model to provide a benchmark for the quality of service provided and to support commissioners and providers to evidence, assess and improve the quality of service provision. This will ensure consistency around service delivery across England.
- 2.20 A full report on the outcomes review and model can be found in Appendices C and D.

RECOMMENDATION 3: STREAMLINED COMMISSIONING SYSTEM

Criticisms of current system: Commissioning arrangements are complex and fragmented; multiple agencies involved at a national, regional and local level resulting in fragmented funding streams, commissioning routes, and a lack of consistency of approach in prisons.

Review Group Recommendation: Shift focus and resources to develop a streamlined, autonomous and accountable system that is coherent, cost effective and enables more effective decision-making by local commissioners and partnerships.

- 2.21 The current complex commissioning systems are characterized by a multitude of funding streams and process targets, which has resulted in a fragmented system with the risk of a 'one-size-fits-all' approach with limited choices in the types of treatment and broader social support available.
- 2.22 In light of this, Lord Patel established an expert Commissioning Sub-Group to consider a range of options to streamline drug treatment and interventions commissioning systems for people in prison, moving between prisons and on release from prison.
- 2.23 Following the work and conclusions of this expert sub-group, we recommend that for the first time in England, the majority of drug funds be jointly commissioned at a local level - this includes NOMS CARATs funding. This would mean that local health commissioners, potentially within the new consortia of GP practices, and local drug partnerships including local authorities, local Directors of Public Health, prison governors, etc. will share the responsibility for commissioning drug treatment both in prisons and on release and will have a collective responsibility to ensure effective joint commissioning and to align/pool budgets to obtain the best outcomes, efficiencies and value for money.
- 2.24 Some commissioning at a national level may still be needed, for example, to ensure the needs of the women estate and under 21-year-old offenders are addressed and under this system, services can be commissioned based on needs, at whichever level (national, regional or local) is appropriate for the intervention.
- 2.25 We are aware that even as our work programme and recommendations were being completed major changes to commissioning systems within the NHS were being announced. Our proposed model, however, is aligned with the Coalition's programme approach for a more autonomous and accountable system and with the NHS White Paper, *Equity and excellence: Liberating the NHS*.
- 2.26 PCTs will be abolished by April 2013; the main commissioning functions will pass to GP consortia and the public health function will pass to local authority commissioners. Healthcare commissioning will be the responsibility of GP

consortiums working with local communities to commission the majority of local health services from the NHS, voluntary sector and private providers.

- 2.27 There is no detail yet about what will happen to local drugs partnerships and where the commissioning of drug treatment will fit - it may be that it would be the remit of GP consortia or be part of the public health remit of the local authority, or it may even be split between the two.
- 2.28 These changes reinforce the need to collaborate and jointly commission locally to ensure that the needs of drug users in prison and on release are met, against a clear strategy that is reflective of consensus on evidence and good practice and clearly aligned with outcomes. The challenge will be persuading GP consortia to engage and support commissioning of community services for drug-using offenders when their focus will primarily be upon their registered patients and other higher volume/cost services.
- 2.29 Therefore, we recommend that the Government consider putting in place this revised commissioning system by 2011/12.
- 2.30 A full report on the work of the Commissioning Sub-Group can be found in Appendix E.

RECOMMENDATION 4: FRAMEWORK FOR SERVICE DELIVERY

Criticisms of current system: There are a number of drug treatment programmes in prison where both the effectiveness and whether it is justifiable to invest resources on the provision of these services is uncertain; financial allocation of funds not linked to impact; lack of consistency of approach e.g. around what prisons provide; unmet demand for psychosocial programmes; poor links with mental health and wraparound programmes e.g. housing and employment; geographical inequity of provision.

Review Group Recommendation: Refocus and increase ambition, quality and innovation in service delivery through an updated national drug treatment and interventions framework that covers both community and prisons to:

- Increase the number of drug users who are able to achieve recovery from dependency and sustain this for the longer-term; and,
- Contribute to a reduction in re-offending and reduced mortality from suicide, accidental drug overdose, blood borne viruses and other chronic health problems.

- 2.31 We carried out a thorough review of the evidence base for drug treatment in prisons incorporating over 160 high quality peer reviewed papers.
- 2.32 This review concluded that good quality drug treatment and interventions are effective and can contribute to a reduction in re-offending and reduced mortality from accidental drugs overdose or chronic health problems such as blood borne viruses.
- 2.33 To address the gaps around the evidence base, which are mostly around psychosocial interventions, we agreed an expert consensus on ‘good-practice’ and the importance of having integrated medical and psychosocial services within a menu of drug treatment services if recovery and rehabilitation of drug users are to be realised.
- 2.34 We also reviewed key research on efficiency savings and value for money on drug treatment and specifically on drug treatment and interventions in prisons. Prison-based treatment services can provide good value for money providing they are linked to rehabilitation and resettlement and offer good potential for improving the life expectancy, reducing costs associated with deaths in custody, and reducing re-offending and future criminal justice system costs.
- 2.35 Helping people get off drugs for good must be a crucial ambition for the drug treatment system. Delivering optimal systems of care that are evidence-based and supported by a range of choices and different pathways that promote reintegration and recovery is a vital challenge in developing a truly effective and balanced treatment system.

- 2.36 Our remit covers drug treatment and interventions for people in prison, people moving between prisons and on release from prison, but not drug treatment in the community. A menu of services must cover both drug treatment in the community and in prisons to avoid creating further ‘silos’ and to enable genuine joint commissioning. Therefore, the appropriate place to develop a clear menu of services must be within a new national drug treatment and interventions framework that spans drug treatment in the community and in prison to ensure consistency and continuity of care.
- 2.37 Therefore, we recommend the Government agree to an updated national framework that for the first time in England:
- Outlines the ambition to maximize drug users prospects for recovery (i.e. becoming free of dependency)
 - Spans drug treatment both in the community and in prison
 - Outlines an appropriate menu of services, including medical treatment, psychosocial interventions, harm minimisation and broader social care that promotes resettlement and recovery
 - Ensures that the service users (and carers) and their recovery are at the heart of all commissioning and service delivery
- 2.38 An effective outcomes framework and commissioning system will require access to a range of treatment and intervention services that are able to meet the varied, and at times, complex needs of drug users. The mix of services within any local area should also be based on local needs assessments to inform local joint commissioning practises.
- 2.39 The development of this national framework should be an early goal of the new drugs strategy.
- 2.40 A full report on the Evidence Base can be found in Appendix B.

RECOMMENDATION 5: SERVICE USER AND CARER ENGAGEMENT

Criticisms of current system: Lack of active involvement of service users in key aspects of decision-making in relation to their care and to the planning, delivery and evaluation of service provision; particular difficulties of drug user engagement across prison estate has led to lack of ambition and will to involve drug-using offenders.

Review Group Recommendation: Increase social capital by identifying 'Recovery Champions' in the community and prisons to reduce poor social cohesion in local communities and support the creation and expansion of volunteering, co^{op} operatives, charities and social enterprises.

- 2.41 A drug treatment system that promotes abstinence needs a robust, realistic narrative of recovery that is meaningful to the drug-users and their families, and endorses 'Recovery Champions', peer support and mentoring groups.
- 2.42 We are aware of the particular difficulties of drug user involvement across the prison estate, but believe that there is a lack of ambition and will to involve drug-using offenders. So, within a short space of time, we established a service user and carer consultation process around drug treatment in prisons, developed with the help of ex-drug users.
- 2.43 The results exceeded expectations - responses were received from 553 drug users, ex-drug users, and carers, and included responses from service user forums held in prisons and service user groups in the community.
- 2.44 We are, therefore, in no doubt that drug users, ex-drug users and their families/carers have an appetite to be more actively involved and opportunities to increase their potential social capital should be addressed.
- 2.45 We recommend that commissioners and local partners focus on increasing the social capital through the identification of 'Recovery Champions' and appropriate community groups - local councillors, business people; families and friends of users; ex-drug users. We need to make more effective use of people who understand the problems of dependency; those who want to understand more; and those who may have resources to help make recovery a more realistic option.
- 2.46 All offenders, irrespective of race, gender, disability, age, ethnicity, religion and sexual orientation should be able to secure the same access to drug treatment services as the rest of the population. It is vital to take into account the differing patterns of drug use and treatment access amongst key groups.

- 2.47 Women prisoners often present with the most complex needs amongst the population particularly in terms of their substance misuse. The disclosed use of prescribed drugs, illicit drug use and alcohol use together with a mental health problem can be common amongst women entering custody.
- 2.48 At a local level, active engagement with users and their families/carers can help tackle the unmet treatment needs and barriers to treatment, including the needs of young people, women drug users, Black or ethnic or other minority communities, sex workers or parents with dependent children - Recovery Champions would need to reflect this diversity.
- 2.49 In order to move away from centralisation and 'big' government to creating a 'Big Society', Recovery Champions, community groups and the families/carers of drug users can play an important role in articulating ambition, championing routes to recovery and challenging partnerships and services to retain a recovery focus – both prior to release and on release. People who have personal experience of problematic drug use and who have achieved successful recovery, and feel ready to volunteer and support others, should be encouraged to become involved in peer support, mentoring groups and other community groups, and talking about what made their recovery a reality e.g. access to housing and jobs.
- 2.50 Increasing social capital is important not only to those who are recovering from substance misuse, but is significant from a community perspective. The role of social capital is important in keeping drug dealers from infiltrating into neighbourhoods - illegal markets tend to flourish in areas where there is poor social cohesion, resulting in difficulties regulating nuisance and problematic behaviours - and increasing social capital can support the well being of drug users and their families and minimize nuisance factors.
- 2.51 A full report and the result of the user and carer consultation are available in Appendix A.

RECOMMENDATION 6: ESTABLISHING LINKS TO WIDER CRIMINAL JUSTICE AND HEALTH AND SOCIAL CARE SYSTEM

Criticisms of current system: Lack of consistency of approach; remand prisoners can get lost when release is unplanned; fragmented care pathways and lack of continuity of care.

Review Group Recommendation: Increase efficiencies and improve cost effectiveness by ensuring drug treatment and interventions strategy in prisons is not developed in isolation but linked to other relevant initiatives and strategies as they develop.

- 2.52 Government Departments need to work closely with external organisations and partners to ensure joined up national thinking across institutional boundaries; to help break down any barriers to local partnership working; establish shared objectives; and, facilitate integrated care pathways between local agencies. This cross-boundary work should also continuously consider improvements in value for money.
- 2.53 Therefore, it is vital that any drug treatment and intervention strategies in the community and in prisons are not developed in isolation but linked to other relevant initiatives and strategies as they emerge.
- 2.54 Previous reports by the National Audit Office, the Committee of Public Accounts and others have identified failures in the delivery of public services that could have been avoided. A 2009 National Audit Office (NAO) report found many instances where major programmes and projects have been either frustrated, or severely hampered, by failure to take on board lesson from their own past experiences or those of others. The main barriers experienced by departments are silo structures, ineffective mechanisms to support learning, a high turnover within the workforce and a lack of time for learning.
- 2.55 To achieve value for money in public services, Government Departments need to learn from success and failure and to improve their capacity to learn from each other. The NAO report found that Departments often found cross-Departmental networks and communities of practice most valuable to supporting learning.
- 2.56 The Coalition's programme indicated a keenness to re-look at issues with regard to drug use, crime and rehabilitation, so presents an opportunity to avoid fragmentation of approach across Government and to increase efficiencies and improve cost effectiveness.
- 2.57 Therefore, we recommend that all efforts are made to effectively link drug treatment issues with a range of other criminal justice, health and social care issues as they are under development, including:

- Green Paper on rehabilitation
- NHS White Paper, *Equity and excellence: Liberating the NHS*
- Review of sentencing policy - ensuring that sentencing for drug use helps offenders come off drugs.
- Exploring drug rehabilitation prisons
- Implementation of the Prisoners' Earnings Act 1996
- New Mental Health Strategy

3. REFERENCES

Borril, J. et al. (2003) Differential substance misuse treatment needs of women, ethnic minorities and young offenders in prison: prevalence of substance misuse and treatment needs Online report 33/03 Home Office

The Bradley Report (2009) Lord Bradley's review of people with mental health problem or learning disabilities in the criminal justice system Department of Health and Ministry of Justice

The Corston Report (2007) A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system Home Office

The Coalition: our programme for government (May 2010) HM Government

Disrupting the supply of illicit drugs into prisons (2008) A report for the Director General of National Offender Management Service by David Blakely CBE QPM DL

Drugs: protecting families and communities The 2008 Drug Strategy HM Government

Drug Strategy 2008-2011 National Offender Management Service (NOMS)

Farrell, M. and Marsden, J. (2005) Drug-related mortality among newly released offenders 1998 to 2000 Home Office Online Report 40/05

A Guide for the Management of Dual Diagnosis for Prisons (2009) Department of Health and Ministry of Justice National Offender Management Service

Helping Government Learn (2009) National Audit Office Report by the Comptroller and Auditor General: HC 129 Session 2008-2009: 27 February 2009

HM Prison Service website – Publications & Documents, Population Figures – Weekly 11 September 2009

Ministry of Justice Offender Management Caseload Statistics 2008 – published 31 July 2009

Moving up a Gear – the Next Steps for DIP (2009) Home Office

Reducing Re-offending by Ex-Prisoners: Social Exclusion Unit Report, July 2002

Report to the Department of Health and Ministry of Justice: Review of Prison-Based Drug Treatment Funding (December 2007) Price Waterhouse Coopers

Service User and Carer Consultation (2009) Prison Drug Treatment Strategy Review Group

Shaw, J. et al. (2008) A national evaluation of prison mental health in-reach services

Singleton, N., Farrell, M. and Meltzer, H. (1998) Substance misuse among prisoners in England and Wales Office for National Statistics

Statistics on Race and the Criminal Justice System 2007/08 (April 2009) A Ministry of Justice publication under Section 95 of the Criminal Justice Act

Stover, H. and Michels, II. (2010) Drug use and opioid substitution treatment for prisoners Harm Reduction Journal www.harmreductionjournal.com

Substance Misuse Accredited Interventions (2010) National Offender Management Service (NOMS) Reducing Re-Offending Policy Group Review

Weaver, T. et al. (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry, Vol 183, pp 304-313

Working toward recovery Getting problem drug users into job (December 2008) UK Drug Policy Commission (UKDPC)

4. LIST OF APPENDICES

- **Appendix A – Service Users and Carer Consultation Report**
- **Appendix B – Evidence Base Review Report**
- **Appendix C – Outcomes Review Report**
- **Appendix D – Outcomes Model Report**
- **Appendix E – Commissioning Sub-Group Report**

Prison Drug Treatment Strategy Review Group

**Service User and Carer Consultation Report
2009**

ACKNOWLEDGEMENTS

This consultation could not have taken place without the support of all those who completed questionnaires and participated in service user and carer forums.

The Prison Drug Treatment Strategy Review Group greatly appreciates the time, effort and attention that all these respondents have taken in participating in this consultation.

We would also like to thank all those who helped in the process including prison staff, community groups, the Ministry of Justice, the National Treatment Agency for Substance Misuse, Government Offices and individual advocates.

Finally, we wish to acknowledge the hard work and commitment of Manjit Singh Johal and Rachael Hunter who made sure that such a wide range of people could take part and ensured that the service user and carer voice is so well represented in the work of the Review Group.

Thank you

Professor Lord Patel of Bradford OBE

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EXECUTIVE SUMMARY

INTRODUCTION

1. This report provides the findings of the consultation that was undertaken between July and October 2009 and involved the return of 553 individual questionnaires and over 200 participants in 26 service user and carer forums.
2. The response rate to the consultation was very good and there is a clear interest amongst many people to remain involved and be consulted further as the work of the Review Group progressed. Involvement of service users and carers was a priority for the Review Group and there was a commitment to ensure that there was open access to the Review Group's work via the website (www.pdtsrg.co.uk).

FINDINGS

What is good about drug treatment in prisons and how has this improved?

3. Respondents recognise that drug treatment has improved and many state this is significant. The factors that are rated as being good about drug treatment can be grouped according to two broad categories of treatment: psychosocial interventions and medical or clinical interventions.

Psychosocial interventions

4. The term psychosocial intervention is used very loosely to refer to all interventions based on human interaction and environment including CARATs, intensive programmes, 12-step and drug free wings, Therapeutic Communities and group work. The factors that are rated as being good about these interventions include:
 - The quality of relationships;
 - Ease of access; and,
 - Experiencing a transformation in which respondents describe their life having being 'turned around'.

Medical interventions

5. The factors that are rated as being good about these interventions include:
 - Speed of access;
 - Being able to exercise choice and having continuity of treatment both on entering prison and during transfer within the prison estate; and,
 - Reducing the need to use illicit drugs in prison and reducing bullying and debt.

What is not so good about drug treatment in prisons and which needs were not addressed?

6. Experience is very varied and this reflects the fact that there are different levels and quality of service experienced by service users. Some key differences are identified below:
- Variances in different categories of prison in access to detoxification or maintenance and availability of certain psychosocial programmes.
 - Lack of choice features prominently especially in terms of issues beyond the person's or the prison's control such as early release from court.
 - Transfers are felt to result in unmet needs when the new prison has a different regime that restricts choice about what medication or programme was being followed. This was also said to affect aftercare adversely.
 - Concerns were raised about poor relationships with prison officers, and between officers and drug treatment workers. These poor relationships are often characterised by security and staffing issues.
 - Respondents with substance use problems other than heroin, e.g. alcohol and crack use, stated that their needs were often unmet.
 - One of the biggest problems cited by respondents as not being met was mental health problems. In particular, respondents cited a lack of awareness and knowledge about dual diagnosis, poor medical responses including long waiting times to see a mental health professional, and differences across categories of prison.
 - Experience of reception and assessments were cited as being problematic especially when the person entered prison on a Friday night and could not be assessed adequately until Monday morning.
 - Respondents also reported having to undertake repeat assessments and feeling that it was difficult to keep stating their needs.
 - Harm minimisation was generally thought to be lacking, in particular with respect to sharing of needles and razors.
 - CARATs are very well regarded, but respondents reported having difficulties in access in some prisons and waiting long periods.

- Intensive courses and programmes including 12-step were very highly valued but respondents reported difficulties in access resulting from waiting times, lack of capacity, and differences across the prison estate.

What are the key factors on release that would prevent returning to old habits?

7. Amongst the factors that respondents stated would prevent them from returning to old habits were:
- Continuity of prescription on release by which they meant having one on the same day. The need for identification or a formal letter was cited as a block to gaining a prescription from a GP in the community.
 - Appropriate accommodation - hostels were frequently cited as being places where drug use was common and as such a risk to those who had been released drug free.
 - Women in particular identified the need to be able to be re-housed away from their old areas as significant to their ongoing progress and remaining drug free.
 - Many respondents cited inadequate access to funds as being a factor that would lead them back to old habits, especially offending.
 - Having something meaningful to do including employment, education and structured programmes was cited as a key determinant in remaining drug free.
 - Respondents identified lack of, or poor, care planning on release as a factor that could influence their progress.
 - More integrated care planning and greater joined-up services between prison and community, including end-to-end management, were cited as improvements that respondents would like to see.
 - In most cases, carers identified themselves as the major support for someone leaving prison, and yet they often felt left out of the treatment process.
 - Carers did recognise that improvements had taken place but they wanted to see carers receive more information early on in treatment and to be more involved prior to release. Early involvement was felt to be especially important with respect to younger offenders.

CONCLUSIONS

8. One of the key themes to emerge is that people need to feel they have choices. This is as important when deciding about treatment options as it is in choosing their own route to recovery.
9. Carers feel very strongly that they should be more involved in decision-making about treatment options and better informed about what happens to people while they are in prison and prior release.
10. There is a very strong call amongst service users and carers for greater continuity of treatment both within and between prisons and from community to prison.
11. There is also a very clearly articulated need for much greater support and help on release especially with respect to appropriate housing, having enough money, having something meaningful to do, and greater integration and co-ordination with community services.

1. INTRODUCTION

- 1.1 Prison Drug Treatment Strategy Review Group (henceforth known as the Review Group), chaired by Professor Lord Patel of Bradford OBE has been tasked by Ministers with overseeing a programme of work to address ways in which drug treatment in prisons can be improved.
- 1.2 In order to inform this work the Review Group has undertaken a consultation with service users and carers about their experiences of drug treatment. This report provides the findings of the consultation, which was undertaken between July and October 2009 and involved the return of 553 individual questionnaires and over 200 participants in 26 service user and carer forums.
- 1.3 Manjit Singh Johal, the service user representative for the Review Group, and Rachael Hunter (Project Team) with additional help in the analysis and presentation of the report from Dr Jon Bashford and Sherife Hasan (Project Team), conducted the consultation.
- 1.4 The consultation sought both positive and negative views about the experience of drug treatment and interventions in prisons and asked respondents to identify which needs they felt were unmet and how this could be improved.
- 1.5 The response rate to the questionnaires was almost a third and the attendance at service user and carer forums varied from two to forty with an average of six people at each event.
- 1.6 This is largely a qualitative piece of work where respondents were asked to provide their views and opinions to a number of open questions. The analysis consisted in the identification of core themes grouped according to the core scripts used in the questionnaires and service user and carer forums. The report is structured around these core questions, which are:
 - What is good about drug treatment in prisons and how has this improved?
 - What is not so good about drug treatment in prisons and which needs were not addressed?
 - What are the key factors on release that would prevent returning to old habits?
- 1.7 There is a final section on the process of the consultation and ways in which respondents have asked to be kept informed about the work of the Review Group and the outcomes from the consultation.
- 1.8 The clear message from the service users and carers is that drug treatment is very personal to the individual and the road to recovery is something people are very passionate about, as shown by the large number of responses received. For

those who have gone through it all and come out the other side they wanted to share their journey with others with the hope it might help someone else, but for each person the process was different. Many of the responses indicated a desire to give something back to others.

- 1.9 For those still struggling with their drug use they had an idea where they are up to and what currently works for them - this varied from person to person. At all stages - entry to prison, moving between prisons, or on release - each person describes their journey towards recovery as being very individual. The wide range of responses demonstrates the variety of experience and knowledge and how different respondents can be anywhere along this spectrum.
- 1.10 Some know a lot about drug treatment having done many courses and experienced many clinical treatments. Some know very little and may be on their first prison sentence with little or no understanding about what addiction means or that there is such a thing as drug treatment.
- 1.11 Many recognise that they need help, but are not sure what that it entails or how to access it.
- 1.12 Others are in different place in terms of their recovery – some people are totally abstinent and have not used for months or years; some are abstinent but lapse or relapse from time to time; some are stable whilst maintained on a prescription and feel that without this they will use drugs again; and some appear to be going through a continuous cycle of drug use, treatment, abstinence and relapse.
- 1.13 One of the key themes to emerge is that people need to feel they have choices. This is as important when deciding about treatment options as it is in choosing their own route to recovery.
- 1.14 Carers feel very strongly that they should be more involved in decision-making about treatment options and better informed about what happens to people while they are in prison and prior release.
- 1.15 There is a very strong call amongst service users and carers for greater continuity of treatment both within and between prisons and from community to prison.
- 1.16 There is also a very clearly articulated need for much greater support and help on release especially with respect to appropriate housing, having enough money and co-ordination with community services.

2. METHODS

Background

- 2.1 The script for the service user forums was developed with the Review Group service user representative and two service users.
- 2.2 The draft Service User Forum Script was discussed at the Review Group meeting in June 2009 and an amended version was approved in July 2009. The first version of the script was piloted with the Greenwich Local Addiction Support Service (GLASS) service user forum to test for usability. Some questions were found to overlap so amendments were made to produce the final version. The final version of the Service User Forum Script was tested with service users from the London Council and no further amendments were made.
- 2.3 On the 24 July 2009, a letter from Lord Patel, with service user scripts for prisons and community attached, was sent to six service user groups, NTA Regional Development Managers, Review Group members and Government officials (See Annex i). It was also posted on the website (www.pdtsrg.co.uk).
- 2.4 A questionnaire was developed after consultation with the Rehabilitation of Addicted Prisoners Trust (RAPt) as this was seen as the best way to consult their graduates (See Annex ii). 1,600 questionnaires were sent to RAPt graduates. Copies of the questionnaire were also available on the website and were sent with copies of Lord Patel's letter.
- 2.5 Pilot visits were made to HMP Wandsworth, Holloway and Belmarsh with two service user facilitators to hold service user forums with 10 people in prison receiving drug treatment. Most of the forum participants were selected through their attendance of the prisons' Short Duration Programme (SDP).
- 2.6 The deadline for responses was the 10 September 2009, although responses received up until the 10 October 2009 have been included in the analysis. In addition to the questionnaire, testing groups and the piloting of a further 25 Forums were conducted by service user groups involving more than 200 participants and 553 individual questionnaires were returned. (A full list of responding organisations can be found in Annex iii).
- 2.7 All the data has been analysed using methods derived from Grounded Theory (Glaser and Strauss, 1967¹) such as category development and comparison in order to identify common thematic groupings. Some limited statistical analysis has been undertaken using an Excel spreadsheet on the questionnaires in order to provide a detailed breakdown of the sample demographics.

¹ Glaser, B.G. and Strauss, A.L. (1967) *The Discovery of Grounded Theory* Chicago: Aldine

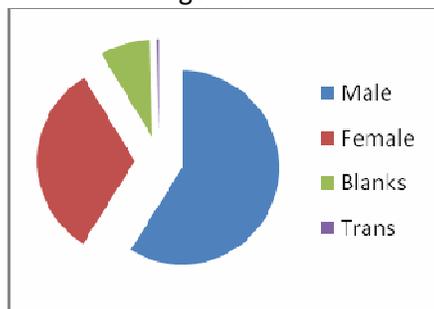
The Sample of Respondents

Questionnaires

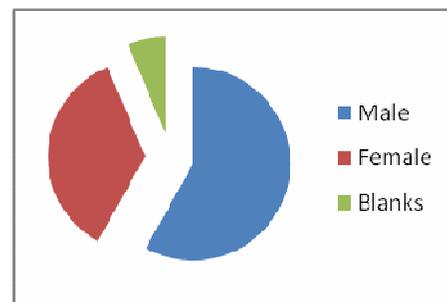
2.8 In total 553 questionnaires were returned. Of these, 299 were from people currently in prison and 254 were from people in the community. One questionnaire was returned from a carer. The following tables provide the demographic breakdown of the prison and community samples.

Prison sample			Community sample		
Gender			Gender		
Male	176	58.86%	Male	147	58.10%
Female	97	32.44%	Female	90	35.57%
Blanks	25	8.36%	Blanks	16	6.32%
Trans	1	0.33%			

Prison gender

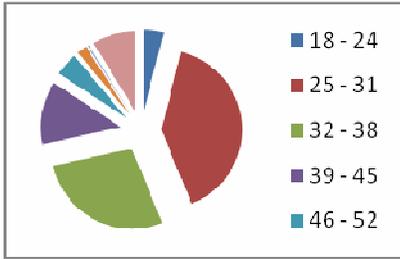


Community gender

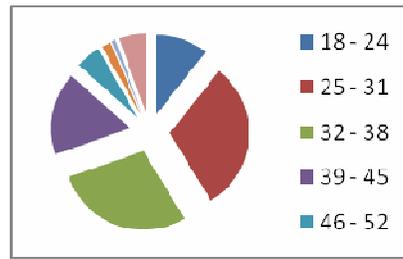


Prison sample			Community sample		
Ages			Ages		
18 - 24	12	4.01%	18 - 24	27	10.67%
25 - 31	119	39.80%	25 - 31	78	30.83%
32 - 38	83	27.76%	32 - 38	72	28.46%
39 - 45	38	12.71%	39 - 45	43	17.00%
46 - 52	14	4.68%	46 - 52	13	5.14%
53 - 59	6	2.01%	53 - 59	5	1.98%
60+	1	0.33%	60+	2	0.79%
Blanks	26	8.70%	Blanks	14	5.53%

Prison ages

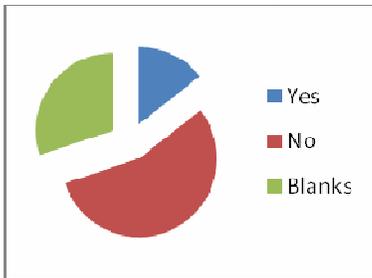


Community ages

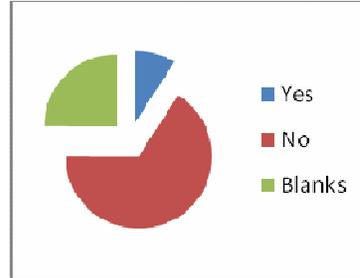


Prison sample			Community sample		
Disability			Disability		
Yes	43	14.38%	Yes	23	9.09%
No	166	55.52%	No	167	66.01%
Blanks	90	30.10%	Blanks	63	24.90%

Prison disability

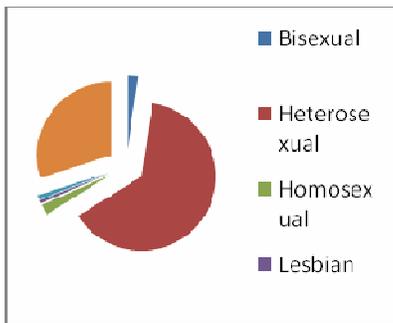


Community disability

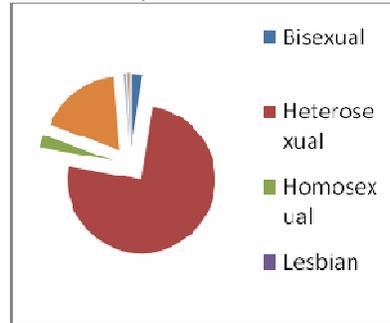


Prison sample			Community sample		
Sexual Orientation			Sexual Orientation		
Bisexual	7	2.34%	Bisexual	6	2.37%
Heterosexual	190	63.55%	Heterosexual	191	75.49%
Homosexual	7	2.34%	Homosexual	7	2.77%
Lesbian	2	0.67%	Lesbian		0.00%
Straight	3	1.00%	Straight		0.00%
Blank	89	29.77%	Blank	46	18.18%
			Gay	1	0.40%
			Open minded	1	0.40%
			?	1	0.40%

Prison Sexual Orientation

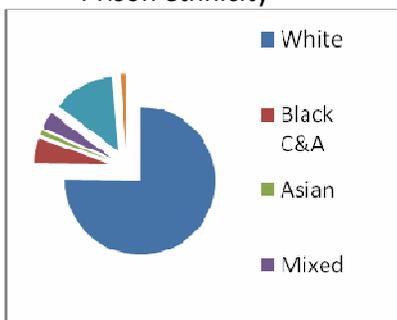


Community Sexual Orientation

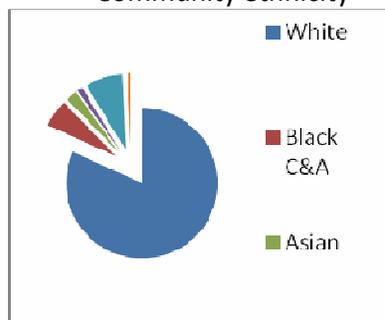


Prison sample			Community sample		
Ethnicity			Ethnicity		
White British	217	72.58%	White British	198	78.26%
White Irish	5	1.67%	White Irish	6	2.37%
Any other WB	3	1.00%	Any other WB	3	1.19%
Mixed W&C	2	0.67%	Mixed W&C		0.00%
Any other mixed	9	3.01%	Any other mixed	3	1.19%
Any other Asian	3	1.00%	Any other Asian	3	1.19%
Black Caribbean	5	1.67%	Black Caribbean	1	0.40%
NOT ANSWERED	40	13.38%	NOT ANSWERED	20	7.91%
Any other Black	11	3.68%	Any other Black	14	5.53%
Error	4	1.34%	Error	2	0.79%
			Asian British Indian	2	0.79%
			Asian British Bangladeshi	1	0.40%

Prison ethnicity

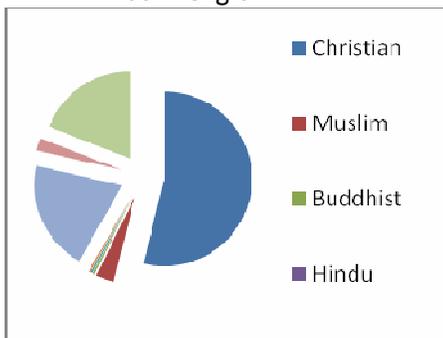


Community ethnicity

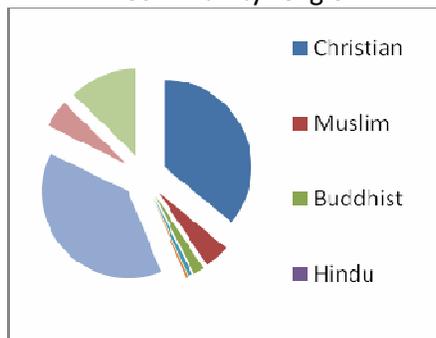


Prison sample			Community sample		
Religion			Religion		
Christian	161	53.85%	Christian	91	35.97%
Muslim	10	3.34%	Muslim	12	4.74%
Buddhist	1	0.33%	Buddhist	5	1.98%
Hindu		0.00%	Hindu		0.00%
Jewish	1	0.33%	Jewish	2	0.79%
Sikh	1	0.33%	Sikh	1	0.40%
Atheist/Non belief	61	20.40%	Atheist/Non belief	97	38.34%
Other	7	2.34%	Other	13	5.14%
Blank	57	19.06%	Blank	32	12.65%

Prison religion



Community religion



2.9 Amongst prison respondents, the average length of time in prison was 18 months ranging from 2.5 months to 22 years.

2.10 Amongst community respondents, the average length of time since last being in prison was 18 months ranging from 1 week to 19 years.

Service user and carer forums

2.11 More than 200 people took part in the service user and carer forums.

Gender

- 2.12 Two service user forums were conducted in women's prisons and in one of the large community forums 40 per cent (40 participants) were female.
- 2.13 The majority of forums were male only and amongst other community-based forums there were often only one or two women participants reported.

Ethnicity

- 2.14 Six forums reported on the ethnicity of participants. Amongst these groups, representation of Black and minority ethnic participants varied from 50 per cent to single participants.

Age

- 2.15 Where age is reported it varies from 21 to 45 years. One forum took place with younger offenders aged 18 – 21 years and consisted of six participants.
- 2.16 No data was returned on disability, religion or belief, or sexual orientation.

3. THE FINDINGS

What is good about drug treatment in prisons and how has this improved?

3.1 There is very broad recognition that prison drug treatment has improved:

“Drug treatment has improved significantly in access to receiving treatment for the physical aspects of withdrawal or maintenance in certain cases...” (Prison questionnaire respondent)

“It has improved because there are some staff who are trained in drug treatment and they're able to empathise with users. The CARAT workers are very helpful and do their best to get you onto a drug free programme as soon as possible.” (Prison questionnaire respondent)

“It has improved a lot because there was only drug awareness but now there are SDP, PASRO and 12-step, which go deeper than they ever did. This is what addicts need for people to be honest.” (Prison questionnaire respondent)

“It's come on leaps and bounds since when I first came to jail in 1993.” (Prison questionnaire respondent)

“There are more treatment centres.” (Community questionnaire respondent)

3.2 However, even though there is recognition of significant improvements, many still do not see this as being enough and there is thought to be too much variance across different prisons:

“I think it is very inconsistent across the prison system. It changes so much from one prison to another. It has improved since 20 years ago but I don't think it has really come on in the last 10 years.” (Community questionnaire respondent)

“In some prisons drug treatment has improved dramatically, but others just pay lip service.” (Prison questionnaire respondent)

“Looking back 10 years ago there was very little help available. There is more help now but still not nearly enough.” (Prison questionnaire respondent)

“...there are significant differences in the jail categories.” (Prison questionnaire respondent)

3.3 When asked to identify those factors, which were seen to be good about drug treatment various themes emerge e.g. being seen quickly, receiving the same treatment including dose and medication as in the community, being treated with dignity and respect, having someone to talk to, group work, access to 12^{step} programmes and drug free wings.

- 3.4 The various categories have been grouped according to two key areas of interventions: psychosocial and medical interventions.

Psychosocial Interventions

- 3.5 The term 'psychosocial' is being used for the purposes of this thematic grouping very loosely to mean any interventions, which are based around human interaction and environment. There are three sub-categories that respondents consistently identify: relationships with drug treatment staff, ease of access, and transformation. These are discussed below.

Relationship with drug treatment staff

- 3.6 One of the most frequently praised aspects of drug treatment interventions is the relationships formed with staff, especially when this is characterised by being listened to, friendly and providing good information:

"CARAT teams were helpful and easy to approach." (Community questionnaire respondent)

"The IDTS staff actually listen to you and ask you how you think you are doing on the medication you're on." (Prison questionnaire respondent)

"Talking to a CARAT worker one-to-one helped, especially when it came near to release and I had thoughts of using again." (Community questionnaire respondent)

"They help you to recognise how and where you have gone wrong and help you to deal with the issues that led you to take drugs. Also there is a lot of help and support from the staff who run the programme." (Prison questionnaire respondent)

"The help and support you get from the staff very often is brilliant. They make you aware how drugs can destroy you and the people around you." (Prison questionnaire respondent)

"Approachable staff" (Service user forum)

"Staff here really listen to you, doesn't feel like I'm just going through the motions." (Prison questionnaire respondent)

"CARATs really explained things to you, help you, advise you and they do really listen to you and do care what your life is about." (Prison questionnaire respondent)

Ease of access

- 3.7 Ease of access is a key determinant for respondents in rating their experience as good:

“Feel able to access service without having to worry about possible negative repercussions from other non-drug using inmates.” (Service user forum)

“A CARAT worker was assigned straightaway.” (Service user forum)

“No waiting list, easy access.” (Prison questionnaire respondent)

- 3.8 Ease of access to group work, intensive programmes and 12-step was viewed as very important:

“The CARAT team were very quick to come and talk to me and offer me a place on the PASRO.” (Prison questionnaire respondent)

“Being able to access courses such as the SDP...” (Prison questionnaire respondent)

Transformation

- 3.9 Many respondents link their experience with CARATs, one-to-one and group work with a transformation in attitude and outlook to life:

“It helps me to focus on turning my life around. It stops me from wanting to use drugs in the prison and I can learn to control my addiction problems and move forward in life. I think it is the best way forward in tackling drugs and it motivates yourself to change your life style.” (Prison questionnaire respondent)

“It’s intense and makes you look at yourself and your attitudes and behaviours and you realise you’re the problem.” (Prison questionnaire respondent)

“...had the access to the RAPt, so I count myself lucky as I done the RAPt and have had the chance to work my life out. This is the first time since 1991 since I’ve been drug free. Without it, I would have gone out committing crime and used drugs so it was money well spent.” (Community questionnaire respondent)

“It saved my life. Set me off on a journey I never wanted to take. Helped me start to lose my selfishness and gave me the ability to truly give away what was freely given to me.” (Community questionnaire respondent)

“It was absolutely life changing and I will be forever grateful to the RAPt.” (Community questionnaire respondent)

*“It turned my way of thinking towards the life I was living on the out and the harm I caused to family, kids, myself and others. Since I have graduated in ‘08 I have remained clean until this date and feel better for doing the programme.”
(Prison questionnaire respondent)*

Medical Interventions

- 3.10 The factors that most influence whether respondents found medical interventions good related to speed of access, choice of treatment, continuity, and preventing use of illicit drugs while in prison. These factors are discussed below.

Speed of access

- 3.11 While the ease with which individual CARAT workers or case workers can be accessed was deemed a significant factor in rating these services as good, when it came to medical interventions it was speed of access that predominated:

“Quick access to detox...” (Community questionnaire respondent)

“You receive treatment virtually straight away.” (Prison questionnaire respondent)

“You see a doctor within 24 hours...” (Prison questionnaire respondent)

“I was seen very quickly.” (Prison questionnaire respondent)

- 3.12 This is often viewed as an essential aspect of reception:

*“Both clients were offered detox immediately and a CARAT worker conducted a one-to-one session explaining the different programmes that were available.”
(Service user forum)*

“Client A (released in July ‘09, first time offender) stated upon entering prison he was suffering from the effects of withdrawal. It had been approximately 24 hours since his last fix (with no attention received when in the custody suite). He was immediately seen by a health worker on the first night and given an initial triage to ascertain his needs. This, he stated, was a surprise because he had been imagining all kinds of unpleasant scenarios.” (Service user forum)

- 3.13 The first night in prison can be a scary and stressful time and at which people can be at their most vulnerable. For some it will be their first time in prison and they will be unsure what will happen to them. Others may be more experienced, but if not provided with the necessary medication withdrawals can make the first night uncomfortable for them and those around them:

*“Normally it’s somebody [sharing a cell with you] that’s got a drug issue, but you don’t know what stage they’re at with their issues, where they are on their journey and where you are on yours. I’ve found that the guy I was in with, he was banging up the wall. He couldn’t sleep at night, he was hallucinating. I spent most of the time in the toilet for two days. I didn’t fancy going to sleep with him there ‘cos he didn’t sleep. He was fighting the walls and talking to the doors and all kinds of s**te.” (Service user forum)*

“The first night was good as you saw a doctor or a nurse when you first arrived. If you couldn’t get the treatment that day, they would give you something for the first night to keep you stable.” (Service user forum)

Choice of treatment

- 3.14 One of the most frequently cited improvements in medical interventions is around having choice:

“I am not forced to have my methadone increased.” (Prison questionnaire respondent)

“...you can be maintained on methadone or subutex without being forced to do a detox.” (Prison questionnaire respondent)

“They offer a wide range of treatment and courses.” (Prison questionnaire respondent)

“The drug treatment in prison has improved due to the fact that no-one likes to be forced to stop like they did a year ago and before. So now when we get released, we can still be on scripts if we choose that we are not ready to stop. Us prisoners basically have more choices now.” (Prison questionnaire respondent)

“They give you what you need and the doctor listens to you and he will give you what you’re more comfortable with subutex or methadone.” (Prison questionnaire respondent)

Continuity

- 3.15 The issue of continuity of treatment is very strongly related to choice as many respondents reported that it is important to receive the same treatment in prison as they were having in the community:

“I got my methadone script in jail and they gave me the same amount as I’m on in the community.” (Community questionnaire respondent)

“For one there is a choice of subutex and methadone. If you were on say 8ml of subutex for example and you put your case across reasonably you will get your 8ml.” (Prison questionnaire respondent)

“Methadone prescribing is more often continued in custody and at the same dose.” (Service user forum)

“They do try to get the treatment you was on in the community and work with you.” (Prison questionnaire respondent)

Prevents illicit use of drugs in prison

- 3.16 One of the aspects of receiving the right treatment that respondents rate as being good is not having to use illicit drugs while in prison:

“Means we don't buy illegal drugs in jail, so we all have money for canteen etc. also puts people off bringing in drugs as they struggle to sell them.” (Prison questionnaire respondent)

“To me it has stopped me looking for drugs in prison...” (Prison questionnaire respondent)

“It stops me using in prison...” (Prison questionnaire respondent)

- 3.17 Various related factors are described that cause problems for prisoners when they cannot get access to appropriate treatment including bullying and getting in to debt:

“It has helped by cutting down drug trafficking, bullying, taxing as people have an alternative drug to help with withdrawal and keep maintaining them on an even keel.” (Prison questionnaire respondent)

“IDTS can help stop bullying...” (Service user forum)

“Maintenance stops a lot of people getting in debt for drugs they can't afford.” (Prison questionnaire respondent)

- 3.18 For some respondents this is directly linked to the amount of substitute prescribing:

“I'm currently on 80ml methadone, the good thing about it is I don't need to use other drugs on top of it and it stops me getting into debt by chasing drugs, i.e. heroin.” (Prison questionnaire respondent)

SUMMARY

- Respondents recognise that drug treatment has improved and many state this is significant.
- Amongst the factors that are rated as being good about drug treatment, these can be grouped according to two broad categories of treatment psychosocial interventions and medical interventions.
- The term psychosocial intervention is used very loosely to refer to all interventions based on human interaction and environment including CARATs, intensive programmes, 12-step and drug free wings, Therapeutic Communities, and group work.
- The factors which are rated as being good about these interventions include the quality of relationships, ease of access, and experiencing a transformation in which respondents describe their life having being 'turned around'.
- Amongst medical interventions that respondents report as being good factors include speed of access, being able to exercise choice and having continuity of treatment both on entering prison and during transfer within the prison estate.
- Respondents also rate good medical treatment as having an impact on reducing the need to use illicit drugs in prison and reducing bullying and debt.

What is not so good about drug treatment in prisons and which needs were not addressed?

- 3.19 What is clear from the feedback in questionnaires and discussions in the service user forums and from carers is that their experiences of drug treatment vary from being very positive to very poor:

"They felt as though, yes things had improved, but that treatment was so lacking in the first place that these improvements still fell very short." (Service user forum)

"No good aspects of the drug treatment in prison." (Prison questionnaire respondent)

"I think it is very inconsistent across the prison system. It changes so much from one prison to another. It has improved since 20 years ago but I don't think it has really come on in the last 10 years." (Community questionnaire respondent)

"There is no drug treatment programme in this prison and if you do go with a problem they refuse to give you medication to help you overcome the problem." (Prison questionnaire respondent)

- 3.20 The factors that respondents most consistently relate as being poor are in direct contrast to those they rate as being good e.g. lack of continuity, poor relationships, and lack of choice. In addition, respondents with problems other than heroin use such as serious alcohol problems or non-opiate based drugs report having a negative experience.

Lack of continuity

- 3.21 While some respondents have clearly had a good experience and received on entry to prison the same medication and dose that they were used to in the community, many reported the opposite experience:

"I was on 10mg of diazepam & 20mg of Temazepam daily pick up with my 70ml of methadone. I am not getting any Diazepam or Temazepam and I'm only on 50ml of methadone and I am not going to be put up to 70ml which I was maintained on for 4 months outside." (Prison questionnaire respondent)

"It's better in some ways with them doing methadone and subutex. It's improved that way but they won't give you what you were on outside which is wrong." (Prison questionnaire respondent)

"It is really hard at first because I was on 50 ml meth and 40ml valium (diazepam). I was really ill and they only give me 15 ml meth and 1<<illegible>> a night and meth up to 20mls then 30mls, it was hard." (Prison questionnaire respondent)

"If on suboxone out here then you should get it in there." (Community questionnaire respondent)

"Shit they put me on 5mls first day then built it up to 30mls by 5mls a day, I was on 85mls on the outside so I don't rate prison as good for drug takers, this is in prisons for women." (Community questionnaire respondent)

"I was on 85ml in community, then I went to prison and was put on 30ml methadone. Reduced 2ml every other day until methadone free, too quick." (Community questionnaire respondent)

- 3.22 Some respondents report this as being due to lack of capacity in the system and waiting times:

"There is both a subutex and a methadone programme. Saying that there is limited spaces which creates a lot of problems i.e. people on prescriptions on the out don't get a space and are left to rattle (withdraw)!!" (Prison questionnaire respondent)

"Service received was poor and had to wait 4-7 days to see a drug worker/counsellor." (Community questionnaire respondent)

"It was crap it took 5 days for my detox to start." (Community questionnaire respondent)

"If they're seeing that many people 'cos they're overcrowded, you might be bottom of the list you might not be seen the next day. It's like the lottery. You're a name and a number, that's all it is." (Service user forum)

"The detox was brief and not done properly to free up beds for more intake of inmates. 5 days off Heroin - I rattled." (Prison questionnaire respondent)

3.23 There are also issues about the time of arrival e.g. Friday nights:

"It depends on what day you get in and what time you get in. Because if you get in at six or seven o'clock you only get booked in. Then you're put into what's known as the overnight holding cells. Nothing happens to you till the next day." (Service user forum)

"Say you've landed on a Friday and it has gone passed the times for the chemist to check, you've got all weekend then until Monday until they arrive before it is found out. So if you say well actually I'm on this medication or that medication they don't give it you." (Service user forum)

Differences according to category of prison

3.24 A related aspect of lack of continuity concerned the differences between different categories of prison. As with the general experiences, there is a wide variety of responses to the experience of drug treatment in different categories of prison from having no treatment to being treated very well. Fewer respondents had experience of Category A prisons but amongst those who had, they more generally reported the experience of drug treatment as being negative:

"Not much help/support." (Prison questionnaire respondent)

"Only been in Cat A and it's not good they treat everybody as if they're still on the street and lying and cheating to get what they can to get high when they really just want to feel calm and sleep at night!!" (Prison questionnaire respondent)

3.25 The experience of Category B prisons was more positive:

"B CAT locales have more agencies involved." (Prison questionnaire respondent)

"Cat B jails are far better, they have more courses." (Service user forum)

3.26 There were few distinctions drawn between Category C and D prisons and the experience was generally reported as being more positive with more options and choice:

"Better access to support (internal and external) better courses." (Prison questionnaire respondent)

- 3.27 However, a number of respondents said that it was much harder to get maintained in Category C and D prisons:

“No methadone or subutex...” (Prison questionnaire respondent)

“Would be better if D Cat did provide methadone etc... as it would reduce absconding etc....” (Prison questionnaire respondent)

“They don't give you Methadone (When I was last in Cat C anyway).” (Prison questionnaire respondent)

“They don't usually give out methadone in Cat D prisons.” (Community questionnaire respondent)

- 3.28 Some respondents also suggested that Category D prisons were a bigger problem because of the amount of illicit drugs available:

“[About Cat D prisons] Problem is that illegal drugs are too prevalent so why take pharmaceutical when drugs are plenty.” (Prison questionnaire respondent)

- 3.29 Smaller prisons were also thought by some to provide a better variety of medication and better support. One respondent when talking about a large local prison stated:

“It is felt that the staff do not have the time to offer the care and understanding that other prisons offer. Also it is felt that other prisons have a better one-to-one care process.” (Service user forum)

- 3.30 The factor most identified with different experiences is length of sentence rather than the Category:

“Long term programmes can be run for long term prisoners.” (Prison questionnaire respondent)

“I think there is more focus on treatment in sentenced prisons whereas in locals it is all about detox.” (Prison questionnaire respondent)

“Courses at Cat B's should be moved to Cat C's because I'm nearer to release and likely to benefit more from the course.” (Service user forum)

- 3.31 One respondent commented on having a better experience in a private prison. Women respondents pointed out that there are no category differences in the women's prisons estate.

Lack of choice

- 3.32 The key factors about lack of choice relate to being able to choose between different medications e.g. methadone or subutex and being able to choose whether to have a detoxification or be maintained:

"It's terrible. Not enough choice if you don't want methadone, detox there's nothing else available." (Prison questionnaire respondent)

"Nothing because they try to detox you as soon as they can. I am on remand and I should be able to stay maintained whether I am sentenced or not." (Prison questionnaire respondent)

"There wasn't any [good experience of treatment] it was just maintenance on methadone it wasn't helpful." (Community questionnaire respondent)

"They prescribed me methadone and I had some support from CARATs but they didn't allow narcotics anonymous meetings." (Community questionnaire respondent)

"Was made to go on methadone when I wanted to have a subutex script." (Community respondent)

"Wasn't prescribed subutex in prison so I had to go cold turkey because I didn't want to go on methadone." (Community respondent)

"I think the worst thing, I don't know, like you said it differs from jail to jail, but if ...you go in on 50ml they put you straight down to something like 25ml, so you're going to rattle anyway." (Service user forum)

"You get 70% of what you're on." (Service user forum)

"The worst experience was being detoxed without any warning or consultation." (Service user forum)

- 3.33 Some respondents reported having to increase their dose when entering prison against their wishes:

"...I was on 4mgs [subutex] when I went in, but they put me on 8mgs and I argued saying 'no I'm on 4mgs and you're putting me back up to 8mgs' and they put me on three weeks detox. They put me up to 8mgs straight away then dragged me all the way back down again. I was like 'why don't you start me on 4 and not do three weeks worth of detox'. No they've got a set way that they're going to do it." (Service user forum)

3.34 For some the lack of choice extends to their release time:

“Not a lot, got a quick detox and wouldn't retox me before release.” (Community respondent)

3.35 Respondents also raise issues about continuity when transferring between prisons which have different regimes:

“The women felt strongly that when a transfer did take place the change in script by the receiving prison without discussion with the prisoner or without reviewing the case history in most cases was detrimental to their continued progress.” (Service user forum)

“There were differences in detox regimes between prison with different timescales and different drugs and doses used.” (Service user forum)

“Methadone maintenance was only allowed for short term prisoners regardless of the person's personal circumstances.” (Service user forum)

“Some prisons won't accept you if you are on subutex.” (Service user forum)

“Even if you're on a prescription, if you go there and that jail doesn't deal with that medication, you ain't going to get it.” (Service user forum)

“I was on a detoxification and I got shipped to another prison and then that particular prison didn't allow people there who were on medication for the high amount I was on. So I had to stay there for two days without anything and they sent me back.” (Service user forum)

3.36 Particular issues arise when people are transferred unexpectedly from court:

“It could even happen while you go to court; your space may have been taken over by the jail that you have come from and you're in the middle of a detox programme, you get shifted out to another jail and you have to start all over again, back to square one. You have to contact a doctor again and all that kind of stuff.” (Service user forum)

3.37 Transferring was also reported to affect people's aftercare:

“The only thing I would say is after I finished the programme and got moved to where I am at present, is there is no after treatment available. At the last prison I was going to meetings each week and doing shares. At this prison there is no aftercare and I feel let down.” (Prison questionnaire respondent)

3.38 Respondents report differing experiences for those entering the prison system who are not on a prescription but have been using illicit drugs:

"I was lucky 'cos I was scripted before I went in, but other people who weren't scripted were turned away, they just had to go cold turkey." (Service user forum)

Provision and timing of sleeping tablets

- 3.39 Problems sleeping often accompany detoxification and other issues related to treatment. Respondents frequently report that medications to aid sleep are not provided:

"Wanted sleepers but were not prescribed." (Prison questionnaire respondent)

"Only the initial medical needs were sorted to stop cold turkey. I needed extra help with sleeping which they wouldn't consider." (Community questionnaire respondent)

"As I keep saying, one of the worst parts of the detox (for me) is night time, no sleep! Why is it that other prisons can give strong sleeping tablets but this one can't?" (Prison questionnaire respondent)

"I was getting sleeping tablets on the out but get none in here." (Prison questionnaire respondent)

"They will not give you sleeping aids, many new arrivals find it difficult to sleep but are refused tablets to help because of the addictiveness of the drugs." (Prison questionnaire respondent)

- 3.40 For others that were prescribed sleeping tablets they reported having no choice about the timing of when these were given:

"...the timings all wrong... sleepers at 4:30 ..." (Community questionnaire respondent)

"When prescribed sleeping tablets, these are often dispensed in the afternoon, but saving this medication until the evening so that they can take it to sleep during the night is often punished." (Service user forum)

"Instead of night-time sleeping medication being given out at 6 p.m., which is of no value whatsoever, they could be given at the same time as other medication at 10.00p.m." (Service user forum)

Poor relationships

- 3.41 Most reports of poor relationships and experiences of negative attitudes relate to medical treatment and prison officers:

"They seem to think that inmates are lying to them when undergoing detox and withdraw, especially with methadone." (Community respondent)

“Every prison I’ve been in they think everyone is on the blag.” (Service user forum)

3.42 Negative attitudes amongst prison officers are often reported:

“Getting things in motion before I leave jail...officers didn't refer me to CARATs for this to happen, appointments to see them went missing.” (Community questionnaire respondent)

“Officers could be more polite...” (Community questionnaire respondent)

“It’s the male prison officers who let you down, their attitudes are degrading and wrong - the female staff do not make us feel like we are the dregs of society.” (Prison questionnaire respondent)

“It’s just that battle between CARAT workers and the Screws. It’s like a faction you hear them when they get out ‘oh them bloody CARAT workers are here again...’ They see them as an interference.” (Service user forum)

“They [prison officers] think that they [CARAT workers] are wasting their time.” (Service user forum)

3.43 Some respondents report that there are tensions between prison officers and drug workers that arise from the conflict between treatment needs and security:

“...the Screws are so understaffed, when the CARAT team come on the wing and the Screws are like, ‘No we’re not unlocking anybody because we haven’t got the staff to supervise you.’ You can see the CARAT team arguing with them saying, ‘We have to see these people to give them some support and help them for when they get out.’ But the Screws are saying, ‘We haven’t got the staff to unlock them and supervise you doing this work.’ I only saw them once and that was on my second day there, then I didn’t see them after that in the whole six months I was there.” (Service user forum)

“...if there’s only three on duty they’re not going to let sixteen of you out to let you wonder into a room [for a group session]... So you’re sat there thinking, “Great I’ve got help coming” and you’re waiting for the door to open and all of a sudden someone will knock saying “not today mate, they’re not coming”. So you have to wait another month maybe or even two weeks before you get that assistance again.” (Service user forum)

3.44 There was some uneasiness about CARAT workers who are also prison officers:

“If you tell them [prison officers acting as CARAT workers] what you do while in prison they might use it against you.” (Service user forum)

Substance use problems other than heroin

- 3.45 Respondents with substance use problems other than heroin report difficulties in receiving treatment:

“The help for heroin addicts is good but I myself need help for depression, crack addiction, alcohol and cannabis and as they are not physically as bad so I don't get any help...” (Prison questionnaire respondent)

“I used crack to knock me out at night and they haven't given me anything for this and I have trouble sleeping at night if at all BECAUSE CRACK ISN'T PHYSICALLY dependant, hell it is for me and I'm now very depressed as well, and time is going SLOWER...” (Prison questionnaire respondent)

- 3.46 Alcohol in particular is raised as a major issue by a number of respondents:

“My problem is alcohol and I don't receive the proper medication I get off my own doctor outside.” (Prison questionnaire respondent)

“There is more visible support for heroin but is this at the expense of alcohol and others?” (Prison questionnaire respondent)

“Alcohol treatment needs were not addressed. Could have given medication and more one to one support.” (Community questionnaire respondent)

Mental health problems

- 3.47 Many respondents stated that they had mental health problems which were not addressed:

“There is not enough attention to mental health problems and it is hard to get the treatment you was on before coming to prison or to get any while here.” (Prison questionnaire respondent)

“I am on anti-depressants and I have still not been seen by a member of the mental health team to assess my health. They seem to want to throw tablets at us to shut us up.” (Prison questionnaire respondent)

“No mental health provision at all. Get 20% of people who are nuts and are using drugs to self medicate.” (Prison questionnaire respondent)

“I don't feel my mental health needs have been addressed, I've now self harmed for 18 months cutting my arms/wrists, hanging myself and taking overdose. I still self harm and I feel nobody cares. I've had no counselling at all and I got bullied and the suicide liaison officer rewarded of the bullies.” (Prison questionnaire respondent)

- 3.48 Some respondents report waiting a long time before their mental health problems were addressed:

“Waited 5 months to get help with mental health problems.” (Prison questionnaire respondent)

“...waiting 4-5 weeks to see mental health stressed me out and impacted on my drug use.” (Community questionnaire respondent)

“Most of the prisoners felt they had to wait a while to speak to someone about their mental health needs. However when they did get this help it was very valuable.” (Service user forum)

“There isn't enough help for us...I've been waiting 6 months to see psychiatrist and I still ain't seen one.” (Prison questionnaire respondent)

“You have to wait months for an appointment to see psychiatrist if you're lucky in this establishment.” (Prison questionnaire respondent)

- 3.49 Where respondents identify their mental health problems with their drug use some report their experience as being better:

“I am currently on IDTS...and I am getting the help I need including mental health problems that go hand in hand with 27 years constant use of Class A drugs.” (Prison questionnaire respondent)

- 3.50 Other respondents thought that dual diagnosis and related mental health problems were not adequately recognised:

“Yes, mental health issues were not acknowledged or addressed at all...PTSD, particularly lack of dual diagnosis.” (Community questionnaire respondent)

“I suffer with bad depression but wasn't given anything for it just placed on the hospital wing... No one seemed to address my mental health needs, if you're on methadone they won't give you anything else, that's what the doctor told me.” (Community questionnaire respondent)

“Needs to be more awareness and training for internal staff to stop and understand mental health issues.” (Community questionnaire respondent)

“If you a mental health problem you are shipped off to the mental health room. They don't have a joint approach. Everything is segregated into mental health and substance misuse.” (Service user forum)

“One service user in this group said that he raised his issue of mental health but it seemed as if this would not be addressed properly. He felt that this was because healthcare staff are overworked with drug treatment and therefore either miss, or

do not respond to, other health issues, primarily mental health.” (Service user forum)

“I am under severe depression whilst been taken off medication without my consent. I have asked for mental health but no good. I had to go to extremes to see someone about my depression.” (Prison questionnaire respondent)

- 3.51 Respondents reporting mental health problems also identified lack of continuity between community and prison:

“One individual felt their mental health issues were not addressed as they were expected to change antidepressant medication when entering custody. This person had felt stable on the medication and was forced to get used to a different type of medication which gave him unpleasant side effects.” (Service user forum)

“I need to see psychologists due to mental health issues. Before I came to prison my drug councillors and doctor had put me forward for a mental health assessment which I still feel the need for. I have and I still am suffering from depression.” (Prison questionnaire respondent)

- 3.52 Inconsistencies between different categories of prison were also thought to affect mental health treatment:

“In local establishments the services are limited so problems such as mental health are not as established as they are in sentenced prisons.” (Prison questionnaire respondent)

“I was on quitapine at my local prison but when I went to a D Cat they stopped it, since being here I told them I need to go back on it.” (Prison questionnaire respondent)

- 3.53 One respondent on describing the move to a Category D prison said that:

“I’m a very paranoid person and suffer with mental health problem and have explained this to doctors. I do not come out of my cell much, I find it hard to talk and mix with people here. I need my meds sorting but it seems like I’m banging my head against a brick wall.” (Prison questionnaire respondent)

- 3.54 For some this was more related to length of sentence:

“You’re in prison not long enough to receive mental health treatment. Don’t really want to start on counselling if you will be released before you’ve had time to deal with all the problems.” (Service user forum)

Reception - quality and timing of assessments

- 3.55 Respondents experience of assessment during reception varies in terms of quality and timing with many stating that this needs to be more thorough in identifying their needs and linked to the community:

"I don't think you get assessed properly there once you arrive, to what your needs are actually to help you when you do arrive." (Service user forum)

"It depends on what day you get in and what time you get in. Because if you get in at six or seven o'clock you only get booked in. Then you're put into what's known as the overnight holding cells. Nothing happens to you till the next day." (Service user forum)

"One good thing about prison was the introduction. They actually tell you quite well what they intend to do with you. They don't deliver it but they tell you." (Service user forum)

- 3.56 Many respondents report having to undergo repeated assessments which they feel should be avoided:

"The assessment process was too lengthy and repetitive." (Service user forum)

- 3.57 For some respondents this issue is overcome by having consistency or named key workers:

"...had the same CARAT worker for 3 years which really helped with not having to keep talking about my history..." (Service user forum)

- 3.58 Reception can also be a difficult issue for those on transfer where the notes and other information does not follow quickly:

"Medical history notes arrive later than service users into the transfer prison. This causes the service user to have to go through all of their history again with the next healthcare team. Also the prescribing changes on what is said to be a temporary basis until the notes arrive, and then does not get reinstated. This prescribing is often different and inadequate. This can make the service user feel frustrated that they have to go through their history all over again can feel embarrassing and awkward." (Service user forum)

"When arriving from a transfer sometimes you only get to see a nurse and have to wait to see a doctor in the morning and as meds do not travel with you this causes immense discomfort." (Service user forum)

Harm Minimisation

- 3.59 Drug treatment has improved in the area of harm minimisation with lots of drug education courses. Some prisons have active harm minimisation awareness sessions or months. This is not the case though for all prisons as some service users reported that there is still not enough provided in terms of resources and information:

“I had not heard of harm minimisation while in treatment.” (Community questionnaire respondent)

- 3.60 Although this person did go on to comment that this may have been a blessing as could have prevented them from adopting abstinence – ‘*I would of taken that option and possibly not be abstinent today.*’

“More harm minimisation education for those who want it and also education around blood borne viruses.” (Community questionnaire respondent)

- 3.61 Some respondents do report using needles in prison and that these were shared:

“There are a lot of problems with needles in prisons, people making them from anything they find (pens for example) or stealing them from clinical waste bins. There are people who already have an abscess who are continuing to inject in prison.” (Service user forum)

- 3.62 Amongst respondents there were mixed views about the efficacy of providing needles in prison:

“Some participants felt that the availability of sterile equipment would help stop the spread of blood borne viruses but others felt it would increase the amount of injecting.” (Service user forum)

- 3.63 A service user reported that women on suicide watch plans cannot have razors, so they use shared razors in the shower rather than waiting for a prison officer to supervise them. In their opinion, they have done riskier things so this is not a cause for concern:

“There are people with hepatitis, people with AIDS and they are shaving their heads with the same razor. They have cut marks all over their heads.” (Service user forum)

- 3.64 People have seen disinfectant tablets in prisons but they are not always sure what they are used for. In some prisons the dispensers are installed but there are no tablets in them:

“No disinfectant tablets as there was no funding identified for it.” (Service user forum)

CARAT (Counselling, Assessment, Referral, Advice and Throughcare) Services

3.65 CARAT services are very highly valued:

“I think that one thing that is important is you have something called the CARAT team and they help you with your drug addictions and stuff.” (Service user forum)

“That’s why CARATs is so important in jail because you’ve been out on the road and because you’re on drugs, so emotionally it’s all cloudy, it’s all blocked out. But when you’re in jail it all starts to get a bit clearer and you start to come out of the mist a bit.” (Service use forum)

3.66 People felt they saw more of CARAT staff now than previously. In one prison CARAT workers saw people on reception, which was particularly positive. However, this is not consistent across all prisons:

“The CARAT teams in some prisons are really good, but the general experience was that the value and effectiveness of these teams varied from really good to really bad.” (Service user forum)

3.67 Many respondents report having difficulties in accessing these services:

“In most prisons it just takes too long to get to see a CARAT worker that would be my main concern.” (Prison questionnaire respondent)

3.68 Service users were also uncomfortable with CARAT workers and other drug workers who were quite obviously fresh out of university and ‘reading out of a text book’:

“We trust the staff and the facilitators on the group, however some staff are uneducated in their approach and could benefit from more training and being more understanding.” (Service user forum)

3.69 It was suggested that in some prisons that CARATs could be advertised better. Although there was recognition that people can be referred through various means, e.g. one respondent said the prison chaplain told him about CARATs.

Key working, case management and counselling

3.70 The amount of key working and case management that people received varies from prison to prison. In some it was very positive:

“You’re not left alone; even key work is really good. They’re always there for you.” (Service user forum)

“The case worker visits within three days of women signing up, they get a second visit within the 1st month. One woman has had the same case worker for three years which really helped with not having to keep talking about her history and in getting the right kind of support.” (Service user forum)

“I completed or participated in the RAPt programme, I addressed and fully explored my issues and I am now in a good place and I've benefited by doing RAPt as it has helped me by staying focused on my recovery.” (Prison questionnaire respondent)

- 3.71 Other people though identified a lack of key working, case management and counselling and felt more was needed:

“I thought counselling services I accessed after RAPt were a long wait to start. I would have liked it to be quicker.” (Community questionnaire respondent)

“There are a lack of counselling sessions and one to one work and a waiting list of 12 weeks.” (Service user forum)

- 3.72 Being transferred to another prison can also affect key working and treatment progress:

“The only thing I would say is after I finished the programme and got moved to where I am at present there is no after treatment available. At the last prison I was going to meetings each week and doing shares, at this prison there is no aftercare and I feel let down.” (Prison questionnaire respondent)

“Asked to go on RAPt but this was not available in the prison I was in as they did not fall in the catchment area. RAPt programme should be available in ALL prisons to those who want and need it.” (Community questionnaire respondent)

- 3.73 Women in particular reported that having to get know a new key worker was problematic:

“The women felt that getting to know a case worker and preparing for resettlement then being moved can knock you back in terms of progress. They felt that it was better to stay a while and go through the process with the same worker as the women felt that they are more likely to complete. Moving means having to form new relationships with new workers a bit like starting all over again which can sometimes make the women feel like giving up (wounded).” (Service user forum)

Courses and Programmes - PASRO and SDP

- 3.74 The general feedback on these programmes was positive.

“Since I have been here I have completed PASRO which has been helpful.” (Prison questionnaire respondent)

“The courses here provide a good foundation for getting clean.” (Service user forum)

“On his last sentence he had gained knowledge regarding addressing his addiction from drug awareness programmes.” (Service user forum)

“I think there are lots of courses to choose from and they're run well in this prison.” (Prison questionnaire respondent)

- 3.75 The Short Duration Programme (SDP) was described as a beginners guide to drug treatment. What it provided was information on what help is available and an introduction to things like triggers and harm minimisation:

“SDP is a good course. Gives you an eye opener as to what recovery is about. SDP is an easy way in, an ice breaker.” (Service user forum)

- 3.76 However, the popularity and restricted number of places on these courses means many people did not get access:

“There is just not enough capacity...smaller more regular groups are needed.” (Service user forum)

- 3.77 Some respondents reported that there was poor integration between the various interventions e.g. between the intensive programmes, treatment and case work:

“The SDP group was a good (short duration) CBT/Relapse prevention etc. Well facilitated. However the overall strategy and CARATs intercommunication was awful.” (Community questionnaire respondent)

- 3.78 Sentence planning in relation to courses can also be a challenge:

“Like myself, PASRO and SDP only is effective for short term addicts or people doing short sentences. What about people who have been in addiction for over 10 years and have deep-rooted issues. They need RAPt. Also if they are long term prisoners PASRO and SDP should be done near to release or RAPt.” (Prison questionnaire respondent)

- 3.79 For some it is hard to get to the prison that runs the course requested by the sentence plan because it is far away. Other people wanted to do certain courses but could not as they did not fit the criteria.

12-Step Programmes

- 3.80 There are a number of organisations that provide 12-step programmes in prison. 12-step received a lot of positive feedback and has helped a lot of people on the road to recovery:

“It's given me the chance to get my life back on track and to live clean and sober. I can now see a future for myself and all I have to do is keep going to my meetings and work my recovery daily.” (Service user forum)

“I completed the RAPt programme. It was well run and very helpful as it made me open up my eyes and there is help.” (Prison questionnaire respondent)

- 3.81 Unfortunately 12-step is not available in every prison, limiting choice of treatment in some prisons:

“When I admitted I had a problem was told that I couldn't do the RAPt course because of the length of my sentence. I believe this is not good enough because if you have a problem you need help.” (Community questionnaire respondent)

- 3.82 In addition, 12-step is not for everyone though and some can find the prospect of total abstinence daunting:

“12-step – whack! and you are in it. The 12-step thing ain't for everybody.” (Service user forum)

- 3.83 12-step can be a particular struggle for people with mental health problems or complex conditions, as in some 12-step programmes abstinence extends beyond Class A drugs to medication and other psychoactive substances.

- 3.84 One of the key issues identified by respondents relates to aftercare:

“The most important part of recovery is what happens after. The aftercare structure here is non-existent.” (Service user forum)

- 3.85 A suggested solution from a number of people were regular Narcotics Anonymous (NA) meetings on the wing, led by more confident or experienced service users in the prison. These would need to be supported by the staff though to keep the programme going when key service users move on.

SUMMARY

- Where respondents identified unmet needs these invariably followed the negative experiences identified in the previous section e.g. continuity in treatment when entering prison from community or transferring between prisons; access to additional support e.g. CARATs, group work etc.

- While many respondents do report having their needs fully met, the key issue remains lack of consistency across different prisons and, in some cases, between different categories of prison.
- Experience is very varied and this reflects the fact that there are different levels and quality of service experienced by service users.
- Some key differences are identified with respect to different categories of prison in particular variances in access to detoxification or maintenance and availability of certain programmes.
- Lack of choice features prominently especially with respect to issues beyond the person's or the prison's control such as early release from court.
- Transfers are also felt to result in unmet needs when the new prison has a different regime that restricts choice about what medication or programme was being followed. This was also said to affect aftercare adversely.
- Concerns are raised about poor relationships with prison officers and between officers and drug treatment workers. These poor relationships are often characterised by security and staffing issues e.g. not enough security staff to enable prisoners to be let out of their cells to participate in programmes or key working.
- Respondents with substance problems other than heroin state that their needs were often unmet e.g. alcohol and crack use were not thought to be treated adequately.
- One of the biggest problems cited by respondents as not being met was mental health problems. Respondents cited lack of awareness and knowledge about dual diagnosis, poor medical responses including long waiting times to see a mental health professional, and differences across categories of prison. Length of sentence was also said to be a factor as those on short sentences did not see the value on starting any counselling.
- Experience of reception and assessments were cited as being problematic especially when the person entered prison on a Friday night and could not be assessed adequately until Monday morning. Respondents reported having to undertake repeat assessments and feeling that it was difficult to keep stating their needs. These problems were compounded by notes arriving after the prisoner on transfer.
- Harm minimisation was generally thought to be lacking, in particular with respect to sharing of needles and razors. Where facilities such as sterilisation machines were installed, it was reported that these would lack the actual disinfectant tablets.
- CARAT services generally are very well regarded but respondents reported having difficulties in access in some prisons and waiting long periods. Respondents report varying experiences of quality and cite issues such as training and lack of promotion about the services.
- Key working, case management and counselling were reported as varying in quality and access across the prison estate and that this could cause particular problems on transfer.
- Intensive courses and programmes including 12-step were very highly valued but respondents reported difficulties in access resulting from waiting times, lack of capacity, and differences across the prison estate.

What are the key factors on release that would prevent returning to old habits?

3.86 Respondents reported that more aftercare in the community was needed and more help in preparation when coming to the end of a sentence or if due to go to court (owing to the sudden nature of release in some cases).

3.87 There was some recognition that practices have improved in terms of being released on a prescription:

*“A positive note was that the medication script is working very well on release.”
(Service user forum)*

3.88 However, this is far from being a common experience and many respondents identified the issues they faced when being released without access to a prescription:

“I think that’s the problem when they give you a release day, but they don’t do anything until you’ve been released. No planning, right. What they do when you’re released, as soon as they have signed you out, that’s when they send information to your GP for instance, and they post it. So you get released on the Monday, the first thing they tell you is ‘You must go to your GP within 24 hours’ but when you make your appointment to go and see him he’s not got your records.” (Service user forum)

“I mean for me I found it quite daunting because I didn’t know when I was going. I was woken up at five in the morning and told to get my stuff because I was leaving and that was it and I was put on the street with a bag.” (Service user forum)

3.89 Having a prescription for the day of release was seen to be one of the most important factors in staying off illicit drugs:

“Getting your medication the day you get out. Sometimes when you get out of jail you have to wait a few days before you can start your script up again ‘cos sometimes it takes a while to get in touch with the jail or whatever excuse they’ve got. But if you get out and you’ve got your script waiting for you, then it might be alright, ‘cos if you haven’t got to go out and do whatever you have to do to make the money and then buy the heroin to substitute.” (Service user forum)

“Ensuring that my script is all set up and ready to collect on release.” (Prison questionnaire respondent)

*“If you're still on methadone you need a script there for you the day you're out.”
(Prison questionnaire respondent)*

“Getting a prescription when released.” (Prison questionnaire respondent)

3.90 Some respondents wanted preparation for release to include retox:

“It is important to retox people on release as you might use on release.” (Service user forum)

3.91 Respondents also stated that there should be more availability of drugs like Naloxone on release:

“Naloxone good on release.” (Service user forum)

3.92 Release from court which is often unexpected cause particular problems:

“If you get released from court that’s worse isn’t it? You’re gonna have to start fending for yourself, which is why it is best to take your time especially if it’s a Friday. You ain’t going to get to see someone till the Monday again.” (Service user forum)

*“If you’re scripted up on medication and you get released from court, you’re basically F****d again, ‘cos everything just stops.” (Service user forum)*

3.93 Many respondents said that not having any identification created problems in sorting out their prescriptions on release:

“You’ve got to have ID for yourself in the first place, what if you ain’t got any ID you won’t be able to register yourself at the Doctors.” (Service user forum)

“You should get a letter written for ID – it is hard without any ID.” (Service user forum)

“Well it took me a while [to register with a GP] ‘cos I hadn’t got any ID.” (Service user forum)

3.94 However, although continuity of medications was seen as very important, most respondents identified social and economic factors as being the most significant in preventing them from returning to old habits e.g. appropriate housing, access to adequate funds and having something to do. These issues are discussed below.

Appropriate housing

3.95 Most respondents cited having somewhere appropriate to live on release as being very important to them. This was due to the fact that they often lost their previous accommodation once they went to prison:

“When I went to prison I had a flat and then they took it off me.” (Service user forum)

“Yeah I lost my flat. They said I made myself intentionally homeless, and I said ‘How have I done that?’ by going to prison. So then they said that I wasn’t entitled to anywhere.” (Service user forum)

- 3.96 Respondents felt that without accommodation they were more likely to return to their old habits of drug use and crime. This was often said to be due to having little choice but to live with previously known drug using friends:

“You’ve got to think, you’re coming out of prison, you’ve got nowhere to go, you’re a crack user all you’re thinking is drugs. The crack house is a place to go.” (Service user forum)

“You’re going back into the jungle that you’ve come from.” (Service user forum)

“It’s a waste if you don’t get any accommodation.” (Service user forum)

- 3.97 Hostel accommodation was reported to be unhelpful due to the amount of drug use that goes on:

“You can do all of the work in prison only to be left with nowhere to live leaving you to go to a hostel which is full of drugs. We need more help in resettlement.” (Service user forum)

- 3.98 For some people it is important that they do not go back to the same area, where they end up hanging out with the same drug users and being stopped by their old dealers. Women in particular felt this was significant:

“The women felt strongly about being re-housed away from their original home address in decent accommodation which would help to give a feeling of ‘a fresh start’ and make a move away from old habits. This can often be hampered by the requirements of some housing associations to have a family connection in order to live in a particular area.” (Service user forum)

- 3.99 For others though it is important to go back to the same areas on release as it is where their friends, family and support are. Each person needs to be assessed as to where it is most appropriate for them to find accommodation. For people who are located in a prison that is far from home organising accommodation and other resettlement needs is more of a challenge.

- 3.100 Residential rehabilitation was also identified as important for people in ensuring that they continued with the progress that they had started in prison:

“I need to go to secondary rehab so that I can keep the work that I’m doing in here. It’s my last chance to stay drug free and I can’t afford to waste it.” (Prison questionnaire respondent)

"I intend to go straight into second stage residential rehab so I'll avoid habits, high risk situations as I want to keep myself safe." (Prison questionnaire respondent)

Access to adequate funds

3.101 Many respondents cite the lack of money as a significant factor in returning to offending. This is often reported to be the result of a delay between benefit claims submitted and the date of payment.

3.102 Respondents say that they need adequate funds on release to help out with clothes and food during the delay waiting for benefits:

"Some people suggested more money should be available to those on the day of release to set up a new life with accommodation, clothes and food. Many people leave prison with nothing and the money given is not sufficient." (Service user forum)

"Lack of money was identified as a cause to returning to offending, often caused by the time period between benefit claims being submitted and the date of payment." (Service user forum)

"Some kind of help with benefits before release, so that there are some benefits in place. This prevents people leaving with just a gate grant and being expected to then survive one or two weeks before benefits are sorted out, with just this money." (Service user forum)

"What annoys me is when you get released you get £47 but a weeks giro for someone our age is £65. It's a big difference from £47 to £65. What's the first thing you do when you get out? Fried breakfast and a beer, you ain't got any money left after that." (Service user forum)

3.103 One respondent contrasts the experience of prison to being on the outside with no money:

"They say to you that there is a thing called a crisis loan, and they don't even give you that. You're sitting there saying I've got no food in my house. When I'm in prison I get three meals a day. I'm now out of prison and I'm not eating." (Service user forum)

3.104 Family members and carers also cited the risk of not having enough funds:

"...the gap between leaving prison and receiving benefit payments can be a dangerous one, as a lack of funds can result in resorting to crime again, which brings the offender back into prison and takes them full circle." (Carer forum)

Having something meaningful to do

- 3.105 Another key factor that respondents cite as being a cause of returning to old habits is having nothing meaningful to do. This may mean employment, education, or being able to participate in structured programmes:

“Boredom is a big thing.” (Service user forum)

“You need something for your time. Your most vulnerable time is the day that you leave prison.” (Service user forum)

- 3.106 Many respondents had gained qualifications while in prison but on the outside found that this did not help them to gain employment:

“The group identified that gaining vocational qualifications in custody was useful, however often they lack the work experience that is required to successfully gain employment.”

- 3.107 It was felt that more help could be given with finding employment:

“More help with getting employment so that you have something to focus on upon release then you would not be going back to the same old routine.” (Service user forum)

“It would have been better to come out to employment and have the chance to apply for jobs prior to release.” (Community questionnaire respondent)

- 3.108 For some employment and housing were linked:

“Have an established pattern/routine on release, like employment and a place to live, because in my experience these are probably the two most difficult aspects of release.” (Prison questionnaire respondent)

Integrated care planning

- 3.109 Lack of communication and integration between prison services and community services including drug services, probation, housing and benefits was seen to be a critical factor on addressing all of the above issues:

“There’s three things that are important when you get released and they are the three things that are least supported. When you get released the first thing that you need is a GP. There’s no link between the prison and the local health service. There’s no link between prison and your benefits, there’s no link at all with those people. So when you actually leave you know you’re released, they know you’re released, nobody else does... And all the people that you would probably rely on to get you up and running back in the community have no knowledge of you.” (Service user forum)

- 3.110 Having a more comprehensive structured plan on release was thought to be helpful in addressing these issues:

“A structured plan from leaving the gates accompanied, being brought home or family's home to ground myself to the outside world, daily contact with peers until settled, help with changing old lifestyle to a new one, work, training, employment.” (Community questionnaire respondent)

- 3.111 Others called for a more integrated approach to addressing the different areas of need:

“Going directly into employment or structured education. Direct link with housing. Support network in place – one-to-one support groups, structure...on the day of release and if they've got none of the above all of the good progress they've done in prison becomes void.” (Community questionnaire respondent)

“‘End to end’ management by community workers even when the clients are in prison should be encouraged. This would mean more involvement of the community worker with the client whilst they are in prison - so that the same worker can continue working with the client on release.” (Service user forum)

- 3.112 Having a more integrated approach was thought to include being met at the prison gates by a community worker:

“It would be nice to get picked up by your drug worker so you don't end up getting drugs on the way home. This [end-to-end case management] could facilitate being picked up from the prison by community workers to ensure appointments were kept.” (Service user forum)

“Someone to meet you from either the local DIP teams or a trusted person to make sure you are not going to slip straight back to your old habits.” (Service user forum)

- 3.113 Some respondents thought this role should be undertaken by peer support workers, family or friends from within NA or AA:

“Get a sponsor to meet you from either NA or AA again to help prevent the slippery slope.” (Service user forum)

Family and carer perspectives

“Families can play a vital role in treatment programmes in general, but their importance is especially evident in criminal justice settings and the context of release from custody. In many cases families are the main – or only – source of support for offenders, be it with accommodation, money, emotional help, company or the search for a new and productive life. Although families have a critical role to play in the treatment of drug and alcohol users, they are also

deserving of support for their own needs: they can improve treatment outcomes, but care should be taken that they are not seen merely as a resource in achieving this end.” (Carer forum)

- 3.114 There were positive feelings expressed by families about drug treatment in prison, particularly in that they see prison as a potential place of safety where people are able to address their drug taking. Families commented that the prison environment can actually provide the opportunity and incentive to change:

“[Prison treatment] is away from the [drug-taking] lifestyle and a place of safety... [prisoners] have a proper detox which they may be unable to get within the community. All the services are close by and linked up with each other.” (Carer forum)

- 3.115 Both prisoners and families commented that the prison environment can actually provide the opportunity and incentive to change:

“It’s easier to stay clean in prison.” (Carer forum)

“Being in prison is the only way to come off drugs.” (Carer forum)

“Prison is the only place in the last 16 years where [a partner] is able to keep off drugs.” (Carer forum)

- 3.116 Many commented that prison could provide a level of structure that treatment in the community cannot. However, the most common complaint from families/carers is that they are *locked out* both physically and emotionally from what is happening to their family member, friend or partner and are left feeling uninvolved and ill-informed:

“Coming out [of prison], the date and what was going to happen was an uncertainty.” (Carer forum)

“I wasn’t even informed that [a partner] had completed the SDP course...I didn’t feel part of the process.” (Carer forum)

- 3.117 There is a strong feeling that carers should be more involved in treatment decisions, especially prior to release:

“On release it is important if there is someone interacting with family and friends to let them know that you will need support.” (Carer forum)

“The support of my family, that’s what would prevent me from coming back to prison as we got too much to lose out there in the real world.” (Community questionnaire respondent)

“Families should have increased involvement in care plans, especially as they often provide accommodation for recently released offenders; there should be continued liaison with, and support for, the family. There was a perceived lack of continuity between treatment in prison and treatment outside, and an offender’s trusting and productive relationship with a CARAT worker can be lost upon release.” (Carer forum)

“Better information sharing and dialogue with families would facilitate a smoother release process and make the family feel more engaged in an issue they invariably have a large stake in.” (Carer forum)

- 3.118 Being better informed at the early stages of treatment can also reduce stress and worry:

“The fact that people were withdrawing had a detrimental effect on their early visits from friends and family – he was so emotional and this was very distressing, it made me worry about him a lot more.” (Service user forum – family member)

- 3.119 Respondents who had been in prison also felt there should be more communication with family members:

“Communication between family connections was not addressed in my treatment jail.” (Service user forum)

“Help with relationships with family and loved ones before release to help build ties, and continued help in the community with this.” (Service user forum)

“Being given time to help re-establish family relationships.” (Prison questionnaire respondent)

“Someone interacting with family and friends to let them know you’re gonna need support.” (Prison questionnaire respondent)

- 3.120 This was particularly evident for the 18 to 21s where family was the main source of support on release:

“Most felt that their family and friends would be their main source of support.” (Service user forum)

SUMMARY

- Amongst the factors that respondents stated would prevent them from returning to old habits was continuity of prescription on release by which they meant having one on the same day.
- Pre-release preparation in the form of retox was thought by some to be important.
- Respondents thought that having greater choice about medication options such as opiate blockers would help them.
- The need for identification or a formal letter was cited as a block to gaining a prescription from a GP in the community. Many respondents linked this with other problems such as gaining access to benefits and housing.
- Appropriate housing was identified as one of the main factors that would prevent returning to old habits. This was especially linked to not having to return to old friends and drug users and being in drug free environments e.g. going straight to rehabilitation centres.
- Hostels were frequently cited as being places where drug use was common and as such a risk to those who had been released drug free.
- Women in particular identified the need to be able to be re-housed away from their old areas as significant to their ongoing progress and remaining drug free.
- Many respondents cited inadequate access to funds as being a factor that would lead them back to old habits, especially offending. Respondents described being unable to meet their basic needs for food, clothes, and warmth.
- Carers also identified lack of access to adequate funds as a key factor in preventing relapse.
- Having something meaningful to do including employment, education, and structured programmes was cited as a key determinant in remaining drug free. Boredom was often cited as a reason people drifted back to old habits.
- Respondents described having trained for various qualifications while in prison but having difficulty finding any employment on the outside and they needed more help with this.
- Respondents identified lack of or poor care planning on release as a factor that could influence their progress. More integrated care planning and greater joined up services between prison and community, including end-to-end management, were cited as improvements that respondents would like to see.
- This extended to being met at the prison gates on release by a key worker. Though some respondents felt this role could be taken by friends or peers in NA or AA.
- Carers identified themselves as the major support for someone leaving prison and yet they often felt left out of the treatment process.
- Carers did recognise that improvements had taken place but they wanted to see carers receive more information early on in treatment and to be more involved prior to release.
- Early involvement was felt to be especially important with respect to younger offenders for whom family support was more significant.

4. ONGOING CONSULTATION

- 4.1 From the outset, Lord Patel has made service user and carer consultation and involvement a key aspect of the work of the Review Group. This consultation exercise in part demonstrates that commitment.
- 4.2 The extent of responses and involvement of such a wide range of groups and agencies in addition to all the individual respondents, is testament to the level of interest that there is in the work of the Review Group and in improving the quality of drug treatment services.
- 4.3 The consultation took a number of measures to ensure as wide a representation as possible could take part. Responses were monitored to determine if there was differential responding from different groups. Concern had originally been raised that questionnaires were not a good way to engage with prison drug treatment service users as it would restrict the number of responses from people with learning difficulties. This was overcome by holding forums but a number of questionnaires returned identified that the respondent was dyslexic and that someone had assisted the person with filling out the questionnaire.
- 4.4 It is also apparent that questionnaires were distributed in the prison system through various means, some of which may have affected the responses e.g. some of the services distributing questionnaires made changes to some questions believing that the respondents might not know how to answer the question or want to provide the information. This is despite the fact that the questionnaire was developed by service users themselves.
- 4.5 Although this was done with the best of intentions, this fits in with service users' feedback that they often feel that their thoughts and views are second-guessed rather than people asking them openly what they think and what they need.
- 4.6 In fact, in one prison service users were discouraged from handing out questionnaires themselves. This may have been due to legitimate security concerns, but it demonstrates some of the challenges involved in ensuring meaningful service user involvement and consultation.
- 4.7 Adfam provided a written submission that summarised the results from various carer forums they were in contact with. This was invaluable as there were very few carers, friends and family represented in the service user forums.
- 4.8 It was welcomed that specific attention had been given to families in this consultation, which is in keeping with the family's crucial role in supporting people not just during their time in prison but also during their reintegration into the community. However, it was noted by families that the questionnaire and process itself was not particularly family-friendly.

- 4.9 Respondents were asked if and how they would want to remain involved with the work of the Review Group and whether they wanted to be part of further consultations. Amongst prison questionnaire respondents, 202 (67 per cent) replied:
- 32 (11 per cent) were unsure
 - 31 (10 per cent) said no.
 - 127 (42 per cent) said they would
- 4.10 Amongst community questionnaire respondents, 62 per cent replied:
- 20 (8 per cent) were unsure
 - 24 (9 per cent) said no
 - 110 (43 per cent) said yes.
- 4.11 The main way in which people expressed their interest in being involved was to receive written and verbal information and to be kept informed of developments. Some requested personal visits or meetings with Review Group members and others wanted to be involved in regular group meetings on these subject areas.
- 4.12 A very similar response was received from participants in the service user and carer forums.
- 4.13 In general, people found the opportunity to feed into the Review Group a positive one. Those given the opportunity to feedback in the forums thoroughly enjoyed them, found them a helpful experience and hope they could have more.

5. CONCLUSIONS

- 5.1 The key messages from service users and carers is that while they recognise the improvements that have been made to drug treatment in prisons it does not yet go far enough.
- 5.2 Respondents may vary in their experiences of treatment and their needs, but there is a widespread call for more overall consistency and continuity both between prisons and community and across the prison estate.
- 5.3 Choice of treatment options, including medical interventions such as detoxification, maintenance, and abstinence programmes are highly valued. Respondents expressed clear opinions on their preferred treatment options whether this is for different medications used in detoxification and maintenance or choice of psychosocial interventions. Choice is a key factor in respondents determining the quality and value of treatment.
- 5.4 Amongst those needs that respondents said were not met, mental health problems and support for alcohol and drug problems other than heroin predominate. Many respondents report having mental health problems that are related to their drug use ranging from depression and anxiety to cutting and feeling suicidal.
- 5.5 Not only do respondents state that their medical needs for mental health problems were not met but they also identify a lack of understanding about mental health problems and poor access to trained professionals.
- 5.6 Interventions such as those provided by CARATs, PASRO, SDP, etc. are very highly valued but respondents report having varied experiences of access. Problems identified include waiting times, capacity issues, and the variance across the prison estate. There is also a call for greater integration between different services and treatment responses e.g. IDTS, CARATs and DIP.
- 5.7 Carers including friends, family and partners feel strongly that they are too often left out of the process, and yet they are often the main support on release. Carers would like to be given more information about treatment that is being given and to be more involved prior to release. Service user respondents also call for more involvement of their family and friends stating that they would like them to be able to better understand their support needs.
- 5.8 The response rate to the consultation was very good and there is a clear interest amongst many people to remain involved and be consulted further on these issues. There is learning from this consultation that can aid further work e.g. targeted questionnaires for carers and involvement of community groups to ensure greater diversity amongst respondents especially amongst younger offenders, women and Black and minority ethnic respondents.

22 July 2009

To: All Drug Treatment Service User Groups

Drug Treatment Service User Forums

In 2008 I was asked by Ministers to chair an independent review group tasked with overseeing a programme of work to consider the recommendations of the Price Waterhouse Coopers (PwC) report, *Review of Prison-Based Drug Treatment Funding*. The Prison Drug Treatment Strategy Review Group (PDTSRG) was formed to review the quality, availability and fairness of drug treatment in prison.

Of particular importance to me is that the views of people who need or have accessed drug treatment in prison are heard and included in the strategy. I have tried to ensure that the Review Group is as open and accessible as possible. The PDTSRG website www.pdtsrg.co.uk went live in February 2009 and includes access to minutes and documents from each meeting. People can also provide comments, feedback and discuss the PDTSRG on the forums.

Trying to get the views of people in prison or people who have been in prison requires active communication. Established Service User groups are in a good position to tell service users about the PDTSRG and to collect information and feedback to the PDTSRG.

To obtain this information I am wondering if your service user group would be happy to conduct a service user forum about the PDTSRG and write back to us with your findings. The PDTSRG Project Team, with the help of Greenwich Local Addiction Support Service's (GLASS) service user group have written and piloted a script for the forum that we would like you to use to feedback. The script should take no more than 1 ½ hours to run through with your service user group.

The PDTSRG is moving fast so if you can help we need you to write back with any findings from your forum by the **10 September 2009**. There will be future consultation opportunities on other aspects of the PDTSRG, but we would like to ensure that we capture the views of service users now so that they inform the current work. I have attached to this letter two versions of the forum script, one for communities and one for prisons. Please choose the one best suited to your service user group. Instructions on how to facilitate the forum and feedback are included in the script. If you need any financial or administrative help (someone to write up your findings for instance) please contact Rachael Hunter at rachael.hunter@dh.gsi.gov.uk, or you can phone 020 7972 4860. We are happy to help you cover the cost of reimbursing service users (through vouchers or lunch) for their time.

The Project Team have also developed a questionnaire, which is attached. Although we would prefer you to write back to us about the results of a forum, there is the option of completing a questionnaire for people who cannot feedback at a forum. An electronic version on the questionnaire can be found on the website.

Thank you for taking the time to consider the PDTSRG. Your views and the views of service users are important to me and the Review Group and may help to shape the future of drug treatment in English prisons.

Kamlesh

Professor Lord Patel of Bradford OBE

Instructions for Service User Forum Facilitators

COMMUNITY FORUMS

Below is a script for service user forums to use to feed back to the Lord Patel Prison Drug Treatment Strategy Review Group. We would appreciate if you could use the introduction and list of questions to hold a forum on drug treatment in prison for service user groups for people in the community who have been in prison sometime in the last two years. The forum should take approximately 1 ½ hours.

Some of the themes we would like you to try to address in the forum include:

- Quality of treatment,
- Service user preferences, and
- Meeting the needs of the client (including housing, training, employment and mental health treatment).

Please write back to us with what was discussed at the forum, putting responses under each of the questions asked. If possible please include specific quotes of what people have said, and if you do please make sure that they are totally anonymous – please do not include any individual's names or identifying information.

If you could advise what the make up of your group was we can examine themes in line with the following:

- Men/women
- Ethnicity
- Disability
- Sexual Orientation and/or
- Age (older prisoners or prisoners under 21).

Although we are interested in a range of drug treatments in prison, we are primarily interested in the treatment of substance misuse for illicit drugs. Alcohol and tobacco, although relevant and can be included, should not make up the core of the conversation.

Thank you for taking the time to ask for service user views for us. It is greatly appreciated and will help to feed into the development of our strategy. We expect that we will do a second consultation process on our draft strategy.

Please mail responses back by September 10 2009 to:

**Rachael Hunter
Wellington House
133-155 Waterloo Road
London
SE1 8UG**

Or e-mail rachael.hunter@dh.gsi.gov.uk

Script for Service User Forums

Introduction about the Lord Patel Prison Drug Treatment Strategy Review Group

- Lord Patel's Review Group is an independent review of drug treatment practices in prisons.
- The Review will look at the quality, availability and fairness of drug treatment in prison. It will also look at whether the same quality of drug treatment is available in all prisons.
- There is also a focus on the service user's treatment journey, particularly from prison into the community and between prisons.
- Lord Patel would like to hear the views of people in prison, people who have been in prison and their families and friends about drug treatment for people in prison. Your views may help shape the future of drug treatment in prison and will form part of the process of writing a prison drug treatment strategy.
- Lord Patel and the Review Group value your views and appreciate you taking time out to input into today's discussion. Any comments you do make will be fed back to the Review Group but will be confidential. Your names will not be associated with any of the views you express during today's discussion.

Facilitator to discuss and ensure the understanding of the group

Questions:

- 1) What, if anything, was good about the drug treatment you had in the last prison you were in?
- 2) If drug treatment in prison has improved how do you think it has improved?
- 3) Has your drug treatment experience differed between different categories of prison or when being transferred between prisons?
- 4) Did you have any drug treatment needs in prison that you feel were not addressed? (*NOTE to Facilitator: Themes in this question to try to draw out include mental health problems and interactions with drug treatment, harm minimisation and treatment preferences*)
- 5) It is the day of your release from prison – what help would most likely prevent you from returning to old habits?
- 6) What other support do you need on release from prison?
- 7) After today's session, how would you like to stay involved with the work of Lord Patel's Review Group?

Instructions for Service User Forum Facilitators

PRISONS

Below is a script for service user forums to use to feed back to the Lord Patel Prison Drug Treatment Strategy Review Group. We would appreciate if you could use the introduction and list of questions to hold a forum on drug treatment in prison for service user groups in prison. The forum should take approximately 1 ½ hours.

Some of the themes we would like you to try to address in the forum include:

- Quality of treatment,
- Service user preferences,
- Meeting the needs of the client (including housing, training, employment and mental health treatment).

Please write back to us with what was discussed at the forum, putting responses under each of the questions asked. If possible please include specific quotes of what people have said, and if you do please make sure that they are totally anonymous – please do not include any individual's names or any identifying information.

If you could advise what the make up of your group was we can examine themes in line with the following:

- Men/women
- Ethnicity
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- Age (older people or people under 21).

Although we are interested in a range of drug treatments in prison, we are primarily interested in the treatment of substance misuse for illicit drugs. Alcohol and tobacco, although relevant and can be included, should not make up the core of the conversation.

Thank you for taking the time to ask for service user views for us. It is greatly appreciated and will help to feed into the development of our strategy. We expect that we will do a second consultation process on our draft strategy.

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London
SE1 8UG**

or e-mail rachael.hunter@dh.gsi.gov.uk

Script for Prison Service User Forums

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- Lord Patel would like to hear the views of people in prison, people who have been in prison and their families and friends about drug treatment for people in prison. Your views may help shape the future of drug treatment in prison and will form part of the process of writing a prison drug treatment strategy.
- Lord Patel and the Review Group value your views and appreciate you taking time out to input into today's discussion. Any comments you do make will be fed back to the Review Group but will be confidential. Your names will not be associated with any of the views you express during today's discussion.

Facilitator to discuss and ensure the understanding of the group

Questions:

- 8) What is good about the drug treatment in this prison or any other prison you have been in?
- 9) If drug treatment in prison has improved how do you think it has improved?
- 10) Has your drug treatment experience differed between different categories of prison or when being transferred between prisons?
- 11) If anything is not working well now, what could happen to make it better?
- 12) Do you have any drug treatment needs in prison that you feel have not been addressed? (*NOTE to Facilitator: Themes in this question to try to draw out include mental health problems and their interaction with drug treatment, harm minimisation and treatment references*)
- 13) It is the day of your release from prison – what help would most likely prevent you from returning to old habits?
- 14) What other support do you need on release from prison?
- 15) After today's session, how would you like to stay involved with the work of Lord Patel's Review Group?

Your Experience of Prison Drug Treatment

Lord Patel Prison Drug Treatment Strategy Review Group (Service users, families and carers consultation questionnaire)

PLEASE RETURN BY SEPTEMBER 10 2009

Please mail your response to (no postage stamp required):

FREEPOST RRLX-ALSB-HJLL
RAPt Aftercare Team
Riverside House
27-29 Vauxhall Grove
London
SW8 1SY

Or e-mail to:

admin@pdtsrg.co.uk

Information

- Lord Patel's Review Group is an independent review of drug treatment practices in prisons.
- The Review will look at the quality, availability and fairness of drug treatment in prison. It will also look at whether the same quality of drug treatment is available in all prisons.
- There is also a focus on the service user's treatment journey, particularly from prison into the community and between prisons.
- Lord Patel would like to hear the views of people in prison, people who have been in prison and their families and friends about drug treatment for people in prison. Your views may help shape the future of drug treatment in prison and will form part of the process of writing a prison drug treatment strategy.
- Lord Patel and the Review Group value your views and appreciate you taking time to fill out this form. Any comments you do make will be fed back to the Review Group and will be confidential. Please try to avoid using names or any information that could identify a person when filling out this form. Try to answer as many questions as possible. If you do not feel comfortable answering a question you do not need to answer it.
- If you have access to the internet you can go to www.pdtsrg.co.uk for more information or to contribute to the forums.

Questions (If you do not feel comfortable answering a question please leave it blank):

16) PLEASE TICK A BOX:

Are you currently:

In prison? (Go to question 2)

In the community? (Go to question 4)

A family member or carer for a person that has received drug treatment in prison?

(Go to question 6 – please answer any prison related questions providing information about what would have helped you or your family member/person you care for)

17) How long have you been in prison this time?

_____ months _____ years

18) What is good about drug treatment in this prison? (Then go to question 6)

19) How long ago were you last in prison?

_____ months _____ years

20) What was good about drug treatment in the last prison you were in?

21) If drug treatment in prison has improved how do you think it has improved?

22) Does the drug treatment provided differ between the following categories of prison? If so how?

Local: _____

Cat A: _____

Cat B: _____

Cat C: _____

Cat D: _____

Other comments: _____

23) Thinking about prison, did you have any drug treatment needs that you feel were not addressed? How would you have liked them to be addressed? This can include mental health problems and their interaction with drug treatment, harm minimisation and treatment preferences.

24) It is the day of your release from prison – what help would most likely prevent you from returning to old habits? (or your family member or person you care for returning to their old habits)

25) How would you like to stay involved with the work of Lord Patel's Review Group?

Personal Information (Optional – If you do not want to answer a question please leave it blank).

- 1) Gender Male Female (Please tick one)
- 2) Age _____
- 3) Ethnicity _____
- 4) Religion _____
- 5) Sexual Orientation _____
- 6) Do you have a disability? If yes please provide details:

PLEASE RETURN BY SEPTEMBER 10 2009

FREE MAIL RETURN (no postage stamp required)

FREEPOST RRLX-ALSB-HJLL
RAPt Aftercare Team
Riverside House
27-29 Vauxhall Grove
London
SW8 1SY

Or e-mail to:

admin@pdtsrg.co.uk

If you have any questions please contact Rachael Hunter at:

E-mail: admin@pdtsrg.co.uk

Phone: 020 7972 4860

Or send a letter to the free post address above.

Thank you - A big thank you to RAPt for receiving the majority of the questionnaires for this work. This would not have been as successful as it was without you.
Thank you to Robert Marshall for helping with some prison service user forums.

Service User Forums:

- Greenwich Local Addiction Support Service (GLASS)
- London Regional User Council
- Action Housing and Support Ltd Sheffield
- Adfam
- BAC-IN
- Barnsley DAAT
- Community Voice
- Fulham Life Action Group
- Gloucestershire Service User Office
- Halton Cheshire Forum
- HMP Belmarsh
- HMP Birmingham
- HMP Brixton
- HMP Chelmsford
- HMP Featherstone
- HMP Haverigg
- HMP Holloway
- HMP Hull
- HMP Styal
- HMP Wandsworth
- Lifeline – HMP Moorland
- Northallerton
- North East Regional Service User Forum
- Revolving Doors
- Telford User Group
- Torquay Service User Consultancy
- User Feedback Organisation (UFO) Safer Bristol
- Wirral DAAT

Questionnaires:

- Cheshire DAAT
- Devon DAAT
- NACRO - Chester
- Northumbria Probation
- Nottinghamshire Probation
- Shrewsbury
- Solihull Integrated Addiction Services
- South Yorkshire
- Suffolk County Council
- Sussex Probation
- Warrington Service User Groups
- Winchester Drug Service

Prison Drug Treatment Strategy Review Group

The Evidence Base Review Report 2009

1. INTRODUCTION

- 1.1. There is consensus amongst providers and commissioners of prison drug treatment that it should be evidenced based. However, there is an absence of high quality research addressing effectiveness of drug treatment in prisons and there are a number of complex issues with respect to the evidence that does exist. Therefore, the desired approach is a multi-modal or flexible approach to treatment that is aligned to or influenced by published evidence for effectiveness. The implications of this approach are that to follow a particular treatment regimen in a dogmatic fashion may not always be practical or indeed desirable.
- 1.2. For example, most of the studies on effectiveness are either from community settings or are international and the same results may not necessarily translate to the UK prison system. There is also a general lack of clarity in the way that psychosocial interventions are categorised e.g. sometimes this is by treatment type, sometimes by characteristics of participants and sometimes in relation to programme intensity or the combination of delivery. Terms are used interchangeably which makes it difficult to understand exactly what is being compared.
- 1.3. This paper attempts to clarify these issues and set the context for an assessment of the evidence base for drug treatment in prisons. The paper is in four parts:
 - Background context
 - Current drug treatment interventions provided in prisons
 - An overview of evidence for effectiveness by treatment modality
 - Discussion of the issues that influence effectiveness and interpretation of evidence
- 1.4. The paper is intended to be read in conjunction with the paper on outcomes as both evidence and outcomes are inter-related. This is especially important in the context of prison drug treatment as outcomes may relate to both drug use and offending behaviour and there needs to be a similar approach to the rigour by which effectiveness is assessed.
- 1.5. The paper identifies a series of treatment modalities that should in principle be delivered in prisons.

2. BACKGROUND CONTEXT

“A comprehensive framework of drug treatment services, spanning Tiers 1–4, should be available in prisons to address the varying needs of drug users. In principle, delivery of drug treatment in prisons is very similar to providing treatment in the community. However, there are specific factors that need to be taken into account, given the different environment in which prison treatment is provided”. (NTA, 2006. 3.4 p. 14)

2.1 Price Waterhouse Coopers (PwC) examined best practice models to inform their report, which reviewed prison-based drug treatment funding. This was not a systematic review of the literature in the research sense. They considered the evidence base for:

- *Detoxification for Opioid Users*
- *Maintenance Prescribing for Opioid Users*
- *Pharmacological Interventions for Cocaine/Amphetamine Users*
- *Psychosocial Programmes*
- *Intensive Drug Treatment Programmes (DTPs)*

2.2 Their conclusion about the evidence was that there was no gold standard drug treatment intervention identified in the literature and that there are several key research gaps in drug treatment effectiveness e.g.

- *Evidence on the effectiveness of brief psychosocial interventions that focus on advice, information and support alone is weak and more research is needed*
- *More research is required on the effectiveness of the 28-day psychosocial intervention package offered by CARATs for PDUs*
- *The evidence base for maintenance prescribing is borrowed from community research (although there is an Australian (RCT) and Canadian prisons study evidence for its effectiveness).*
- *More information is needed to support UK policy for maintenance prescribing in prisons*
- *There is limited evidence to support any pharmacological interventions for substances other than heroin in both a community and prison setting. (PwC, 2007 A3. p. 55 – 56)*

2.3 PwC acknowledged several limitations within the existing literature on effectiveness of prison drug treatment e.g.

- *Variations in the definition used for a problem drug user e.g. whether this was restricted to dependence or included problematic use without dependency*
- *The relative reliance on research on effectiveness that comes from either an international source or is based on community settings e.g. fails to take adequate account of the specific UK context of prison based drug treatment*
- *Failure to take adequate account of the unique operating issues within UK prisons*
- *Difficulties in assessing effectiveness of care pathways due to the multiplicity of treatment options and services*
- *Relative weighting in consideration of the evidence base towards interventions that lend themselves well to measurement e.g. pharmacological and clinical interventions at the expense of psychosocial and other interventions (PwC, 2007 A3. p. 67)*

2.4 The United Kingdom Drug Policy Commission (UKDPC) has since published a review of evidence for problem drug-using offenders: *Reducing Drug Use, Reducing Reoffending. Are programmes for problem drug-using offenders in the UK supported by the evidence?* (UKDPC. March, 2008)

2.5 The UKDPC review found that:

There is reasonable evidence to support:

- Drug courts; community sentences such as DTTOs and DRRs; prison-based
- Therapeutic communities; opioid detoxification and methadone maintenance within prisons; and the RApT 12-step abstinence-based programme.
- However, there is no cost-benefit analysis of the two UK drug courts; the 2008 Ministry of Justice review of drug courts was relatively positive, but it noted that continuity of judiciary appeared to be a key factor for the enhancement of good outcomes. The Bradley Report of people with mental health problems or learning disabilities in the criminal justice system (2009) also noted that the Ministry of Justice report did not address dual diagnosis.

There are no published evaluations of the effectiveness of:

- CARAT interventions; drug-free wings; programmes based on cognitive behavioural therapy, such as short-duration programmes and PASRO (Prison Addressing Substance Related Offending) programmes; conditional cautions; diversion from prosecution schemes; and Intervention Orders.

There is mixed evidence for:

- Criminal Justice Integrated Teams; Restrictions on Bail; and the added value of drug testing as part of a community order.

(pp. 11 – 12)

2.6 UKDPC concluded that:

- The principle of using criminal justice system based interventions to encourage engagement with treatment is supported by the evidence.
- Following a period of expansion and a focus on quantity, attention should now focus on quality.
- Net-widening to include additional groups of drug-using offenders in criminal justice system based interventions may have negative consequences.
- Community punishments are likely to be more appropriate than imprisonment for most problem drug-using offenders.
- Prison drug services frequently fall short of even minimum standards.

- Given the sizeable investment in criminal justice system interventions for drug-dependent offenders, we know remarkably little about what works and for whom.
(pp 12 – 15)

3. A DESCRIPTION OF PRISON DRUG TREATMENT IN ENGLAND AND WALES

3.1 The configuration of prison drug treatment and the terminology used to describe it differ slightly from the community. There are three basic categories: clinical substance misuse services; CARAT teams; and Accredited Drug Treatment Programmes.

Clinical substance misuse services

3.2 These are provided or under introduction in 117 adult prisons in England and 3 in Wales. These are medical services restricted largely to detoxification, maintenance and Naltrexone prescribing. Clinical drug treatment services link to wider healthcare services.

CARAT (Counselling Assessment Referral Advice and Throughcare) Services

3.3 These are provided in 129 of the 135 establishments in England and Wales. CARAT services are essentially key working, care planning and low-intensity interventions for adult and young offender (18+) prisoners.

3.4 CARATs may refer clients to more intensive accredited drug treatment programmes in prison. CARATs represent the key through-care link with the community through the Drug Intervention Programme (DIP).

3.5 These two components of drug treatment, clinical and CARATs, are combined to form the Integrated Drug Treatment System (IDTS). IDTS is funded in all adult prisons in England. The main features of IDTS are:

- Improved clinical management with greater use of maintenance prescriptions
- Intensive CARATs support and interventions during the first 28 days of intense clinical management for all patients
- Greater integration of drug treatment generally but a particular emphasis on clinical and CARAT services, with the objective of creating multi-disciplinary teams.

Accredited Psychosocial Drug Treatment Programmes

3.6 These are exclusively psychological drug treatment programmes. They cover a range of therapeutic approaches

a) Cognitive Behavioural Therapy (CBT) Programmes:

3.7 There are four types of CBT drug treatment programmes in prisons:

i) Short Duration Programme (SDP)

3.8 **Provided in 43 prisons**, SDP is a medium-intensity CBT programme that incorporates harm minimisation and relapse prevention. The programme targets prisoners who are on remand, or those who have been sentenced to 12 months or less. It aims to motivate and direct offenders to remain in treatment or seek further support.

3.9 SDP can also be delivered in Category D prisons as a 'booster' programme to those prisoners who want to prepare themselves sufficiently to cope on release. SDP consists of twenty, two-and-a-half-hour sessions delivered over a period of four weeks.

ii) Prisoner – Addressing Substance Related Offending (P-ASRO)

3.10 **Provided in 40 prisons**, this is a low- to medium-intensity programme. All participants need to be serving sentences of 12 months or more, with a low to medium risk of re-offending, and with a score of between four and seven on the Significance of Dependence Scale (SDS). P-ASRO aims to reduce the likelihood of drug related re-offending.

3.11 P-ASRO for male adult and young offenders consists of twenty, two-and-a-half-hour sessions delivered over a five- to six-week period. For female adult and young offenders, the programme consists of twenty-four, two-and-a-half-hour sessions delivered over a period of eight weeks.

iii) Substance Treatment & Offending Programme (STOP)

3.12 **Operating in 7 prisons**, this programme adopts a cognitive behavioural approach to understanding and treating problem behaviour associated with substance-related offending. The aim of STOP is to achieve abstinence, and targets male adults of 21 years and above, serving sentences of over 12 months with medium to high risk of re-offending and a score of seven or more on SDS. STOP comprises 76 one-hour sessions delivered over a period of 11 to 13 weeks.

iv) FOCUS

3.13 **Provided in five prisons**, FOCUS is founded on a social learning perspective for the development of adult substance use problems that incorporates a strategic combination of behavioural and cognitive behavioural treatment modalities and techniques. The programme is designed specifically to target male adults aged 21 and above, serving sentences of over 12 months with medium to high risk of re-offending and a score of seven or more on SDS. Individual are required to have an IQ of at least 80 and score 30 or more on the Hare PCL-R psychopathy test. The programme comprises 62 sessions delivered over a period of 18 weeks.

b) 12-Step Approach

3.14 There are currently two accredited 12-step programmes **provided in a total of 12 prisons:**

- *Prison Partnership Twelve-Step Programme (PPTSP)* This programme takes between 15 and 19 weeks
- Rehabilitation of Addictive Prisoners trust (RAPt) *Substance Abuse Treatment Programme (SATP)* Completion can take up to 23 weeks

c) Therapeutic Communities (TC):

Prison Partnership Therapeutic Community Programme (PPTCP)

3.15 ***This programme is currently available in five prisons,*** and is based on a hierarchical Therapeutic Community (TC) model. It is designed for prisoners aged 21 and over with a medium and high risk of reconviction and level of dependence on drugs. A TC for women prisoners received accreditation in April 2008 and is currently being run at HMP Drake Hall.

3.16 As a rule, therapeutic community programmes are based on the principle of social learning, with new residents given instruction in the means to a drug-free life by more established residents (*“peers’ history and in getting the right kind of support.” (Service user forum)*). In practice, there can be variation in treatment philosophy, from a strictly behavioural hierarchical model of treatment, to a 12-step or cognitive-founded approach, or an eclectic mix of interventions.

4. OVERVIEW OF EVIDENCE BY TREATMENT MODALITY

4.1 The following evidence is not intended to be an exhaustive review but rather is presented in order to give the reader a sense of the key issues when considering the evidence for drug treatment in prison. The evidence is structured according to the treatment modalities used in Models of Care (update July 2006) whilst recognising that some modalities such as structured day programmes are not provided in the same way within prisons.

- Substance misuse related advice and information
- Harm reduction interventions
- Prescribing interventions including specialist prescribing
- Structured day programmes
- Structured psychosocial interventions
- “Other structured treatment”
- Drug treatment within specialist areas
- Residential rehabilitation
- Aftercare

(Adapted from Models of Care update 2006 (NTA, 2006))

4.2 The evidence cited has been chosen because it reaches a high standard of quality (e.g. 3 or 4 on the Maryland scale of scientific methods). However, as discussed in the final section of the paper there are issues when considering the quality and appropriateness of the evidence base and there is a need to agree the level of quality and standards which should be applied for prison drug treatment. Where this review draws evidence from offender or prison studies, the corresponding reference is underlined [e.g. (Boys, 2002)].

Substance misuse related advice and information

4.3 There is not a great deal of evidence, either within or outside prisons on the effectiveness of substance misuse related advice and information. Although there is some support for brief interventions for those not engaged in formal treatment.

4.4 In their review of the evidence base, NICE (2007a) concluded that people who misuse cannabis or stimulants, and are not in formal drug treatment, appear to respond well to brief interventions, both in terms of increased abstinence levels and reduced drug use.

4.5 By contrast, for people already receiving formal drug treatment, an additional brief intervention did not appear, in the view of NICE (2007a), to have much effect on abstinence or drug use.

4.6 CARAT services do include elements of advice and information and this is generally reported as being valued by prisoners. There is insufficient evidence to link this to evidence of outcomes as no such studies or formal evaluation has yet been undertaken. However, this is one element of CARATs which needs to be viewed in a broader context of the range of interventions provided e.g. key working and case management.

Harm reduction interventions

4.7 There is a range of harm minimisation and prevention strategies in prisons currently for example, harm reduction interventions such as hepatitis B vaccination and hepatitis C treatment. Prison presents an opportunity and a challenge to address these issues amongst drug users. In fact, prison is now the most common place for injecting drug users to be vaccinated against hepatitis B and a range of leaflets and DVDs are available to prisoners informing them how to reduce the risk of contracting blood borne viruses.

Rates of drug use and injecting

4.8 Drug use in prisons fluctuates across sites and time. Individual prisons may experience short-lived drug inundations, or have a more persistent serious problem with drug smuggling. However, research evidence shows that drug use amongst prisoners generally falls dramatically compared to pre-prison levels of misuse. The best national

indicator of drug use in prisons is provided by the random mandatory drug testing (MDT) programme. For a number of reasons, random MDT results cannot be a complete measure of the prevalence of drugs-misuse in prisons. However, independent research carried out by the Office for National Statistics in 2005 concluded that random MDT provides a reliable and statistically valid way of measuring patterns and trends of drug use in prisons at national and regional level. The random MDT positive rate has fallen by 68 per cent since 1996/97 – from 24.4 per cent to 7.7 per cent in 2008/09.

4.9 Injecting drug use carries a high risk to personal and public health. One UK study (Judd, 2005) found a baseline prevalence of antibodies to hepatitis C virus was 44 per cent and of antibodies to HIV 4 per cent among injecting drug users. The majority of injecting drug users are sent to prison (Dept Health 2002). Approximately half of all prisoners are problematic drug users. 37 per cent of problematic drug users entering prisons report injecting drug use within the 28 days preceding custody (Home Office, 2003). Imprisonment in the UK is also related to a reduction in the prevalence of injecting drug use (Bellis, 1997; Shewan, 1994), but cases of initiation into injection in prison have been identified (Boys, 2002). Although it reduces in custody, injecting drug use in prison is more likely to involve the use of shared equipment (Bellis, 1997). Imprisonment is associated with higher rates of blood borne virus infection among injecting drug users (Weild, 2000).

Blood Borne Viruses

4.10 The Health Protection Agency monitors levels of infections amongst Injecting Drug Users (IDU). Their report *Shooting Up*² shows there is cause for concern with this group as they continue to be affected by various infectious diseases associated with injecting:

Hepatitis C: The prevalence of hepatitis C infection among IDUs remains high overall with prevalence in England broadly stable in recent years at 43 per cent but with very marked regional variations, following a rise since the beginning of the decade (the UK prevalence in 2000 was only 33 per cent). In 2006, the number of confirmed hepatitis C infections reported in England rose to 8,346, 10 per cent higher than in 2005. Injecting drug use remains the single most important reported risk factor for acquiring hepatitis C infection (HPA, 2007). Crack cocaine injectors show rates of 59 per cent compared to non-crack injectors with rates of 34 per cent.

Overall, almost half of IDUs in the UK have been infected with hepatitis C. However, there are marked variations in hepatitis C prevalence within the UK, with low prevalence found in some areas. There are indications that current levels of hepatitis C transmission remain elevated.

HIV: HIV infection among IDUs has remained relatively uncommon in the UK, probably as a result of prompt community and public health responses. The annual number of HIV diagnosis among IDUs in recent years has been low and relatively stable. The overall

² Shooting Up – Infections among injecting drug users in the United Kingdom 2006 – An update: October 2007. Health Protection Agency

prevalence of HIV seen among IDUs in 2006 was similar to that seen in recent years, and remains higher than that seen in the late 1990s. In London, the prevalence was 5.0 per cent, whilst elsewhere in England it was 0.66 per cent.

The prevalence of HIV among the 'recent initiates' has remained higher than it was prior to 2003, with the prevalence being 0.77 per cent in 2006 (in 2002 it was 0.25 per cent).

Vaccination: Hepatitis B infection is a vaccine-preventable disease. Vaccination requires three doses that can be given over a period of three weeks to those in high-risk groups such as IDUs. The proportion of IDUs who have taken up an offer of the hepatitis B vaccination has increased markedly over time, rising from around quarter (25 per cent) in 1998 to two thirds (65 per cent) in 2006, with almost two-thirds self-reported receiving three or more doses (61 per cent) compared with 42 per cent in 1998.

This improvement in uptake of the vaccine probably reflects improved provision through drug services and, in particular, the prison vaccination programmes. However, there is still a great deal of work to be done in effectively targeting those problem-drug users with hepatitis B vaccine programmes delivered in the community, including through enhanced needle and syringe exchange (NEX) programmes, drug treatment units and GPs.

Injecting in prisons – needle exchange and disinfecting tablets

4.11 The sharing of needles and syringes (direct sharing) is a key route by which infections may be transmitted amongst IDUs. In England, direct sharing was reported by 23 per cent in 2006. Whilst this is lower than the rate of around a third seen in 2002, it is still higher than the level seen in the mid 1990s. The sharing of filters, mixing containers and flushing water can also pass on infections. In England, 45 per cent of current injectors reported sharing these items in 2006.

4.12 Although we know that there is far less injecting behaviour in prisons where it does occur, there is a potentially much higher risk of sharing injecting equipment due to its scarcity. The Singleton survey in prisoners conducted in 1997 found that 26 per cent of prisoners had injected at some time, but only 2 per cent had injected during their current prison sentence.

4.13 Prison Service Instruction 34/2007 makes it mandatory that disinfecting tablets are available across the adult prison estate. Although this is an evolving area, there is increasing evidence of the effectiveness of disinfectant tablets and there is as yet no evidence on what effect introducing needle exchange into an environment where injecting is reduced might have on injecting behaviour. NICE published guidance on Needle and Syringe programmes however it reports that: *'There is a lack of good quality UK research on the effectiveness of prison-based interventions. As a result, they have been omitted from the recommendations'* (NICE, 2009) <http://www.nice.org.uk/PH18>

4.14 In community settings the most common intervention designed to reduce injection and sexual risk behaviour is psycho-education. This approach commonly combines education about blood borne viruses (such as HIV or hepatitis C) with skills training in areas such as assertiveness. NICE (2007a) reviewed 15 trials of psycho-educational programmes, concluding that they had little or no effect on injection risk behaviour and a limited and inconsistent impact on the reduction of sexual risk behaviour in people who misuse drugs.

Prescribing interventions including specialist prescribing

Opioid substitution

4.15 Marsch (1998) conducted a meta-analysis review of the effect of methadone maintenance on opiate use, HIV risk and criminal activities. Of 43 studies, 24 (23 from USA or Canada, 1 UK) measured the impact of methadone maintenance treatment on criminal activity. The results demonstrated a consistent, statistically significant relationship between methadone maintenance treatment (MMT) and the reduction of illicit opiate use, HIV risk behaviours and drug and property-related criminal behaviours. The effectiveness of MMT was found to be highest in its ability to reduce drug-related criminal behaviour.

4.16 In a systematic review of drug and alcohol interventions in prison and community criminal justice settings, Roberts et al. (2007) reported that: 82 per cent of all findings presented indicate that this intervention was more effective than at least one comparison intervention in reducing criminal behaviour. 55 per cent of findings showed that it was more effective than all other comparisons included in the study.

4.17 In a literature review of substitution treatment in prisons, Stallwitz and Stover (2007) concluded that prison-based methadone is effective across health and offending domains, and that higher dose treatment was more effective than lower dose. Mitchell, (2005) in a meta-analysis of 26 evaluations of prison-based drug treatment programmes, did not find that methadone programmes reduced offending.

4.18 Dolan (2003; 2005), in a randomised controlled trial, found statistically significant evidence that a prison methadone programme can reduce re-incarceration and fatal overdose upon release. Gordon (2008), in a prison methadone RCT, found that the programme reduced re-incarceration to a statistically significant effect,

Naltrexone

4.19 Naltrexone is recommended by NICE (2007b) as a treatment option in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence programme. There are now long-acting forms of Naltrexone (e.g. sustained release implants) which may be of value as a new formulation of this drug. However, as yet these remain unlicensed and there is no UK research data for prisons. They also fell outside the scope of the 2007 NICE Naltrexone Technology Appraisal 115.

4.20 There is some evidence (e.g. Carroll et al. 2001) that contingency management, behavioural couples therapy and family-based interventions may all be beneficial adjuncts to Naltrexone treatment as a consequence of improved prescription compliance.

Structured day programmes

4.21 Structured day programmes for drug treatment are not provided in prisons, although there are structured interventions that are provided on an intensive basis and therapeutic communities where there is a day programme approach. It should also be noted that much of the evidence for support of structured interventions is predicated on the requirement of aftercare to ensure that benefits are sustained.

Structured psychosocial interventions

4.22 It is not always clear what constitutes a structured psychosocial intervention and this should be borne in mind when considering the evidence as it is likely that terms used may not be interchangeable. The above point regarding sustaining benefits with aftercare also applies. For example, Cognitive Behavioural Therapy (CBT) may involve a range of methods and the emphasis on these could differ between particular programmes. Some of the common methods used in CBT are:

- Skills training - for example, assertiveness skills or social skills to implant and practice new behaviours. This will involve instruction, modelling, role-play, feedback and coaching.
- Self instructional training (SIT) - clients are taught a series of instructions to repeat to in order to control their behaviour. The statements which the client makes to himself during the problematic behaviour are then elicited and attempts are made to replace them with more adaptive self-statements.
- Behavioural analysis - which places great emphasis on the need to educate the subject and provide him with a framework to understand his behavioural problems. This will often involve self-monitoring over a prolonged period.
- Problem solving skills - clients are taught a simple step by step approach to identifying and resolving social and inter-personal problems which they then apply to their own situation.
- Emotional management – clients are taught a range of techniques such as relaxation training, thought stopping, time out and distraction to assist them in managing states of arousal.
- Motivational strategies - motivation to change is not a fixed personality trait and varies from time to time. Most CBT programmes include exercise based on the decisional balance technique, and exercises to create cognitive dissonance in order to increase and motivate clients to change.

- Relapse prevention - clients are taught strategies to cope with the set backs that inevitably occur in the process of change. These are rehearsed in advance so that when a minor lapse occurs this does not lead to complete abandonment of new way of behaving. Relapse prevention also includes identifying the environmental triggers which might lead to relapse and making plans to avoid these.

4.23 Holloway et al. (2008) found positive effects for psychosocial interventions for both drug use and offending. Although they also conclude that: *“more needs to be known about variations in effectiveness and the influence of programme type, intensity, and context on crime outcomes”*.

Psychosocial interventions for problematic stimulant use

4.24 Knapp et al. (2001) carried out a Cochrane review of psychosocial interventions for problematic use of cocaine and other psycho-stimulants. They included 27 randomised controlled trials, covering a total of 3,663 participants, where psychosocial interventions were compared with other behavioural or psychosocial treatment. The authors concluded that they could determine *“Little significant behavioural changes with reductions in rates of drug [cocaine] consumption following an intervention”*.

Standard CBT studies for the treatment of problem stimulant use considered by NICE

4.25 These studies are of the treatment of cocaine and the findings are not directly applicable to treatment of heroin dependence. This was not done in the NICE document and has led to some misinterpretations of its recommendations. It is also important to note that these studies are also specifically relevant to the issue of aftercare since they tend to support continuing aftercare as the key factor in effectiveness rather than Therapeutic Communities. (See also section on Aftercare.)

4.26 Crits-Cristoph and colleagues (1999) carried out a multi-site randomised controlled trial, involving 487 participants. They compared the effectiveness of two psychotherapies (psychodynamic and cognitive treatments) with individual drug counselling and individual plus group counselling approaches. These individual and group counselling approaches were based on a 12-step approach. Both of these modalities were found to be superior to cognitive therapy.

4.27 Maude-Griffin et al. (1998) randomly assigned 128 participants to either a CBT or 12-step treatment programme. CBT was found to be superior to a statistically significant extent across a range of client variables.

4.28 Putting together these two studies (Crits-Cristoph 1999 and Maude-Griffin 1998) produces a combined result of nil treatment effect from CBT versus standard care. As a principle consequence of this result, NICE (2007a) have recommended; *“Cognitive behavioural therapy and psychodynamic therapy focused on the treatment of drug use should not be offered routinely to people presenting for treatment of cannabis or stimulant misuse [or those receiving opioid maintenance treatment]”*.

CBT and cannabis use

4.29 A comparison, based on economic modelling, of CBT with waiting list control for cannabis users has suggested that CBT is not a cost-effective intervention (NICE 2007a, reviewing Stephens 2000; Stephens 2002).

CBT programmes for women

4.30 Compared to no treatment and no treatment plus parole supervision, Hall (2004) found that women engaged in a CBT programme in prison showed statistically significant reductions in re-incarceration. This effect was enhanced by a CBT programme plus parole supervision.

CBT generalised drug dependence

4.31 Johnson and Hunter (1992) found a reduced level of re-offending as a result of a cognitive behavioural approach against a more generic treatment programme for drug-dependent offenders at one year-follow up. Participants rated social skills training first, assertiveness training second and options appraisal third as the most useful elements of the treatment programme.

Drug-focused counselling

4.32 Pearson and Lipton (1999) reviewed 1,606 evaluations of prisons-based drug treatment programmes reported from 1968-1996. They found that drug-focused counselling was largely ineffective.

“Other structured treatment”

Multi-modal short programme

4.33 Hughey & Klemeke (1996) compared re-offending rates for completers of a five week prison treatment programme, non-completers, and a matched control group. Re-incarceration rates were lowest among the completer group, but these did not reach statistical significance

12-step meetings

4.34 Several studies have found that attendance at 12-step meetings positively influences alcohol and illicit drug use (Fiorentine 1999; Gossop et al. 2003; Humphreys and Moos 2001; Moos et al. 2001; Morgenstern et al. 1997; Morgenstern et al. 2003; Project MATCH Research Group 1997). It should be noted that attendance might not improve other outcomes such as quality of life and psychosocial functioning (Humphreys 2004).

4.35 Morgenstern et al. (2003) found that 12-step meeting attendance was the best single predictor of positive outcome following treatment for substance use disorders, a factor that increases in conjunction with severity of dependence (Tonigan et al. 1996).

4.36 There is also evidence that the probability of stable remission increases with the number of meetings attended early on (Pisani et al. 1993; Humphreys, Moos, and Cohen 1997).

Contingency Management (CM)

- ***CM and families***

4.37 Lewis and Petry (2005) studied the effect of contingency management on encouraging participation in family activities. Clients who participated (N= 29) remained in treatment longer, were abstinent for more weeks, and reported greater reduction in family conflict compared to participants who did not engage in family activities (N= 130). The significance of the finding is diluted potentially by the fact that 72 per cent of the 29 engagers were female, women having on average better outcomes to drug treatment per se than men (Dennis, Foss & Scott, 2007; Scott et al. 2005).

4.38 NICE (2007a) also concluded that contingency management for cannabis misuse did not appear to be effective during treatment as for cocaine misuse.

- ***Duration of CM Effect***

4.39 Petry et al. (2006) found that contingency management was superior to standard treatment in reduction of drug use (largely cocaine) over the first 3 months of treatment, but they found no difference in abstinence rates (CM v standard treatment) at 6- and 9th month follow-ups. A similar pattern of dilution of beneficial CM effect over time was reported by Epstein et al. (2003) in a study of cocaine use by methadone-maintained patients.

4.40 There is one robust study (Higgins et al. 1994) of the efficacy of contingency management in managing cocaine use over the course of a full year. Cocaine users in the contingency management group received a £3 voucher for each week they remained abstinent from cocaine during the first 6 weeks in treatment, a £5 voucher for each week of abstinence during the next 6 weeks in treatment and a £10 voucher each time they were found to be abstinent in checks performed at 26, 39 and 52 weeks. This voucher-based trial produced a Relative Risk of 1.42 in favour of CM over a 'standard care' intervention.

- ***CM and value of rewards***

4.41 Sindelar et al. (2007) measured the cost effectiveness of lower-value versus higher-value reward contingency management treatment for problematic cocaine users. The higher payout contingency management was calculated to be more cost-effective.

Psychodynamic interventions

4.42 NICE (2007a), in reviewing five RCT studies (Catalano 1999, Woody 1983, Woody 1983, Fals-Stewart 2001, Woody 1995), concluded that the evidence suggested mostly limited benefits from psychodynamic interventions.

Behavioural Couples Therapy

4.43 NICE (2007a) looked at three trials of couples-based interventions (Fals-Stewart 1996, Kelley 2002, Winters 2002). The evidence from these studies suggests that for individuals who have contact with a family member or carer, and who are receiving methadone maintenance treatment, the addition of behavioural couples therapy can lead to reduction in the use of illicit opioids or cocaine.

4.44 Additionally, Fals-Stewart 1997, found that behavioural couples therapy was more cost effective than individual-based treatment across a range of outcomes (e.g. days of abstinence, health and offending) for methadone maintenance patients.

Drug treatment within specialist areas of the prison or prison hospital setting

Therapeutic Communities

4.45 As a rule, therapeutic community programmes are based on the principle of social learning, with new residents given instruction in the means to a drug-free life by more established residents ('peers'). In practice, there can be variation in treatment philosophy, from a strictly behavioural hierarchical model of treatment, to a 12-step or cognitive-founded approach, or an eclectic mix of interventions.

4.46 Wexler et al. (1999) studied the effectiveness of Therapeutic Community drug treatment provided to offenders in a California prison. There were three study groups: (no treatment; TC only; TC plus a community-based aftercare programme following release). At three-year follow up, only 27 per cent of prison programme graduates who also completed community aftercare were re-incarcerated, contrasting strongly with around 75 per cent of the subjects in all other study groups who returned to prison. There has been a lower-level of return to prison among TC attendees versus non-treatment at 2 year follow-up, but this effect had eroded by the end of year 3.

4.47 A study of a Texas prison TC (Knight et al. 1999) reported similar findings. Participants were divided between Therapeutic Community attendance only, TC plus aftercare, and non-treatment [non-randomised] control group. The aftercare completers again had a lower return-to-prison rate after three years than both the TC + aftercare non-completers and the control (25 per cent vs. 41 per cent and 42 per cent, respectively).

4.48 In a Sacks et al. (2004) study of Therapeutic Community, clients were assigned randomly to either modified therapeutic community (MTC), or mental health (MH) treatment programmes. 43 of the 75 entrants to the MTC programme also entered an

aftercare programme. The results at 12 month follow-up favoured strongly MTC + aftercare (5 per cent re-incarceration) over MTC only (16 per cent) and MH (33 per cent return to custody).

4.49 As with Wexler (1999) and Knight (1999) prison TC studies, voluntary entry to aftercare represents a potential selection bias. It should also be noted that this was a study of interventions for prisoners with dual diagnosis. Smith (2006) commented that the mental health intervention group were younger, more likely to be unemployed in the year prior to imprisonment, to have used alcohol at an earlier age, and were less likely to report drugs as the principal reason for their offending

4.50 Nielsen et al. (1996) studied the impact of a combined Therapeutic Community and resettlement (work release) programme for problem drug users in a Delaware prison. Compared to non-participants, programme completers showed significant improvement in self-reported drug use and offending behaviour at 12-month follow-up. There appeared to be no appreciable difference in outcomes for course drop-outs v. non-participants.

4.51 Chanhathasilpa (2000) examined fifteen studies of outpatient drug treatment to determine the overall effectiveness of treatment programmes for chemically dependent offenders in reducing recidivism. Programmes that combined in-prison Therapeutic Communities with follow-up community treatment were regarded as effective in reducing recidivism, a finding echoed by Perry et al. (2006), in their Cochrane review of drug treatment for offenders.

4.52 NICE (2007a) judged that only two RCTs, providing data on 673 participants, (Greenwood 2001; Nemes 1999), met the eligibility criteria for inclusion in the psychosocial guidelines CG51.

4.53 NICE agreed with the conclusion reached by Smith et al. (2006), in their systematic review of TCs, that there is a lack of research assessing the effectiveness of Therapeutic Communities, or whether one type of Therapeutic Community is superior to another. They also concluded, however that: *“Prison TC may be better than prison on its own or Mental Health Treatment Programmes to prevent re-offending post-release for in-mates”*.

4.54 The finding from NTORS was that longer times in residential treatment were related to better treatment outcomes (Gossop et al. 1999) and that treatment retention was related to better methadone treatment outcomes (Gossop et al. 2001).

4.55 Farrell (2000) studied the effectiveness of therapeutic community versus a work-release programme for drug-dependent women in prison. Other than a reduction in alcohol consumption, the TC programme was found to have had no statistical significant influence on drug consumption, or on re-offending.

Residential rehabilitation

- **12-step Treatment Programmes**

4.56 NICE (2007a) assessed the effectiveness of 12-step-based residential treatment. Only one trial (Finney et al. 1998), met their inclusion criteria. This was a large prospective cohort (n=3,018) study that compared 12-step-based residential treatment with relapse-prevention CBT and eclectic (combined elements of 12-step and CBT approaches) residential treatments (Finney, 1998).

4.57 NICE concluded that the study demonstrated those in the 12-step group were more likely to remain abstinent and had fewer substance use problems than participants in the other two arms of the study, but noted that this treatment differential was modest.

Aftercare

4.58 Continuity of treatment and aftercare from prison drug treatment are extremely important from a number of perspectives. These include the short-term nature of prison sentences and rapid movements between prisons and areas; post release morbidity and recognition that risk and protective factors are managed best within a release package that addresses wrap-around resettlement services such as education, employment and housing.

National Treatment Outcomes Research Study (NTORS)

4.59 The relationship between drug use and crime is complex and makes interpretation of the drugs-crime link inherently problematic. Even so, NTORS (Gossop 2005) reviewed changes in offending behaviour after drug treatment and its findings indicate the important role that drug treatment may play in reducing some types of criminal behaviour among drug users.

Key findings include:

- There were substantial reductions in crime at all follow-up points after treatment, both for acquisitive crimes and drug selling crimes. Acquisitive and drug selling crimes after five years were reduced to about a quarter of the levels at intake.
- Clients from residential and methadone maintenance programmes, who remained in treatment for longer periods of time, achieved better crime and other outcomes than those who left earlier. Heroin users who were facing pressure from the criminal justice system when commencing treatment had worse outcomes, in terms of illicit heroin use, than other clients after treatment.
- The reductions in crime provide substantial and immediate benefits to society through the reduced economic costs of crime.

- Crime and addiction do not inevitably go together. Half of the NTORS clients reported committing no acquisitive crimes and more than two-thirds reported committing no drug offences during the period before admission.

4.60 Brown (2001) compared outcomes for an aftercare intervention comprising individual counselling, case management, skills building, family relations, harm minimisation skills and peer support provided to offenders (both newly released and those on community sentences). A no-aftercare group were followed up a control. There was a statistically significant reduction in offending at six-month follow-up; the effect became attenuated at 12 months.

Independent Factors

4.61 Studies across a number of years have identified an extensive list of external and independent risk factors for the emergence and persistence of drug dependence, and for its resistance to treatment. These indicators are:

Personal

Family factors, including family history of substance abuse
 Neighbourhood disorganisation
 Parental psychological problems
 Risk taking and sensation-seeking
 Lack of social support
 Psychiatric co-morbidity and low social attachment

Social

Life stressors
 Substance using peers
 Homelessness
 Low income
 Availability of drugs

4.62 McLellan et al. 2000; Hser 2007; Weisner et al. 2003 identified low socioeconomic status, co-morbid psychiatric conditions and lack of family and social supports among the most important predictors of relapse following treatment.

4.63 Hser at al (2007) found that relapsed drug users differed from their ‘recovered’ peers in their tendency to use substances in coping with stressful conditions, to have spouses/partners who also abused drugs, and to lack non-drug-using social support. Stable recovery among the study cohort 10 years later was predicted only by ethnicity, self-efficacy, and psychological distress.

4.64 Conversely, (Hawkins, Catalano, and Miller, 1992; West, 2001) identified external and internal protective factors (e.g., family factors such as supportive relationships, individual factors such as academic involvement and self-esteem)

4.65 Cloud & Granfield, (2004) found that the principal strategies employed by 46 formerly dependent alcohol and drug users for sustaining the cessation of addiction included engaging in alternative activities (e.g., religious conversion, returning to education, community service), relying on relationships with family and friends, and avoiding drug users and the social cues associated with use. However, the applicability of this study is limited, as participants were well educated with a history of employment.

4.66 In a review of 124 studies of recovery, White and Kurtz (2006) reached two conclusions:

1. Locating clients with high problem severity and low recovery capital within sober living communities can enhance long-term recovery outcomes

2. Post-treatment check-ups and support and assertive linkage to communities of recovery and other recovery support services can enhance significantly long-term recovery outcomes.

4.67 On this second assertion, the authors cite the finding of McKay (2005) that beneficial effects can be achieved through relatively inexpensive interventions such as telephone-based check-ups and support.

Life Skills

4.68 A review by Moos and Moos (2007) of 48 studies reporting that the odds of sustaining abstinence was positively associated with abstinence 'self-efficacy', approach coping styles, vocational engagement, income, having clean and sober friends, and having 'social and spiritual support'.

Treatment outcome indicators

4.69 Weisner, Ray, et al. (2003) and Scott, Foss, and Dennis (2003) found that long-term effects of treatment were predicted by the client's short-term response to treatment plus participation in aftercare and self-help.

4.70 These findings are consistent with developing understanding other findings in recent years that suggest strongly that a longer-term approach to drug dependence brings better outcomes than short-term (McLellan 2002; McLellan et al. 2005; Moos 2003; Weisner and Schmidt 1993, 1995; Weisner et al. 2001; Weisner 2002; Wexler et al. 1999).

4.71 Abstinence is also associated with a more 'approach' coping style (such as logical analysis, seeking guidance, problem solving, seeking alternative rewards, and positive reappraisal) (Carpenter and Hasin 1999; Chung et al. 2001; Finney and Moos 1995; Holahan et al. 2003; Moggi et al. 1999; Moos and Moos 2005).

4.72 Using a multinomial logistic regression of data from other studies, Scott et al. (2005a) found that the odds of 'sustaining recovery another year' were higher for females, those with more legal involvement, those having more clean and sober friends, and weeks of treatment but lower for those with more treatment episodes or who were homeless.

4.73 Dennis et al. (2007) studied 1,132 people entering prison, and followed up more than 94 per cent of them over the course of eight years to determine the amount of abstinence that each had been able to achieve over that time. Very similar levels of lifetime physical abuse, emotional abuse, sexual abuse and homelessness at the commencement of the study (i.e. at baseline) were found among those who eventually

managed less than one year's abstinence and the group that managed five years or more 'clean time'.

4.74 Many of the participants required several episodes of treatment across the eight years. Dennis's findings appear to support the observations of McLellan et al. (2005) that a more extended treatment approach is required for the management of many cases of dependence.

4.75 Falck, Wang, and Carlson (2006) and Scott, Foss, and Dennis (2003) reported persistent use or high relapse rates among drug users in their long-term follow-up studies. Hser, Hoffman, et al. (2001) found that even among those abstinent from heroin for as long as 15 years, a quarter had eventually relapsed during the course of the next 18 years.

4.76 Hser et al. (2007) in a regression analysis of a thirty-three year study, reported that although some heroin-dependent individuals will stop relatively early in their careers, they constitute only a minority of opiate-dependents; even among this sub² group, it takes 8 to 10 years before stable recovery is reached. Patterns of stimulant use are less well understood, but frequent use can persist over decades (Hser et al. 2007).

4.77 Dolan et al. (2003; 2005) found that retention after release in prison-initiated methadone maintenance treatment was associated with reduced mortality, re-incarceration rates and hepatitis C infection.

4.78 Simpson (1997) found that retention in treatment, (a general indicator of good outcome), was significantly associated with the quality of a relationship with the counsellor, satisfaction with treatment, attendance at education classes while in treatment (a six-fold indicator of retention), and engagement in continuing care and 12² step and other support groups in the follow-up phase.

4.79 Studies by Martin and Scarpitti (1993) and Deschenes et al. (1995) reported evidence to support intensive supervision following release. (See also section below on combining modalities.)

5. FACTORS THAT INFLUENCE EFFECTIVENESS

5.1 The factors that affect evidence are varied and complex including intensity of treatment programme; combination of treatment modalities; infrastructure support including interventions to support participation and engagement in treatment; and variables such as gender and ethnicity.

Intensity of treatment programmes and/or supervision

5.2 Taking the term 'programme' to mean either a pharmacological or psychological intervention for the treatment of problematic drug use, Holloway (2005), in her review of the effectiveness of treatment programmes in reducing drug-related crime, stated that:

'The meta-analysis showed that higher intensity programmes were 50% more likely to reduce criminal behaviour than their low intensity equivalents.....This applies to dosage levels, whether the programme is continuous or interrupted, time in treatment, whether the subject completes or terminates the programme, and whether treatments are combined in some way (e.g. detoxification plus aftercare).'

5.3 Coviello et al. (2001) found that 12-week day treatment programme more effective (to a statistically significant extent) than six-week programme. Ghodse et al. (2002) found 'intensive' aftercare more effective than 'non-intensive'.

5.4 Turner (1992) investigated the effect of intensive probation or parole for offenders versus standard supervision. She found that the intensive group secured a higher (statistically significant) rate of employment, but were returned to prison at a higher rate. The type of offences that led to breaches were of a more technical, less serious nature, suggesting to the author that this was a consequence of a higher level of probation scrutiny.

5.5 Holloway and colleagues (2005), in a systematic review of 52 studies of drug interventions for offenders, concluded that *'The evidence for treating dependence on substances other than opioids shows very limited success to date in community settings, and is non-existent in offender settings'*. The report did, however, find that *'Higher intensity programmes were more likely to result in reduction of criminal behaviour than low intensity equivalents'*. These 'higher-intensity programmes' included clinical, psychological and aftercare elements, either as single discrete interventions, or any combinations of the three components.

5.6 In a follow-up meta-analysis, Holloway et al. (2008) concluded that the two most effective interventions for the reduction of crime among drug-using offenders were Therapeutic Communities and supervision.

5.7 A major meta-analysis (Prendergast 2002) of comparison group studies found treatment reduced illicit drug use and reduced crime significantly and to clinically meaningful levels.

Combining interventions and programmes

5.8 One of the criticisms of the evidence base is that it does not sufficiently recognise comparisons between different treatment modalities and the potential for there to be mutually enhancing affects on outcomes.

5.9 NICE (2007a) compared studies from three different types of multi-modal programmes:

i. Intensive outpatient treatment (four trials – Coviello 2001; McClellan, 1993; Volpicelli 2000, Weinstein 1997)

ii. Intensive outpatient treatment with reinforcement-based treatment (Jones 2005, Silverman 2001, Silverman 2007)

iii. Structured day treatment (Avants 1999, Marlowe 2003)

NICE (2007a) concluded that:

'The evidence related to intensive outpatient treatments and day treatments (defined respectively as at least 9 and 20 hours of group work per week) does not support the notion that "more is better" when comparing more intensive treatments to standard outpatient treatment in relation to drug-use outcomes'.

None of the above studies related directly to prisons or probation.

5.10 There are also studies that have addressed the combination of prescribing either for substitution therapy or as an adjunct to detoxification with various other treatment modalities.

Opioid substitution plus CBT

5.11 NICE (2007a), in an analysis of four randomised controlled trials, concluded that relapse-prevention CBT (Epstein 2003; UKCBTMM 2004; Rawson 2002) and standard CBT (Woody, 1983) do not appear to be effective treatment options for people undergoing methadone maintenance treatment. They added, however that there was some evidence that: *'Standard CBT may be beneficial for a sub-sample who experienced high levels of psychiatric co-morbidity'.*

Opioid substitution plus Contingency Management

5.12 In reviewing the evidence related to opioid treatment plus CM (incorporating Petry et al. 2005; Silverman et al. 2004), NICE (2007a) concluded that contingency management for people undergoing methadone maintenance treatment is strongly and consistently associated with longer, continuous periods of abstinence during treatment and point abstinence at 6- and 12-month follow-up. These findings were consistent for studies using vouchers, prizes and privileges as reinforcers. However, NICE found no evidence to support CM for people undergoing buprenorphine maintenance treatment.

Opioid detoxification plus psychosocial interventions

5.13 Amato et al. (2004), in reviewing outcomes from opioid detoxification with adjunctive psychosocial interventions against unsupported detoxification, found that stand-alone detoxification was the poorer treatment option in terms of retention in treatment, completion of treatment and average time elapsed prior to relapse. The high rates of treatment drop-out and relapse (Mattick and Hall, 1996), suggest that complementary psychosocial interventions are indicated to sustain early recovery from opiate dependence. NICE, in reviewing 7 RCTs, found significant evidence in support of

family interventions (Yandoli 2002), Contingency Management (McCaul 1984), and social network interventions (Galanter 2002).

Complex needs (dual diagnosis)

5.14 Charney et al. 2001; Hesse 2004 and Watkins et al. 2006 all reported evidence that integrated mental health and drug interventions for people with combined drug and mental health problems can reduce their drug use. (See also 'Opioid substitution plus CBT' above).

Infrastructure and interventions to support participation and engagement in treatment

5.15 Amongst the factors that influence effectiveness are the infrastructure to support treatment programme delivery and interventions that are designed to support participation and engagement in treatment.

Support for carers/families

5.16 From an evaluation of three studies, (Kirby et al. 1999; Meyers et al. 2002, Copello et al. 2007) NICE (2007a) concluded that self-help interventions appear to be as effective as more intensive psychological interventions in reducing stress and improving psychological functioning for carers and families of problem drug users

Alternative therapies

5.17 Roberts et al. (2007) reviewed a Bowen 2006 study of the effect of vipassana meditation (VM) compared with a substance use treatment as usual control group (n=78). The VM group showed significantly lower levels of alcohol use after the 3 month follow up period, but no difference in re-offending was found between the groups. The authors concluded that Vipassana Meditation was effective as a treatment for alcohol-related problems, but not effective in reducing later criminal activity.

Case management

5.18 Evidence for case management as an intervention in its own right is not favourable, for example, one study assessed the effectiveness of a community-based offender case management intervention. Participants were randomly assigned to ACT (assertive community treatment) case management or to routine parole. No impact on drug use or criminality was found (Martin 1993). Also, NICE (2007a) in reviewing ten studies from the USA (e.g. Morgenstern, 2006; Needels, 2005), decided that case management has very little impact on drug use, but some effect in assisting people to access more formal treatment.

5.19 However, it is also important to recognise the potential role and contribution of case management as a supportive intervention to increase participation and engagement in treatment, especially with respect to aftercare.

Infrastructure

5.20 Aside from modality or intensity of treatment approach, Simpson (2006) found evidence that innovation adoption based on training for improving treatment engagement was significantly related to client self-reports of improved treatment participation and rapport recorded several months later, suggesting that effort to change and improve programmes may have a beneficial effect on client outcomes.

Other therapeutic factors

5.21 The therapist and client's working relationship has been shown to be significant in relation to outcomes from treatment. Orford (2008) reported that the most common positive factor attributed by UKATT (2005) clients to positive changes they had made was to relationship they had with their therapist. This was statistically superior to the clients' assessments of the beneficial impact of either of the two studied interventions.

5.22 There is evidence from Project MATCH (Connors 2000) and from other psychotherapy studies (Hanson, 2002; Martin 2000), that better treatment outcomes are associated with the rating of more positive 'working alliance' by both clients and therapists. See also Connors et al. (2000); Martin D et al. (2000); Hanson et al. (2002) and UK Alcohol Treatment Trial (UKATT) Research Team (2005).

6. FACTORS THAT INFLUENCE INTERPRETATION OF EVIDENCE

6.1 In addition to the factors that influence effectiveness there are a number of factors that influence interpretation of the evidence for effectiveness. These include methodological questions such as extrapolating evidence from community settings to the prison environment; having sufficient clarity and shared understanding of the different definitions used by researchers for particular types of interventions; having sufficient appreciation of the full range of evidence to be included and finally having a methodology by which evidence can be scored and assessed.

Extrapolating community studies to the prison setting

6.2 There is a lack of high quality research into prison drug treatment, so important evidence from community studies has been included. However, it is by no means clear that findings from these studies can be extrapolated to prison settings where there are numerous factors that would affect the delivery of the same interventions.

Clarity and understanding around definitions of various interventions

6.3 There is a need for greater clarity and understanding about the various terms used by researchers to describe psychosocial interventions and cognitive therapies e.g.

- There is a general lack of clarity in the way that psychosocial interventions are categorised. Sometime this is by treatment type, sometimes by characteristics of participants and sometimes in relation to programme intensity or the combination of delivery.
- Terms are used inter-changeably which makes it difficult to understand exactly what is being compared.
- It is not always clear what constitutes Cognitive Behavioural Therapy (CBT) as opposed to cognitive therapy or psychodynamic approaches.

6.4 One of the main implications for this is that services such as CARATs and IDTS, which use a range of psychosocial interventions including CBT are often deemed to have a negative or very low scoring evidence base. Roberts et al. (2007) asserted that: *'The 28-day [IDTS] psychosocial intervention recommended for prisoners with problematic drug use does not have a strong evidence base behind it and should be evaluated as a priority'*. The UK Drug Policy Commission (2008) offered a similar opinion.

6.5 PwC also concluded that *'more research is required on the effectiveness of the 28-day psychosocial intervention package offered by CARATs for PDUs'* (p.55). While it is true that there needs to be specific research on CARATs and effectiveness it is not straightforward to make conclusions based on related research of one element of the service. CARATs provide a range of interventions including information, advice and most importantly linkages with other treatment service within and outside the prison environment. Effectiveness of CARATs and IDTS should be considered within this broader context of infrastructure support and engagement with treatment (see below).

The lack of a comprehensive coverage of the entire research base

6.6 This paper is not intended to cover the entire evidence base and many of the reviews cited are similarly focused on specific sets of research. This is arguably true of any area of research and review of evidence; it would not be possible to include the entire evidence base in any single paper. The key issue for prison drug treatment is that there are research studies from the perspective of health that focus on drug related outcomes and there is also an evidence base from the perspective of offending behaviour that includes drug related outcomes.

6.7 Although some of the studies covered by this paper did not measure re-offending rates, reductions in drug use have often been found to be associated with rapid reductions in criminal activity (Dismuke et al. 2004; Gossop 2003). It was not the purpose of this paper to focus solely on offender outcomes but it is important that both these perspectives are included in any consideration of the evidence base.

Drug treatment, crime and coerced treatment (summarised from McSweeney, Stevens and Hunts)³

³ The quasi-compulsory treatment of drug-dependent offenders in Europe – Final National Report, England. McSweeney T., Stevens A. & Hunt N. February 2006

6.8 Large proportions of arrestees and criminals are regular users of illicit drugs. In addition, many regular users of illicit drugs also commit crimes. Drug users tend to commit more crime during periods of heavy use. However, the causal nature of the drugs-crime connection is not clear. It is likely that drug users commit crimes (and criminals take drugs) for a variety of reasons. There is a large body of literature that shows that drug treatment is effective in reducing drug use and crime, and in increasing health and employment of dependent drug users.

6.9 There was, until the 1970s, a long history of failure in coerced drug treatment. More recent efforts appear to have been more successful, although problems of high drop-out and inadequate comparison limit confidence in the findings to date. They tend to show that legally coerced treatment produces similar or better outcomes than treatment entered without legal pressure.

6.10 Hall and Wild et al. both also criticise these studies for methodological shortcomings and argue that the benefits of coerced treatment have been overstated (Hall 1997; Wild 1999).

6.11 The relationship between drug use and crime is complex and makes interpretation of the drugs-crime link inherently problematic. Even so, NTORS reviewed changes in offending behaviour after drug treatment and its findings, along with the US studies mentioned above, indicate the important role that drug treatment may play in reducing some types of criminal behaviour among drug users.

Key findings include:

- There were substantial reductions in crime at all follow-up points after treatment, both for acquisitive crimes and drug selling crimes. Acquisitive and drug selling crimes after five years were reduced to about a quarter of the levels at intake⁴.
- Clients from residential and methadone maintenance programmes, who remained in treatment for longer periods of time, achieved better crime and other outcomes than those who left earlier. Heroin users who were facing pressure from the criminal justice system when commencing treatment had worse outcomes, in terms of illicit heroin use, than other clients after treatment.
- The reductions in crime provide substantial and immediate benefits to society through the reduced economic costs of crime.
- Crime and addiction do not inevitably go together. Half of the NTORS clients reported committing no acquisitive crimes and more than two-thirds reported committing no drug offences during the period before admission.

Use of Meta-analysis and consensus on scoring methods

⁴ Gossop M., Trakada K., Stewart D. and Witton J. (2005). Reduction in criminal convictions after addiction treatment: five-year follow-up. *Drug and Alcohol Dependence*, 79, 296-302.

6.12 The standard approach to assessing the efficacy of various treatment modalities through study of the available research is meta-analysis. This is the most common method employed in producing NICE guidelines and is commonly used for Cochrane reviews.

6.13 The evidence presented in this paper is based on a number of large-scale reviews of drug treatment, related principally to people in prison, which have evaluated research studies of a high standard of academic rigour, scoring at either levels 4 and 5 on the Maryland scale of scientific methods (Sherman 1997). The Maryland scale describes increasing methodological quality as follows:

Level 1:

Observed correlation between an intervention and outcomes at a single point in time. A study that only measured the impact of the service using a questionnaire at the end of the intervention would fall into this level.

Level 2:

Temporal sequence between the intervention and the outcome clearly observed; or the presence of a comparison group that cannot be demonstrated to be comparable. A study that measured the outcomes of people who used a service before it was set up and after it finished would fit into this level.

Level 3:

A comparison between two or more comparable units of analysis, one with and one without the intervention. A matched-area design using two locations in the same country would fit into this category if the individuals in the research and the areas themselves were comparable.

Level 4:

Comparison between multiple units with and without the intervention, controlling for other factors or using comparison units that evidence only minor differences. A method such as propensity score matching, that used statistical techniques to ensure that the programme and comparison groups were similar would fall into this category.

Level 5:

Random assignment and analysis of comparable units to intervention and control groups. A well-conducted Randomised Controlled Trial fits into this category.

6.14 Only evidence drawn from either Maryland scale levels 4 or 5 has been scored Table 1. The scoring is based on the following:

1 Point:

- (a) Limited level 4 or level 5 finding for effectiveness, or
- (b) Single level 5 study demonstrating statistically significant evidence of effectiveness, but one or more other level 5 studies demonstrate ineffectiveness.

2 Points:

- (a) Single level 5 study demonstrating statistically significant effectiveness – no study demonstrating contrary findings, or
- (b) Multiple level 4 findings demonstrating statistically significant evidence for effectiveness:

3 Points:

Statistically significant evidence of effectiveness drawn from two or more level 5 studies

Table 1: Scoring Matrix for evidence of effectiveness

Interventions already available in *some* prisons are set in light grey. Interventions not currently available in prisons are set in dark grey.

Treatment Type	Reduced Drug Use	Reduced Use in Prison	Reduced Re-Offending	Total Value
12-step Programme	2			2
12-step Meetings	3			3
Therapeutic Communities	2		2	4
Case Management	1			1
Brief Interventions	3			3
Drug-Focused Counselling	1			1
Intensive Support on Release	3		3	6
Psychodynamic	1			1
Harm Reduction (Group)				0
Opioid Substitution	3	2	3	8
Naltrexone	2			2
Psychosocial Support				
Cognitive Behavioural Therapy				
For Stimulant Use	1			1
For Cannabis Dependence				0
For Methadone Maintenance Clients			0	0*
For Generalised Drug Dependence			1	1
For Women Drug Users	1		0	1
Contingency Management:				

Treatment Type	Reduced Drug Use	Reduced Use in Prison	Reduced Re-Offending	Total Value
	3		2	5
Maintenance Clients				
Other Categorisations:				
Higher-Intensity (All Treatment Types)***	2		2	4
Beneficial Non-Treatment Factors:				
Enhanced Life Skills	3		2	5

* Evidence for effectiveness in the treatment of dual diagnosis

** Evidence for improved psychological well-being among carers and families

*** Includes clinical and psychosocial programmes, and combinations of both

6.15 Although meta-analysis is a commonly used methodology and seeks to ensure that a fair and impartial evaluation is being undertaken there are nevertheless issues with respect to prison drug treatment that may need additional consideration. For example:

- Meta-analysis is dependent on there being sufficient scale to judge effects which is not always the case with drug use studies
- Meta-analysis tends to be over-reliant on studies that use Randomised Control Trials (RCTs) to judge effectiveness which can have the effect of under-valuing alternative methodologies
- Treatment effectiveness is often demonstrated in studies where a no-treatment control group is used but the same is not demonstrated when different treatment modalities are compared with each other
- RCTs will score well in meta-analysis but these studies are often not good at demonstrating interactive effects between treatments and between variables within treatments e.g. specific characteristics of the prison setting
- The results of meta-analysis are strongly influenced by the search strategies employed by the researchers . So two meta-analytic studies may well produce conflicting results depending on the peer review journal searched and the source materials included.

6.16 While the analysis used to compile table 1 provides a useful and approach to assessing the evidence, it does not take into account the above issues. It will be important in considering the evidence to find some consensus on the most suitable basis for assessing evidence that does not weaken the quality of the assessment.

7. CONCLUSION

7.1 It is well established that drug treatment for offenders can reduce both drug use and rates of re-offending. Therapeutic Communities, opioid substitution and intensive support/supervision on release have particularly strong evidential support.

7.2 Recognition of the importance of a wide range of individual, family and social risk/vulnerability factors in addiction, points to the need for a wide range of specific treatment interventions (pharmacological and psychosocial as well as other supportive 'wraparound' interventions) to achieve positive outcomes (McLellan 1993). The appropriate combination of such interventions helps individuals to re-establish their lives and integration within the community.

7.3 The specific treatment approaches used in community and prison treatment programmes address the substance use itself or address other relevant contributory factors. For example, interventions used in prison treatment include motivational approaches and positive reinforcement approaches to support abstinence. Substitute drugs are used to manage detoxification and as maintenance. Other interventions are used to address more directly the impact of particular underlying risk factors in individuals. These could include interventions to address childhood sexual or physical abuse, or to control anger management problems, or could include use of specific treatments for co-morbid disorders such as depression or psychosis.

7.4 In addition, particularly for those stabilised on medication or those working to sustain abstinence, housing, training and employment support can also help to address risk factors for relapse.

7.5 Combination of appropriate pharmacological and psychosocial interventions and other support is most likely to provide enhanced responses over individual approaches alone. However, there is a need to use the evidence base to determine the best ways in which to combine these approaches within the context of prison drug treatment and aftercare.

7.6 Having an evidence based effective treatment and aftercare system for prisons essential. Where interventions are known to be ineffective or to have negative impacts they should cease to be provided. However, the key issue is that the existing evidence base for UK prison based drug treatment is incomplete and there is a need for a national strategic approach to commissioning new evidence where this is required and agreeing a shared basis by which evidence is used and assessed that encompasses both health and offender outcomes.

REFERENCES

- Amato L, Minozzi S, Davoli M, Vecchi S, Ferri M & Mayet S (2004) Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. *Cochrane Database of Systematic Reviews* 2004, 4 CD005031
- Avants, S. K., Margolin, A., Sindelar, J. L., et al. (1999) Day treatment versus enhanced standard methadone services for opioid-dependent patients: a comparison of clinical efficacy and cost. *The American Journal of Psychiatry*, 156, 27–33.
- Bellis M A, Weild A W, Beeching N J, Mutton K & Syed Q (1997) Prevalence of HIV and injecting drug use in men entering Liverpool prison, *British Medical Journal*, July 5; 415 (7099) 30-31
- Bowen S, Witkiewitz K, Dillworth TM, Chawla N, Simpson TL, Ostafin, BD, Larimer ME, Blume AW, Parks G & Marlatt GA (2006) Mindfulness Meditation and Substance Use in an Incarcerated Population. *Psychology of Addictive Behaviours* 20(3), 343-347
- Boys A, Farrell M., Bebbington., Brugha T., Coid J., Jenkins R., Lewis G., Marsden J, Meltzer H., Singleton N., Taylor C. (2002) Drug use and initiation in prison: results from a national prison study in England and Wales.. *Addiction* **97**: 1551-1560
- Britt, C.L., Gottfredson, M.R., and Goldkamp, J.S. (1992) 'Drug testing and pretrial misconduct: an experiment on the specific deterrent effects of drug monitoring dependents on pretrial release', *Journal of Research in Crime and Delinquency*, 29(1), pp. 62-78.
- Brown, B.S., O'Grady, K.E., Battjes, R.J., Farrell, E.V., Smith, N.P., and Nurco, D.N. (2001), Effectiveness of a stand-alone aftercare programme for drug-involved offenders, *Journal of Substance Abuse Treatment*, 21, 185-192.
- Carpenter, K., and D. Hasin. 1999. Drinking to cope with negative affect and DSM-IV alcohol use disorders: A test of three alternative explanations. *Journal of Studies on Alcohol* 60: 694–704.
- Carroll, K. M., Ball, S.A., Nich, C., et al. (2001) Targeting behavioral therapies to enhance naltrexone treatment of opioid dependence: efficacy of contingency management and significant other involvement. *Archives of General Psychiatry*, 58, 755–761
- Catalano, R. F., Gainey, R. R., Fleming, C. B., et al. (1999) An experimental intervention with families of substance abusers: one-year follow-up of the focus on families project. *Addiction*, 94, 241–254.
- Chanhatasilpa, C., MacKenzie, D. and Hickman, L. (2000) 'The effectiveness of community-based programmes for chemically dependent offenders: A review and assessment of the research', *Journal of Substance Abuse Treatment*, 19, pp. 383-393.

- Charney, D. A., Paraherakis, A. M. & Gill, K. J. (2001) Integrated treatment of comorbid depression and substance use disorders. *Journal of Clinical Psychiatry*, 62, 672–677.
- Chung, T., J. Langenbucher, E. Labouvie, R. J. Pandina, and R. H. Moos. 2001. Changes in alcoholic patients' coping responses predict 12-month treatment outcomes. *Journal of Consulting and Clinical Psychology* 69 (1): 92–100.
- Cloud, W., and R. Granfield. 2004. The social process of exiting addiction: A life course perspective In *Addiction and life course*, ed. J. Blomqvist, A. Koski-Jannes, and L. Ojesjo, 185-202. Helsinki, Finland: Nordic Council on Alcohol and Drug Research.
- Connors G. J., DiClemente C. C., Dermen K. H., Kadden R., Carroll K. M., Frone M. R.(2000), Predicting the therapeutic alliance in alcoholism treatment. *J Stud Alcohol*; **61**: 139–49.
- Copello, A., Templeton, L., Orford, J. et al. (2007) The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomised trial. [Unpublished manuscript].
- Coviello, D., Alterman, A., Rutherford, M., Cacciola, J., McKay, J., and Zanis, D. (2001) 'The effectiveness of two intensities of psychosocial treatment for cocaine dependence', *Drug and Alcohol Dependence*, 61, pp. 145-154.
- Crits-Christoph, P., Siqueland, L., Blaine, J., et al. (1999) Psychosocial treatments for cocaine dependence. *Archives of General Psychiatry*, 56, 493–502.
- Dennis M L, Foss M A and Scott C K (2007), An Eight-Year Perspective on the Relationship Between the Duration of Abstinence and Other Aspects of Recovery, *Evaluation Review* 2007; 31; 585
- Department. of Health (2002), *Prevalence of HIV and hepatitis infections in the United Kingdom, Annual report of the Unlinked Anonymous Prevalence Monitoring Programme*, Dept Health, London
- Deschenes EP, Turner S & Petersilia J (1995) A dual experiment in intensive community supervision: Minnesota's prison diversion and enhanced supervised release programs. *The Prison Journal* 75(3), 330-356
- Dismuke, C. E., M. T. French, H. J. Salome, M. A. Foss, C. K. Scott, and M. L. Dennis. 2004. Out of touch or on the money: Do the clinical objectives of addiction treatment coincide with economic evaluation results? *Journal of Substance Abuse Treatment* 27 (3): 253–63.
- Dolan KA, Shearer J, MacDonald M, Mattick RP, Hall W & Wodak AS (2003) A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence* 72(1), 59-65

Dolan K A et al. (2005), Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection, *Addiction* 100, 820–828

Epstein, D. H., Hawkins, W. E., Covi, L., et al. (2003) Cognitive-behavioral therapy plus contingency management for cocaine use: findings during treatment and across 12-month follow-up. *Psychology of Addictive Behaviors*, 17, 73–82.

Falck, R., J. Wang, and R. Carlson. 2006. The natural history of crack-cocaine use: A midwestern perspective. Paper presented at the Addiction Health Service Research conference, Little Rock, AR, October.

Fals-Stewart, W., Birchler, G. R. & O'Farrell, T. J. (1996) Behavioral couples therapy for male substance-abusing patients: effects on relationship adjustment and drug-using behaviour. *Journal of Consulting and Clinical Psychology*, 64, 959–972.

Fals-Stewart, W., O'Farrell, T. J. & Bircher, G. R. (1997) Behavioral couples therapy for male substance-abusing patients: a cost outcomes analysis. *Journal of Consulting and Clinical Psychology*, 65, 789–802.

Fals-Stewart, W., O'Farrell, T. J. & Birchler, G. R. (2001) Behavioral couples therapy for male methadone maintenance patients: effects on drug-using behavior and relationship adjustment. *Behavior Therapy*, 32, 391–411.

Farrell, A. (2000). 'Women, crime and drugs: testing the effect of therapeutic communities', *Women and Criminal Justice*, 11(1), 21-48.

Finney, J. W., and R. H. Moos. (1995). Entering treatment for alcohol abuse: A stress and coping model. *Addiction* 90: 1223–40.

Finney, J. W., Noyes, C. A., Coutts A. I. et al. (1998) Evaluating substance abuse treatment process models: I. Changes on proximal outcome variables during 12-step and cognitive-behavioral treatment. *Journal of Studies on Alcohol*, 59, 371–380.

Fiorentine R (1999). After drug treatment: are 12-step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse*. 1999;25:93–116.

Galanter M; Dermatis H; Keller D; Trujillo M. (2002) Network therapy for cocaine abuse: use of family and peer supports. *American Journal on Addictions*,;11: 161-166

Ghodse, A. H., Reynolds, M., Baldacchino, A.M., Dunmore, E., Byrne, S., Oyefeso, A., Clancy, C & Crawford, V (2002) Treating an opiate dependent inpatient population: A one year follow-up study of treatment completers and noncompleters, *Addictive Behaviors*, 27, 765-778

Gordon M, Kinlock T, Schwartz R & OGrady K (2008) A randomized clinical trial of methadone maintenance for prisoners: findings at 6 months post-release *Addiction*, 103, 1333-1342

Gossop M., Trakada K., Stewart D. and Witton J. (2005). Reductions in criminal convictions after addiction treatment: five-year follow-up. *Drug and Alcohol Dependence*, 79, 296-302.

Gossop, M., Marsden, J., Stewart, D., et al. (1999) Treatment retention and 1 year outcomes for residential programmes in England. *Drug and Alcohol Dependence*, 57, 89 – 98

Gossop, M., Marsden, J. and Stewart, D. (2001): *NTORS after five years. Changes in substance use, health and criminal behaviour during the five years after intake*, National Treatment Outcome Research Study, National Addiction Centre, London.

Gossop, M., Marsden, J., Stewart, D., et al. (2003) The National Treatment Outcome Research Study (NTORS): 4–5 year follow-up results. *Addiction*, 98, 291–303.

Gossop, M (2003) Randomised and controlled, but irrelevant? In: H.Waal, E.Haga (eds.). *Maintenance Treatment of Heroin: Evidence at the Crossroads*. Akademisk Forlag, Oslo.

Greenwood, G. L., Woods, W. J., Guldish, J., et al. (2001) Relapse outcomes in a randomised trial of residential and day drug abuse treatment. *Journal of Substance Abuse Treatment*, 20, 15–23.

Haapanen, R. and Britton, L. (2002) 'Drug testing for youthful offenders on parole: An experimental evaluation', *Criminology and Public Policy*, 1(2), pp. 217-244

Hall E, Prendergast M, Wellisch J & Cao Y (2004), Treating drug-abusing women prisoners: an outcomes evaluation of the Forever Free programme, *The Prison Journal*, 84, 1, 81-105

Hanson W. E., Curry K. T., Bandalos D. L. (2002) Reliability generalization of working alliance inventory scale scores. *Educ Psychol Meas*; 62: 659–73.

Hawkins, J., R. Catalano, and J. Miller (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin* 112:64-105.

Health Protection Agency (2007) Hepatitis C in England The Health Protection Agency Annual Report 2007

Hesse, M. (2004) Achieving abstinence by treating depression in the presence of substance-use disorders. *Addictive Behaviors*, 29, 1137–1141

Higgins, S. T., Budney, A. J., Bickel, W. K., et al. (1994) Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. *Archives of General Psychiatry*, 51, 568–576.

Holloway K, Bennett T & Farrington D (2005) The effectiveness of criminal justice and treatment programmes in reducing drug-related crime: a systematic review. Home Office Online Report 26/05. Home Office; London

Holloway K, Bennett T & Farrington D (2008) Effectiveness of Treatment in Reducing Drug-Related Crime. Report for Bra. Bra, Sweedon. Holahan, C. J., R. Moos, C. K.

Holahan, R. Cronkite, and P. K. Randall. 2003. Drinking to cope and alcohol use and abuse in unipolar depression: A 10-year model. *Journal of Abnormal Psychology* 112: 159–65.

Home Office (2003) An Analysis of CARAT Research Data as at 3 December 2002. Research, Development and Statistics Directorate, Home Office, London.

Hough, M., Clancy, A., McSweeney, T., and Turnbull, P.J. (2003) 'The impact of drug treatment and testing orders on offending: two year reconviction results', Home Office Research Findings No. 184, London: Home Office.

Hser, Y., D. Huang, C.-P. Chou, and M. D. Anglin. (2007). Trajectories of heroin addiction: Growth mixture modelling results based on a 33-year follow-up study. *Evaluation Review* 31(6): 548-563.

Hser, Y., V. Hoffman, C. E. Grella, and M. D. Anglin. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry* 58:503-8.

Hubbard, R. L., Craddock, S. G., Flynn, P. M., Anderson, J., & Etheridge, R. M. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviours*, 11(4), 261-278

Hughey, R., and Klemke, L.W. (1996) 'Evaluation of a jail-based substance abuse treatment program', *Federal Probation*, 60(4), pp 40-44.

Humphreys K (2004), *Circles of Recovery: self help organizations for addictions*. Cambridge University Press, UK.

Humphreys, K. 1991. Factors predicting attendance at self-help groups after substance abuse treatment. *Journal of Consulting & Clinical Psychology* 594:591-3.

Humphreys, K., Mankowski, E., Moos, R., & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, 21(1), 54-60.

- Humphreys K., and R. Moos. 2001. Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care: A quasi-experimental study. *Alcoholism: Clinical and Experimental Research* 255:711-6.
- Humphreys, K., R. J. Moos, and C. Cohen. 1997. Social and community resources and longterm recovery from treated and untreated alcoholism. *Journal of Studies on Alcohol* 58:231-238.
- Jason, L. A., Davis, M. I., Ferrari, J. R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*, 31(1), 1-27.
- Johnson G & Hunter R (1992), Evaluation of the Specialized Drug Offender Program, Centre for Action Research, University of Colorado, Boulder.
- Jones, H. E., Wong, C. J., Tuten, M., et al. (2005) Reinforcement-based therapy: 12-month evaluation of an outpatient drug-free treatment for heroin abusers. *Drug and Alcohol Dependence*, 79, 119–128.
- Jones, P.R., and Goldkamp, J.S. (1993) 'Implementing pretrial drug-testing programs in two experimental sites: some deterrence and jail bed implications', *The Prison Journal*, 73(2), pp. 199- 219.
- Judd, A., Hickman, M., Jones, S., et al. (2005) Incidence of hepatitis C virus and HIV among new injecting drug users in London: prospective cohort study. *British Medical Journal*, 330, 24–25.
- Kelley, M. L. & Fals-Stewart, W. (2002) Couples- versus individual-based therapy for alcohol and drug abuse: effects on children's psychosocial functioning. *Journal of Consulting and Clinical Psychology*, 70, 417–427.
- Kirby, K. C., Marlowe, D. B., Festinger, D. S., et al. (1999) Community reinforcement training for family and significant others of drug abusers: a unilateral intervention to increase treatment entry of drug users. *Drug and Alcohol Dependence*, 56, 85–96.
- Knapp WP, Soares BGO, Farrell M, Lima MS (2001) Psychosocial interventions for cocaine and psychostimulant amphetamines related disorders. *Cochrane Database of Systematic Reviews* 2001, 3 CD003023
- Knight, J. R., Shrier, L. A., Bravender, T. D., et al. (1999) A new brief screen for adolescent substance abuse. *Archives of Pediatrics and Adolescent Medicine*, 153, 591–596.
- Laub, J. H., and R. J. Sampson. 1993. Turning points in the life course: Why change matters to the study of crime. *Criminology* 31 (31): 301-25.
- Laub, J. H., and R. J. Sampson. 2003. Shared beginnings, divergent lives: Delinquent boys to age 70. Cambridge, MA: Harvard University Press.

Laudet A, Stanick V & Sands B (2007) An Exploration of the Effect of On-Site 12-Step Meetings on Post-Treatment Outcomes among Polysubstance-Dependent Outpatient Clients. *Evaluation Review* Volume 31 Number 6 December 2007 613-646

Lewis M & Petry N (2005), Contingency management treatments that reinforce completion of goal-related activities: Participation in family activities and its association with outcomes, *Drug and Alcohol Dependence* 79 267–27

McBride, D.C., and Inciardi, J.A. (1993) 'The focused offender disposition program: philosophy, procedures, and preliminary findings', *Journal of Drug Issues*, Winter, pp. 143-160.

McCaul ME, Stitzer ML, Bigelow GE, Liebson IA (1984). Contingency management interventions: effects on treatment outcome during methadone detoxification. *Journal of Applied Behaviour Analysis* 17(1):35-43.

McKay, J. R., Lynch, K. G., Shephard, D. S., & Pettinati, H. M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence. *Archives of General Psychiatry*, 62(2), 199-207.

McLellan, A. T., D. C. Lewis, C. P. O'Brien, and H. D. Kleber. 2000. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association* 284:1689-95.

McLellan, A. T. 2002. Have we evaluated addiction treatment correctly? Implications from a chronic care perspective. *Addiction* 97 (3): 249-52.

McLellan, A. T., Arndt, I. O., Metzger, D. S., et al. (1993) The effects of psychological services in substance abuse treatment. *The Journal of the American Medical Association*, 269, 1953–1959.

McLellan, A. T., J. R. McKay, R. Forman, J. Cacciola, and J. Kemp. 2005. Reconsidering the evaluation of addiction treatment: From retrospective follow-up to concurrent recovery monitoring. *Addiction* 100 (4): 447-58

McSweeney T., Stevens A. & Hunt N. (2006), *The quasi-compulsory treatment of drug-dependent offenders in Europe – Final National Report*, England.

Marlowe, D. B., Kirby, K. C., Festinger, D. S., et al. (2003) Day treatment for cocaine dependence: incremental utility over outpatient counseling and voucher incentives. *Addictive Behaviors*, 28, 387–398.

Marsch, L. (1998) 'The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: a meta-analysis', *Addiction*, 93(4), pp. 515-532.

Martin, S. S. & Scarpitti, F. R. (1993) An intensive case management approach for paroled IV drug users. *The Journal of Drug Issues*, 23, 43–59.

Martin, S. S., Butzin, C. A., Saum, C. A., & Inciardi, J. A. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. *The Prison Journal*, Vol. 79, pp. 294-320

Martin D. J., Garske J. P., Davis M. K. (2000), Relation of the therapeutic alliance with outcome and other variables: a metaanalytic review. *J Consult Clin Psychol*; **68**: 438–50

Marzillier, J. (2004), The myth of evidence based psychotherapy, *The Psychologist*, vol. 17, no 7, pp 392-395

Mattrick RP and Hall W (1996) Are detoxification programmes effective? *The Lancet*, 347: 97-100.

Maude-Griffin, P. M., Hohenstein, J. M., Humfleet, G. L., et al. (1998) Superior efficacy of cognitive-behavioural therapy for urban crack cocaine abusers: main and matching effects. *Journal of Consulting and Clinical Psychology*, 66, 832–837.

Meyers, R. J., Miller, W. R., Smith, J. E., et al. (2002) A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology*, 70, 1182–1185.

Mitchell, O., MacKenzie, D.L. and Wilson, D.B. (2006) Incarceration-based drug treatment', in B.C. Welsh and D.P. Farrington (Eds.): *Preventing Crime: What Works for Children, Offenders, Victims and Places* (103-116), Dordrecht, Netherlands: Springer.

Moggi, F., P. C. Ouimette, R. H. Moos, and J. W. Finney. 1999. Dual diagnosis patients in substance abuse treatment: Relationship of general coping and substance-specific coping to 1-year outcomes. *Addiction* 94 (12): 1805–16.

Moos, R., J. Schaefer, J. Andrassy, and B. Moos. 2001. Outpatient mental health care, self-help groups, and patients' one-year treatment outcomes. *Journal of Clinical Psychology* 57(3): 273-87.

Moos, R. H. 2003. Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors* 17:3-12.

Moos, R. H., and B. S. Moos. 2004. Long-term influence of duration and frequency of participation in alcoholics anonymous on individuals with alcohol use disorders. *Journal of Consulting and Clinical Psychology* 72 (1): 81-90.

Moos, R. H., and B. S. Moos. 2006. Rates and predictors of relapse after natural and treated remission from alcohol use disorders. *Addiction* 101:212-22.

Moos, R. H., and B. S. Moos. 2007. Treated and untreated alcohol use disorders: course and predictors of remission and relapse. *Evaluation Review* 31(6): 564-584.

Moos, R. H. and B. S. Moos. 2005. Sixteen-year changes and stable remission among treated and untreated individuals with alcohol use disorders. *Drug and Alcohol Dependence* 80 (3): 337-47.

Morgenstern, J., E. Labouvie, B. S. McCray, C. W. Kahler, and R. M. Frey. 1997. Affiliation with Alcoholics Anonymous after treatment: A study of its therapeutic effects and mechanisms of action. *Journal of Consulting and Clinical Psychology* 65:768-77.

Morgenstern, J., D. Bux, E. Labouvie, T. Morgan, K. A. Blanchard, and F. Muench. 2003. Examining mechanisms of action in 12-step community outpatient treatment. *Drug and Alcohol Dependence* 72:237-47.

Morgenstern, J., Blanchard, K. A., McCrady, B. S., et al. (2006) Effectiveness of intensive case management for substance-dependent women receiving temporary assistance for needy families. *American Journal of Public Health*, 96, 2016-2023.

National Institute for health and Clinical Excellence (2007a) CG51 Clinical guideline 51 Drug use: psychosocial interventions, London

National Institute for Health & Clinical Excellence (2007b), Naltrexone for the management of opioid dependence NICE technology appraisal guidance 115, London

National Offender Manager Service (2008), Random mandatory drug testing figures, July 2008, Interventions Group & Substance Misuse

Needels, K., James-Burdumy, S. & Burghardt, J. (2005) Community case management for former jail inmates: its impacts on rearrest, drug use, and HIV risk. *Journal of Urban Health*, 82, 420-433

Nemes, S., Wish, E. D. & Messina, N. (1999) Comparing the impact of standard and abbreviated treatment in a therapeutic community. Findings from the district of Columbia treatment initiative experiment. *Journal of Substance Abuse Treatment*, 17, 339-347.

Nielsen A L, Scarpitti F R & Inciardi J (1996,) Integrating the Therapeutic Community and Work Release for Drug-Involved Offenders. The CREST Program *Journal of Substance Abuse Treatment*, Vol. 13, No. 4, pp. 349-358, 1996

Orford, J (2008) Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. *Addiction*, 103, 875-85, 2008

Pearson, F. and Lipton, D. (1999) 'A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse', *Prison Journal*, 79 (4), pp. 384-410.

Perry A, Coulton S, Glanville J, Godfrey C, Lunn J, McDougall C & Neale Z (2006), Interventions for drug-using offenders in the courts, secure establishments and the community (Review), Cochrane Database of Systematic Reviews 2006, Issue 3. Art. No.: CD005193. DOI: 10.1002/14651858.CD005193.pub2.

Petry, N.M., Alessi, S.M., Carroll, K.M, et al. (2006). Contingency management treatments: Reinforcing abstinence versus adherence with goal related activities. *Journal of Consulting and Clinical Psychology*, 74, 592-601

Petry, N. M., Martin, B. & Simcic, F. Jr. (2005c) Prize reinforcement contingency management for cocaine dependence: integration with group therapy in a methadone clinic. *Journal of Consulting and Clinical Psychology*, 73, 354–359.

Pisani, V. D., J. Fawcett, D. C. Clark, and M. McGuire. 1993. The relative contributions of medication adherence and AA meeting attendance to abstinent outcome of chronic alcoholics. *Journal of Studies on Alcohol* 54:115-19.

Prendergast M.L., Podus D., Chang E. and Urada D. (2002). The effectiveness of drug abuse treatment: a meta-analysis of comparison group studies. *Drug and Alcohol Dependence*, 67, 53-72

Project MATCH Research Group. 1997. Matching alcoholism treatments to client heterogeneity: Project MATCH Post-treatment drinking outcomes. *Journal of Studies on Alcohol* 58 (1): 7-29.

Rawson, R. A., Huber, A., McCann, M., et al. (2002) A comparison of contingency management and cognitive-behavioral approaches during methadone maintenance treatment for cocaine dependence. *Archives of General Psychiatry*, 59, 817–824.

Roberts A J, Hayes A J, Carlisle J & Shaw J (2007), Review of Drug and Alcohol Treatments in Prison and Community Settings. A Systematic Review Conducted on Behalf of the Prison Health Research Network, University of Manchester, November 2007

Rossman S, Sridharan S, Gouvis C, Buck J, Morley E (1999). Impact of the Opportunity to Succeed (OPTS) aftercare program for substance-abusing felons: Comprehensive final report Washington D.C. Urban Institute, 1999

Sacks S, Sacks JY, McKendrick K, Banks S & Stommel J (2004) Modified TC for MICA inmates in correctional settings: crime outcomes. *Behavioural Sciences and the Law* 22(4), 477-501

Sampson, R. J., and J. H. Laub. 1992. Crime and deviance in the life course. *Annual Review of Sociology* 8:63-84.

Scott, C. K, M. A. Foss, A. J. Lurigio, and M. L. Dennis. 2003. Pathways to recovery after substance abuse treatment: Leaving a life of crime behind. *Evaluation and Program Planning* 26 (4): 403–12.

Scott, C. K., M. A. Foss, and M. L. Dennis. 2005a. Pathways in the relapse, treatment, and recovery cycle over three years. *Journal of Substance Abuse Treatment* 28 (2S): S63–S72.

Sherman (1997) Maryland Scale of Scientific Methods www.gsr.gov.uk/professional-guidance

Shewan, D. et al. (1994). Prison as a modifier of drug using behaviour. *Addiction Research* 2(2): 203-215

Shewan, D., H. Stöver and K. Dolan (2005). Injecting in prisons. In: R. Pates, A. McBride and K. Arnold. *Injecting illicit drugs*. Oxford, Blackwell: 69-81

Silverman, K., Svikis, D., Robles, E., et al. (2001) A reinforcement-based therapeutic workplace for the treatment of drug abuse: six-month abstinence outcomes. *Experimental and Clinical Psychopharmacology*, 9, 14–23.

Silverman, K., Robles, E., Mudric, T., et al. (2004) A randomized trial of long-term reinforcement of cocaine abstinence in methadone-maintained patients who inject drugs. *Journal of Consulting and Clinical Psychology*, 72, 839–854.

Silverman, K., Wong, C. J., Needham, M., et al. (2007) A randomized trial of employment-based reinforcement of cocaine abstinence in injection drug users, *Journal of Applied Behaviour Analysis*, 40, 387-410

Simpson D, Joe G and Rowan-Szal G (2007). Linking the elements of change: Program and client responses to innovation, *Journal of Substance Abuse Treatment* 33, 2, 111-120

Simpson, D., Joe, G.W., and Brown, B.S. (1997) Treatment retention and follow-up outcomes in the drug abuse treatment outcome study (DATOS), *Psychology of Addictive Behaviours*, 11(4), 294-307

Sindelar, J., Elbel, B. & Petry, N.M. (2007) What do we get for our money? Cost effectiveness of adding contingency management. *Addiction*, 102, 309–316.

Smith, L. A., Gates, S. & Foxcroft, D. (2006) Therapeutic communities for substance related disorder. *Cochrane Database of Systematic Reviews*, 1, CD005338.

Stallwitz A & Stover H (2007) The impact of substitution treatment in prisons - A literature review *International Journal of Drug Policy* 18 (2007) 464–474

Stephens, R. S., Roffman, R. A. & Curtin, L. (2000) Comparison of extended versus brief treatments for marijuana use. *Journal of Consulting and Clinical Psychology*, 68, 898–908.

Stephens, R. S., Babor, T. F., Kadden, R., et al. (2002) The Marijuana Treatment Project: rationale, design and participant characteristics. *Addiction*, 97 (Suppl. 1), 109–124.

Strathdee, S. A., Ricketts, E. P., Huettner, S., et al. (2006) Facilitating entry into drug treatment among injection drug users referred from a needle exchange program: results from a community-based behavioral intervention trial. *Drug and Alcohol Dependence*, 83, 225–232

Tonigan, J. S., R. Toscova, and W. R. Miller. (1996). Meta-analysis of the literature on Alcoholics Anonymous: Sample and study characteristics moderate findings. *Journal Studies on Alcohol* 57:65-72.

Turner, S., Petersilia, J. and Deschenes, E.P. (1992) Evaluating intensive supervision probation/parole (ISP) for drug offenders, *Crime and Delinquency*, 38(4), 539-556. Offender Health

Turner, S., Greenwood, P., Fain, T., and Deschenes, E. (1999) 'National Drug Court Institute review: perceptions of drug court: How offenders view ease of program completion, strengths and weaknesses, and the impact on their lives,' *National Drug Court Review* 2(1), pp. 61-86.

UKCBTMM Project Group (2004) The Effectiveness and Cost Effectiveness of Cognitive Behaviour Therapy for Opiate Misusers in Methadone Maintenance Treatment: a Multicentre, Randomised, Controlled Trial. Final Report to the Funding Organisation: R & D Directorate of the Department of Health as Part of the Drug use Research Initiative. London: Dept Health.

UK Alcohol Treatment Trial (UKATT) Research Team (2005). Effectiveness of treatment for alcohol problems: findings of the randomised United Kingdom Alcohol Treatment Trial (UKATT). *BMJ* 2005; **331**: 541–4.

UK Drug Policy Commission (2008), *Reducing Drug Use, Reducing Re-offending*, London, ISBN 978-1-906246-05-1

Volpicelli, J. R., Markman, I., Monterosso, J., et al. (2000) Psychologically enhanced treatment for cocaine-dependent mothers: evidence of efficacy. *Journal of Substance Abuse Treatment*, 18, 41–49.

Watkins, K. E., Paddock, S. M., Zhang, L., et al. (2006) Improving care for depression in patients with comorbid substance misuse. *American Journal of Psychiatry*, 163, 125–132.

Weild A R (2000), Prevalence of HIV, hepatitis B and hepatitis C antibodies in prisoners in England and Wales, a national survey, *Comm Dis Public Health*, **3** (2)121-126

Weinstein, S. P., Gottheil, E. & Sterling, R. C. (1997) Randomized comparison of intensive outpatient vs. individual therapy for cocaine abusers. *Journal of Addictive Diseases*, 16, 41–56.

Weisner, C., and L. Schmidt. (1993). Alcohol and drug problems among diverse health and social service populations. *American Journal of Public Health* 83 (6): 824-29

Weisner, C., G. T. Ray, J. R. Mertens, D. D. Satre, and C. Moore. (2003). Short-term alcohol and drug treatment outcomes predict long-term outcome. *Drug and Alcohol Dependence* 107 (3): 281-94.

Weisner C, (1995). The community epidemiology laboratory: Studying alcohol problems in community and agency-based populations. *Addiction* 90 (3): 329-41.

Weisner C (2002). What is the scope of the problem and its impact on health and social systems? In *Changing substance abuse through health and social systems*, ed. W. R. Miller and C. M. Weisner, 3-14. New York: Kluwer Academic/Plenum.

West, R. (2001). Theories of addiction (editorial). *Addiction* 96:3-13.

Wexler, H. K., Melnick, G., Lowe, L., & Peters, J. (1999). 3-year reincarceration outcomes for amity in-prison therapeutic community and aftercare in California. *The Prison Journal*, Vol. 79, pp. 321-336

White W and Kurtz E (2006), *Recovery: Linking addiction treatment and communities of recovery: a primer for counselors*.

http://www.facesandvoicesofrecovery.org/pdf/White/recovery_monograph_06.pdf

Winters, J., Fals-Stewart, W., O'Farrell, T. J., et al. (2002) Behavioral couples therapy for female substance-abusing patients: effects on substance use and relationship adjustment. *Journal of Consulting and Clinical Psychology*, 70, 344–355.

Woody, G. E., Luborsky, L., McLellan, A. T., et al. (1983) Psychotherapy for opiate addicts. Does it help? *Archives of General Psychiatry*, 40, 639–645.

Woody, G. E., McLellan, A. T., Luborsky, L., et al. (1995) Psychotherapy in community methadone programs: a validation study. *The American Journal of Psychiatry*, 152, 1302–1308.

Yandoli D, Eisler I, Robbins C, Mulleady G, Dare C. A comparative study of family therapy in the treatment of opiate users in a London drug clinic. *The Association for Family Therapy and Systemic Practice* 2002;24:402-22.

Prison Drug Treatment Strategy Review Group

Outcomes Review Report 2009

1. TASK FOR THE REVIEW GROUP

The Prison Drug Treatment Strategy Review Group are asked to determine and agree the key outcomes needed for prisoners and offenders, both in prison and on release into the community.

2. BACKGROUND CONTEXT

2.1 In considering the above, the Review Group must take into account and have an understanding of the national context and the key factors that are currently shaping the drug treatment sector and which may have an impact in determining outcomes for drug-using prisoners and offenders. These are briefly summarised below:

The 2008 Drug Strategy

The National Drug Strategy, *Drugs: protecting families and communities (2008)*, provides the policy context within which the work of the Review Group, including work on outcomes, must be considered. The Drugs Strategy features an undertaking to get drug-misusing offenders into effective treatment and to improve prison treatment programmes. The strategy also concentrates more on families, addressing the needs of parents and children, and working with whole families to prevent drug use, reduce risk, and get people into treatment (*see Sections 6 and 7 of this paper*).

Treatment Effectiveness

2.3 National and international evidence shows that good quality drug treatment can be effective in reducing illegal drug use, improving the health of drug users, reducing drug-related offending, reducing the risk of death due to overdose, reducing the risk of death due to infections (such as blood borne viruses) and improving social functioning.

2.4 With the development of the National Treatment Agency's (NTA) *Models of Care for the treatment of adult drug users: Update 2006*, there has been a greater focus on improving drug users' experience across the treatment system. It is recognised that drug treatment is not so much a singular event as a process, usually involving engagement with different drug treatment services, perhaps over many years. Every drug user's treatment needs are different and depend on a range of factors that often vary across time, including health status, relationships, accommodation, nature of the drug problem and the quality of the drug treatment or treatments they receive.

2.5 Drug treatment use is also often episodic, with drug users dipping in and out of treatment over time. Evidence indicates that entry into treatment often has an immediate positive impact on drug use and crime. However, this may not be sustained if the drug user is not retained in treatment. Optimised treatment usually involves retaining drug users in treatment for a minimum of three months. This is the point at which treatment begins to accrue generalised long-term benefits.

The 'Recovery' Debate

2.6 There is an ongoing debate in the UK that has misleadingly portrayed abstinence and maintenance approaches to drug treatment as an antagonistic 'either/or' issue, with little reference to the evidence on treatment effectiveness, which indicates a treatment system should be composed of a range of different services to meet different needs.

2.7 This debate appears to be diverting attention away from key issues such as whether drug users in need of treatment have enough choice, the variability in quality of services, and the focus on outputs such as numbers in treatment, rather than outcomes.

2.8 The UK Drug Policy Commission established a consensus group to agree a definition and published a vision statement in their document *The UK Drug Policy Commission Recovery Consensus Group. A vision of recovery (July 2008)*:

'The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.'

Effective Drug Treatment in Prisons

2.9 There is no doubt that prison presents a great opportunity to help those who want to be drug free. There are now increasing opportunities for drug-using offenders in prison who are assessed as requiring drug-replacement for a period of time. Effective drug treatment raises considerably the quality of prison life, for example, reduced illicit drug use by an offender can result in better health outcomes for that individual.

2.10 Prison treatment goals have a key influence on the treatment modalities available in prison and on defining prison treatment outcomes. Treatment goals will depend very much on individual need at the time. The effectiveness of prison treatment, when judged against most potential outcomes, is influenced by Prison Service treatment policy, which is to provide appropriate treatment and support for those who have the goal to be drug free (this may be a less realistic goal for those in prison for only a short length of time).

Reintegration/Continuity of care

2.11 The effectiveness of prison treatment is influenced as much by the interventions and support received in the community and the extent to which reintegration needs are met. If accommodation needs, benefits support, education and training, family linkage and ultimately, employment needs are met, most drug treatment modalities, wherever delivered, are far more likely to be effective. If these needs are not met this will reduce considerably the likelihood of successful reintegration.

2.12 This effect is much more pronounced for those staying in prison for short periods of time (the majority of prisoners).

2.13 The above issues are discussed in more detail in the attached Annex A.

3. ESTABLISHING OUTCOMES IN PRISON

3.1 The range of existing outputs data, outcomes, surveys, etc. presents potentially a very complex picture that creates difficulties in establishing and measuring prison treatment outcomes. Whilst some treatment outcomes may be common to all prisoners, outcomes may vary considerably and in a way that is not always readily quantifiable. Factors that will have an impact include:

- Gender, age, ethnicity;
- Nature/severity of drug dependency;
- Treatment goals;
- Type and quality of treatment provided;
- Extent of co-morbidity;
- Levels of accommodation and support post release
- Length of time in prison; and
- Discharge distance from home.

3.2 Thought clearly needs to be given to establishing an outcome based model or framework, which should be considered appropriate for use.

3.3 Arguably, the key outcome measure of interest to the public will be of sustained stability post-release (however, this is measured e.g. reduction in illicit drug use, sustained abstinence, reduction in crime, etc.). However, other measures, such as health outcomes should also be considered, including prevention of the spread of blood borne viruses.

3.4 Another key question to consider is whether it is best to focus on developing a few high-level outcomes that apply universally to all prisoners or develop a more complex matrix of outcomes, which more closely reflects prisoner segmentation. Thought also needs to be given to how all potential outcomes are measured.

3.5 The Review Group will need to make decisions as to what can be used as 'evidence' i.e. there is a risk that if the Review Group is too restrictive as to what is evidence they may miss the opportunity to develop key outcomes but if the Review Group is too flexible they may lead to straying from effective, evidence-based practice.

3.6 Therefore, the Review Group need to consider a programme of work that determines:

- What are the key outcomes for offenders in prison and for offenders on release into the community (i.e. continuity of care);
- What are the factors that will impact on potential prison and community-based outcomes;
- What can be learnt from the existing evidence-base and what are the gaps;
- What outcomes can be measured (including what output and outcome monitoring tools already exist in the community and in prisons);

- What are the existing initiatives and strategies that would have an impact on this work, such as the Reducing Re-offending National Action Plan, the Drug System Change Pilots, The NHS Operating Framework, Treatment Outcomes Profile (TOP), etc.; and
- Users and carers views on what constitute desirable outcomes.

3.7 There is a wide range of literature on outcomes, so to assist the Review Group the attached paper in Annex 1 is intended to provide a summary of the issues to help inform discussions, but it is important to note that the information provided is in no way definitive. The attached summary paper includes:

- Background information on outcomes measures;
- Factors that affect outcomes in prisons;
- An outline of Government targets; and
- An outline of existing relevant output data/information, outcome measures and surveys, etc.

3.8 The attached paper (Annex 1) needs to be read in conjunction with the paper on the evidence-base.

Annex 1

REVIEW GROUP SUMMARY PAPER ON OUTCOMES

1. INTRODUCTION

- 1.1 The last ten years have seen significant improvements in the provision of drug services. There are now far more people in treatment than ten years ago, waiting times have fallen sharply and there is a range of good practice in multi-agency working.
- 1.2 The Drug Strategy acknowledges that while there have been successes particularly in fast-tracking people into treatment, there is a need to focus more upon the outcomes of treatment, including its impact on crime, health, and harms caused to families.
- 1.3 Treatment to address drug use can take many forms. The evidence base informs national policy and the regional and local decisions that are made to provide the best outcomes for those using drugs, both in prisons and in the community. There is evidence that interventions, which aim to reduce offending by addressing the drug use of dependent users who offend, do work to reduce offending. Research shows that drug treatment can achieve reductions in offending behaviour.
- 1.4 The Drug Strategy also states that aftercare and wraparound provision are associated with better outcomes for prisoners. Treatment is often most effective when combined with additional support to tackle the underlying contributory issues such as homelessness, long-term unemployment or mental health problems. Evidence cited by the Drug Strategy, for example, demonstrates that mental health problems suffered by drug users, left unaddressed, can impact negatively on drug treatment outcomes.
- 1.5 The Price Waterhouse Cooper (PwC) report, *Review of Prison-Based Drug Treatment Funding (2007)* was conducted within the policy context of the Drug Strategy. The PwC report considered what realistic, achievable and measurable outcomes could be set for the provision of drug treatment in prisons. The report's recommendations on outcomes are to:
 - 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 understand how their performance contributes to the achievement of the outcomes; and
 - Set out how current activities (initiatives) align with key outcomes and design others to fill gaps.

2. BACKGROUND CONTEXT ON OUTCOMES

- 2.1 Outcomes are simply the effects or changes brought about by the activities of an organisation or individuals. An outcome is the measurement of the effectiveness of an activity, rather than its size, efficiency or productivity.
- 2.2 It must be noted that outputs and outcomes are often imposed by Government, so they are rarely within the control and influence of the organisations to which the outcomes are assigned.
- 2.3 That said, an outcomes approach can help organisations deliver more effective services for their client group by making services more user-focused and needs led, identifying what works well in services and what could be improved. Other benefits include:
- Improved and shared clarity of what organisations, Government Departments or services are trying to achieve;
 - Assists services in creating structure and focus to client-worker interactions through regular reviews that cover outcomes areas;
 - Encourages staff and clients by providing evidence of progress; and
 - A means to reviewing whether funding allocations are cost-effective and needs based.
- 2.4 Drug treatment outcome studies, such as the National Treatment Outcomes Research Study (NTORS), have played an important role in improving our understanding of treatment effectiveness. They provide information about drug users and their problems as well as the nature of their involvement with treatment services. They can also help us to understand the changes that occur in drug use and other problem behaviours after treatment. These studies tend to group drug treatment outcomes into four key domains:
- Drug and alcohol use
 - Physical and psychological health
 - Social functioning
 - Offending and criminal involvement
- 2.5 These domains should already be used in care planning and in care plan reviews. Some validated tools to measure outcomes in drug treatment do already exist. However, these are relatively long and complex and there is no widespread agreement on which is the most suitable and in what context. The challenge has been to develop a simple but effective, validated tool that can be incorporated into national monitoring systems such as the National Drug Treatment Monitoring System (NDTMS) and regular care plan reviews by keyworkers.
- 2.6 Moreover, the interventions taking place during treatment are just part of a much wider range of factors that can influence outcomes. In many cases, treatment may be neither the most important nor the most powerful influence upon outcomes. Environmental supports and stresses can influence outcomes.

Peer and family relationships, unemployment and living arrangements can all have an important effect. The gains produced by an effective treatment programme can be undermined or neutralised by adverse social and environment factors.

- 2.7 The National Treatment Agency for Substance Misuse (NTA) has developed the Treatment Outcomes Profile (TOP), which is being used by drug services in the community in England. TOP is an instrument for drug treatment service outcomes monitoring and related research applications. However, it is too early to assess the effectiveness of TOP as a national outcome monitoring tool and in its current form may not be appropriate for use in prisons (more details on TOP can be found in section 5.15).
- 2.8 While there are data on outputs on drug-using offenders in prison, there is currently little evidence or data that indicate the positive outcomes for drug-using offenders in prison of treatment programmes i.e. prescribing programmes or psychosocial programmes for drug-using offenders aiming to remain drug free.

3. OUTLINE OF GOVERNMENT TARGETS

- 3.1 One of the difficulties of establishing national outcomes measures arises from the fact that each government department has its own aims and objectives, for example:
- Ministry of Justice – To protect the public and reduce re-offending
 - Department of Health – Improve the health and well-being of people in England
 - Home Office – Reduce the harm that drugs cause to society, to communities, individuals and their families.
- 3.2 These aims are monitored through Public Service Agreements (PSAs). The PSA target that measures drug treatment in the community and prison is *PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs*.
- 3.3 Each Government Department also has departmental Strategic Objectives (DSOs), for example, the Ministry of Justice's DSO is to *Support the efficient and effective delivery of justice*.
- 3.4 Local Area Agreements (LAAs) are the mechanism by which central Government sets improvement targets for outcomes to be delivered through local government in England. These targets are selected from a set of 198 national indicators (NIs) for local authorities and their partners. There are a number of national indicators (NIs) relevant to drug users such as *NI 40: number of drug users recorded as being in effective treatment*. The relevant PSAs and NIs are outlined in Annex 2.

- 3.5 PSAs, DSO and NIs may be an effective way to measure activity but they are not effective at measuring outcomes due to the limited range of information provided. PSAs are restricted in that they only count episodes of care and hence do not provide much information on the quality of treatment or other important information about the client experience. Moreover, although local areas do have to act on all the 198 national indicators, they choose which 35 indicators they will prioritise based on local needs assessments and priorities. For example, only 74 of the 149 local areas in England have included NI 40 as one of their priority areas.
- 3.6 That said, the provision of drug treatment is not an optional activity within the NHS in England: all primary care trusts have to ensure the provision of effective treatment as one of the Tier 2 Vital Signs indicators within the 2009/10 NHS Operating Framework. Tier 2 indicators are ranked as national priorities for local delivery, to be signed off by the regional Strategic Health Authority. The indicator, *VSB14: Number of Drug Users Recorded as Being in Effective Treatment* is overseen by the NTA, supported by Strategic Health Authorities and by the Care Quality Commission. It is underlined and informed by three National Institute for health and Clinical Excellence [NICE] guidance documents: Drug use: psychosocial interventions (Clinical Guideline 51), Drug use: opioid detoxification (Clinical Guideline 52) and Interventions to reduce substance misuse among vulnerable young people (Public Health Intervention 4)⁵.
- 3.7 PSAs can cover distinct quantities and measurements of a service being provided, for example, PSA 25 and NI 40 also refer to “effective treatment”, which is defined as:
- Discharged from the treatment system 12 weeks or more after triage;
 - Or that remain in treatment 12 weeks after triage;
 - Or that were discharged in less than 12 weeks in a care planned way.
- 3.8 Whilst time in treatment is important, it is not the only measure of interest for drug treatment. There are other metrics that can provide additional information on whether Government Departments are achieving their aims, but some important areas, such as well-being and re-offending are more difficult to measure in terms of distinct episodes of care. Moreover, definitions around quality may not always be clear.
- 3.9 Finally, it is important to note that in terms of target setting within LAAs, local authorities and their partners also need to take into consideration two aspects of the Race Relations Act 1976 (as amended), as the majority of bodies involved in LAAs are public bodies, and as such have obligation under this Act. Specifically, they need to be mindful of what is known as the General Duty under the Act, which is, (a) to eliminate racial discrimination, (b) to promote equal opportunities

⁵ <http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281&set=true>

and (c) to promote good relations between different racial groups. The Act also requires public bodies to monitor the impact of their activities in relation to racial equality where that is relevant. In the context of LAAs, local authorities and their partners will need to consider how the delivery of the LAA commitments is impacting upon different minority groups.

4. FACTORS THAT AFFECT OUTCOMES IN PRISON

- 4.1 As previously mentioned, the interventions taking place during treatment are part of a much wider range of factors that can influence outcomes. In many cases, treatment may be neither the most important nor the most powerful influence upon outcomes. Accordingly, outlined below are some of the factors that will have an impact on outcomes in prison.

Characteristics of the Prison Population

- 4.2 The majority of prisoners spend a short time spent in custody. The average time served, excluding remands and determinate sentences in 2005 was eight months. Such short lengths of stay in prison mean that access to prison drug treatment interventions is also short. Those needing most help with a drug problem often seem to fit into the short stay category, as they are either on remand or have received a short sentence, only half of which is spent in custody. Length of stay in prison has a particular impact on outcomes. The shorter the time spent in prison, the more constrained the range of outcomes.
- 4.3 Short length of stay means offenders can access the 28 days clinical interventions, CARATs support, and PASRO and Short Duration Programmes (SDP). However, access to longer programmes such as 12-step programmes would be unlikely in this length of time.
- 4.4 There are also around 100,000 inter-prison transfers annually. This places additional pressure on ensuring treatment continuity and additional demands on treatment teams who have to engage frequently with new clients.

Substance Use

- 4.5 Data shows that substance misuse affects 50 per cent of the male and 65 per cent of the female prison population (Singleton et al. 1997). Patterns of drug use and depth of dependency determine treatment need and can have a considerable impact on treatment outcomes. Figures published in the Psychiatric Morbidity Study paint a similar picture to new ADAM studies and the Criminology Survey 2000 (table below). The CARAT drug service research database reported that 36 per cent of CARAT clients reported injecting behaviour in the 30 days before custody. The ADAM study reported that 14 per cent had injected in the last month, with 22 per cent of injectors reporting the sharing of equipment.

- 4.6 Injecting drug use carries a high risk to personal and public health. One UK study (Judd 2005) found a baseline prevalence of antibodies to hepatitis C virus was 44 per cent and of antibodies to HIV 4 per cent among injecting drug users. In 2006, the number of confirmed hepatitis C infections reported in England rose to 8,346, 10 per cent higher than in 2005. Injecting drug use remains the single most important reported risk factor for acquiring hepatitis C infection (HPA 2007). The number of years of injecting has been found to be associated with hepatitis B and hepatitis C infection (Noble 2000).
- 4.7 The majority of injecting drug users are sent to prison (DH 2002). Approximately half of all prisoners are problematic drug users. 36 per cent of problematic drug users entering prisons report injecting drug use within the 28 days preceding custody (Home Office 2003).
- 4.8 Drug use in prisons fluctuates across sites and time. Individual prisons may experience short-lived drug inundations or have a more persistent serious problem with drug smuggling. Randomised mandatory drug testing (rMDT) is the best national indicator of drug use in prisons. rMDT indicates that, as a national average, drug use reduces markedly in prison, from 55 per cent at point of arrest to 8.9 per cent during prison custody (NOMS 2008).
- 4.9 Imprisonment in the UK is also related to a reduction in the prevalence of injecting drug use (Bellis 1997; Shewan 1994), but cases of initiation into injection in prison have been identified (Boys 2002). Although it reduces in custody, injecting drug use in prison is more likely to involve the use of shared equipment (Bellis, 1997). Imprisonment is associated with higher rates of blood borne virus infection among injecting drug users (Weild 2000).
- 4.10 McLellan et al. 2000; Hser 2007; and Weisner et al. 2003 identified low socioeconomic status, co-morbid psychiatric conditions and lack of family and social supports among the most important predictors of relapse following treatment. In a UK study, Gossop et al. (2002) found that clients who relapsed to heroin use after treatment were more likely to have had pre-treatment legal problems, and that those who relapsed were more frequent users of heroin prior to treatment. The study found that relapse typically occurred very soon after leaving treatment, with more than half of the relapses occurring within three days of leaving treatment, and three-quarters within one week.
- 4.11 Hser et al (2007) found that relapsed drug users differed from their 'recovered' peers in their tendency to use substances in coping with stressful conditions, to have spouses/partners who also misused drugs, and to lack non-drug-using social support. Stable recovery among the entire study cohort 10 years later was predicted only by ethnicity, self-efficacy, and psychological distress.

Women and Substance Use

- 4.12 Plugge et al. (2006) published results of a study of the health of women in prison. It investigated the important role prison played in the treatment of the women's substance misuse. They found that prison was a time for them to become abstinent and to address previously untreated physical health problems. Women said that their physical and mental health problems had been ignored previously 'on the outside'. There was evidence of self-medicating in the community – using drugs to relieve or block out feelings. These feelings would return during detoxification, resulting in extreme emotions, which is one of the causes of suicide and self-harm in prisons.
- 4.13 The study also highlighted the importance of throughcare and having the care required on release. Women who had support on release were more likely to have successful drug treatment outcomes in the community. Women who accessed drug treatment early in custody had the most improvement in physical and psychological wellbeing.
- 4.14 Appropriate identification and treatment of women with substance misuse problems coming into prison can result in healthier pregnancies that progress to full-term and fitter babies.

Dual Diagnosis

- 4.15 Drug dependency is often complicated by co-morbidity of substance misuse and mental health problems. The Office of National Statistics (ONS) Survey of Psychiatric Morbidity among Prisoners in England and Wales reported that over three quarters of those prisoners in the ONS study who were drug dependent before prison, were assessed as having two or more other mental disorders (Singleton et al. 1999). Potentially, this could have a significant impact on drug treatment outcomes.

Self-Harm

- 4.16 There is a high rate of self-harm in prison. Self-harm is particularly prevalent in the women's estate, as demonstrated by the table below.

A review of self-harm incidents by the Safer Custody group in 2003

	No. of Incidents	No. of Individuals	of Incident (IR)*	Ratio
OVERALL	16,221	5,430	3.0	
Gender				
Female	7,408	1,347	5.5	
Male	8,813	4,083	2.2	

4.17 Twenty-seven individuals self-harmed over 50 times during the year: 25 of whom were female, and four women (no men) self-harmed more than 100 times in one year. The 1997 ONS Survey of Psychiatric Morbidity Among Prisoners in England and Wales found that 10 per cent of women had self-harmed without suicidal intent during their current prison sentence. The prevalence of self-harm during their current prison term is higher amongst women with neurotic disorders (20 per cent) and those with post-traumatic stress disorder (25 per cent). The prevalence of self-harm also increased the longer the time in prison - only 3 per cent of women who spent less than a month in prison having self-harmed compared to 23 per cent for those who spent two years or more in prison (Singleton et al. 1997). A NOMS Safer Custody group analysis made similar findings - women who self-harmed did so more than five times each time they were in custody. Men that self-harmed did so more than twice.

Suicides

- 4.18 The National Confidential Inquiry (NCI) has completed a comprehensive analysis of six years of suicides in prison, from January 1999 to December 2004. Their findings were as follows:
- 529 self-inflicted deaths occurred among prisoners in 96 prisons, averaging 88 deaths per year.
 - Thirty-nine (7 per cent) deaths occurred within 24 hours of reception into prison; 147 (28 per cent) were within one week.
 - Self-inflicted death was significantly more likely to occur within 28 days in prisoners with a primary diagnosis of drug dependence (86 per cent) than those with a primary diagnosis of schizophrenia (27 per cent) or affective disorder (38 per cent). 55 (43 per cent) of those with a primary diagnosis of drug dependence died within the first week of custody.
- 4.19 This is in line with the initial analysis of suicides in prison from 1999-2000, which noted that self-inflicted deaths for those drug dependent prisoners peak in the first week in custody (Shaw et al. 2003). The six-year review has found a downward trend in self-inflicted deaths for drug dependent prisoners. This would concur with an increased investment of clinical drug treatment and CARATs in prisons.
- 4.20 Self-inflicted deaths of prisoners with a recorded history of substance misuse can be used as a measure of the effectiveness of interventions. If interventions were effective, it would be expected that deaths would reduce. The NCI continue to collect information on self-inflicted deaths in prison. The PPO is developing a database of deaths to look at trends over time.

Length of treatment and aftercare/support systems for offenders

4.21 Weisner, Ray, et al. (2003) and Scott, Foss, and Dennis (2003) found that long-term effects of treatment were predicted by the client's short-term response to treatment plus participation in aftercare and self-help.

- 4.22 These findings are consistent with other findings in recent years that suggest strongly that a longer-term approach to drug dependence brings better outcomes than short-term (McLellan 2002; McLellan et al. 2005; Moos 2003; Weisner and Schmidt 1993, 1995; Weisner et al. 2001; Weisner 2002; Wexler et al. 1999). A UK study (Gossop et al. 1999) showed that drug dependent patients who remained in treatment in residential programmes for longer periods of time achieved better outcomes than those who left earlier, in terms of abstinence from opiates, abstinence from stimulants, reductions in injecting drug use, and reductions in both drug selling and acquisitive crimes.
- 4.23 Scott et al. (2005a) found that the odds of “sustaining recovery another year” were higher for females, those with more legal involvement, those having more clean and sober friends, and weeks of treatment, but lower for those with more treatment episodes or who were homeless.
- 4.24 Dennis et al. (2007) studied 1,132 people entering prison, and followed up more than 94 per cent of them over the course of eight years to determine the amount of abstinence that each had been able to achieve over that time. Very similar levels of lifetime physical abuse, emotional abuse, sexual abuse and homelessness at the commencement of the study (i.e. at baseline) were found among those who eventually managed less than one year’s abstinence and the group that managed five years or more ‘clean time’. Many of the participants required several episodes of treatment across the eight years. Dennis’s findings appear to support the observations of McLellan et al. (2005) that a more extended treatment approach is required for the management of many cases of dependence.

Recovery Factors

- 4.25 Cloud & Granfield, (2004) found that the principal strategies employed by 46 formerly dependent alcohol and drug users for sustaining the cessation of addiction included engaging in alternative activities (e.g., religious conversion, returning to education, community service), relying on relationships with family and friends, and avoiding drug users and the social cues associated with use. However, the applicability of this study is limited, as participants were well educated with a history of employment.
- 4.26 In a review of 124 studies of recovery, White and Kurtz (2006), reached two conclusions:
- Locating clients with high problem severity and low recovery capital within sober living communities can enhance long-term recovery outcomes (Jason et al. 2001).
 - Post-treatment check-ups and support, and assertive linkage to communities of recovery and other recovery support services can enhance significantly long-term recovery outcomes. .

- 4.27 On this second assertion, the authors cite the finding of McKay (2005) that beneficial effects can be achieved through relatively inexpensive interventions such as telephone-based check-ups and support.

Transmission of Blood Borne Viruses (BBVS)

- 4.28 Prisoners as a population are more vulnerable to viral hepatitis than the general population because of higher levels of risk taking behaviour, including intravenous drug use, tattooing and the sharing of potentially blood contaminated items such as razors and scissors.
- 4.29 The last extensive study of the prevalence of hepatitis B and C in the prison population was Weild et al. (2000). Prisoners in eight prisons were surveyed in 1997 and 1998 to determine prevalence of risk factors in the transmission of BBVs in prison. Of those tested, 8 per cent were positive for hepatitis B antibodies and 7 per cent for hepatitis C. High levels of intravenous drug use were found – 24 per cent having ever injected and 30 per cent of whom injected in prison. The percentage of intravenous drug users testing positive to hepatitis B and C was 20 per cent and 31 per cent respectively.

Teeth

- 4.30 Poor oral health is linked to the misuse of opiates and other drugs. Prolonged drug use is often associated with self-neglect and the adoption of a diet which promotes tooth decay. In 2002, a Scottish prison survey was conducted to provide accurate and up-to-date information on the dental health of the Scottish prison population. 559 prisoners from the men's, women's and young offenders' estates participated in the survey. The results showed that on average the prison population had more decayed but fewer filled teeth than the Scottish population.
- 4.31 The severity of tooth decay was also considerably worse in the prison population, especially for female prisoners. Reported length of stay data showed that it took two years to improve the dental health of prisoners. An Oral Health Impact Profile found that poor dental health resulted in painful aching in the mouth, feeling self-conscious, tense, embarrassed, irritable, psychological discomfort, psychological disability and social disability (Jones et al. 2002).

5. OUTLINE OF EXISTING DATA/INFORMATION

- 5.1 The information below outlines primarily the output data/information (and a few outcome measures) currently collected on offenders in prisons and on release. This is not intended to be a definitive list, but outlines some of the key monitoring and survey measures currently available.

In Prison

Measuring the Quality of Prison Life (MQPL)

- 5.2 Liebling and Arnold (2002) developed a survey of measures for prison life and quality in addition to those already in place (such as KPIs and Standards Audits). The Prison Service Standards Audit Unit (SAU) administers the MPQL in each adult and young offender institution in England and Wales once every two years.
- 5.3 Questionnaire statements are grouped into 16 dimensions, which address various aspects of prison life. Dimensions are based on relationships and regime and include respect, humanity, trust, fairness, order and security, and safety. Prisoners are asked to rate their level of agreement on a 5 point scale, from strongly agree to strongly disagree to a list of statements. From this, mean scores are produced for each dimension. The questionnaire survey:
- Provides a detailed assessment of life in an individual prison
 - Identifies and measures differences between prisons
 - Measures differences over time on particular establishments

The Offender Assessment System (OASys)

- 5.4 This is a joint risk-needs assessment instrument in use across the National Probation Service and Prison Service. It identifies and classifies offending related needs, such as anger management, potential drug dependency and poor literacy. OASys also provides a structured risk assessment and if appropriate, suggests areas for further assessment. The results of these assessments are used in the development of sentence plans. OASys is made up of the following sections:
- **Offending related factors:** This part of OASys has 13 sections. The first 12 examine factors that are related to risk of reconviction.
 - **Risk of Harm:** This covers risk of serious harm, risks to the individual and other risks.
 - **Sentence Planning:** This section is made up of an initial plan and a review plan.
- 5.5 OASys may be useful in determining an individual's needs and the extent that these have been met during their prison term. It also provides a measure of risk of re-offending in both the overall OASys score and Offender Group Reconviction Scale's (OGRS) scores. However, its usefulness is limited as many prisoners will never receive OASys assessment and for those that do, the assessment may take place too far down the line to influence the direction of treatment or determine need, or to serve as a post-treatment measure.

Levels of Bullying and Violence Reduction

- 5.6 Prisons now have a violence reduction strategy as set out in Prison Service Order 2750. Each prison has a violence reduction coordinator who monitors trends over time and reasons for change in that prison, and can provide source data on levels of bullying and violence.

Random Mandatory Drug Testing

- 5.7 Monthly figures are available for random mandatory drug testing by prison and by drug type; this includes opiates, cannabis and benzodiazepines. Universal buprenorphine testing was introduced from 1 April 2008.

Deaths Database

- 5.8 The Safer Custody prison service individual information has provided data on all deaths in prison custody since 1 January 1978.

Incident Data (IRS)

- 5.9 Information has been collected and analysed by HM Prison Service's Safer Custody Group on 27 types of incidents including self-harm, assaults and drugs since 2000 (data on self-harm was included in 2004).

Hepatitis B Vaccinations

- 5.10 The Health Protection Agency monitors the number of hepatitis B vaccinations in prisons. Data is available by prison on a monthly basis.

On Release – Reducing Re-Offending

Measurement of Re-Offending

- 5.11 Re-offending can be inherently difficult to measure as identifying people who have re-offended requires working within a number of complex systems and will only capture those caught and convicted. For example, Dolan et al. (2005) used re-incarceration rates. The UK study NTORS (Gossop et al. 2003; 2001; 1999) looked separately at crime both in terms of reductions in offending behaviour and in reductions in convictions and found that the results were consistent with both of these measures, indicating improved outcomes after treatment.
- 5.12 The link between crime/re-offending and drug dependency is well established, but the relationship is a complex one. On average, around 50per cent of offenders (eg ADAM, Criminality Survey 2000) report their crime is linked to drug dependency. This generates or fuels a substantial volume of crime.

- 5.13 This raises the question of how drug treatment should be targeted. If a key outcome is to reduce re-offending, careful attention needs to be paid to identify the target group at greater risk of re-offending and consideration is required as to how re-offending will be defined and measured.

On Release – Health and Well-Being

Deaths of Recently Released Prisoners

- 5.14 Information on deaths on release from prison is an indicator of the quality of contact that ex-prisoners have with the services they need. However, the information is not routinely collected. Further surveys would be required to collect information on deaths on release, but could be done by comparing IIS database with NCI and ONS databases to identify all those who have died in a given period.

Treatment Outcomes Profile (TOP)

- 5.15 TOP [see Annex 3] is the national outcomes monitoring instrument for drug treatment in the community in England established by the NTA. Prior to TOP, the NTA had relied upon process and proxy outcome measures – such as waiting times and retention – to indicate the effectiveness of drug treatment.
- 5.16 The NTA developed TOP to be used at the start of treatment and in care plan reviews. TOP is reported through the National Drug Treatment Monitoring System (NDTMS).
- 5.17 TOP contains a set of questions based on the four domains established internationally, which are drug and alcohol use, physical and psychological health, offending and criminal involvement, and social functioning. TOP allows key workers and service users to track progress on measures within these domains, and compare pre-treatment functioning and behaviour with these phenomena at stages in (and even beyond) treatment.
- 5.18 TOP has been designed with the following principles and requirements in mind:
- It must reflect the main problems (risks and harms) that clients in structured substance misuse interventions experience
 - It must be straightforward to complete
 - It should be in a form that is useful in clinical practice and can provide helpful feedback to clients to build and maintain change motivation
 - It must be as brief as possible, to minimise the time taken to collect the information
- 5.19 While TOP may be a useful tool in measuring the outcomes of offenders released into the community, it is too early to assess the effectiveness of TOP as a national outcome monitoring tool. In its current form TOP may not be suitable for use in prisons (the TOP questions, for instance about shoplifting and risk of eviction are not relevant to a prison environment).

National Drug Treatment Monitoring System (NDTMS)

- 5.20 The NDTMS collects, collates and analyses information from, and for those involved in the drug treatment sector in the community. The NDTMS is a development of the Regional Drug use Databases, which have been in place since the late 1980s. It provides data on the progress of the drug treatment PSA target. Drug treatment agencies provide information to the NDTMS on their activities each month – known as the Core Data Set. The data items are gathered under the following headings:
- Client details
 - Episode details
 - Treatment modality/interventions details
 - TOP details
 - Local/regional fields whose usage depends on local/regional requirements
- 5.21 NDTMS has been used by prisons from April 2009, as part of an updated Drug Interventions Record.

Drug Interventions Record (DIR)

- 5.22 The DIR is used by criminal justice drug workers in the community, and CARATs and clinical workers in prison as:
- The key tool for continuity of care and monitoring and research in relation to the Drug Interventions Programme (DIP) – used by Criminal Justice Intervention Teams (CJITs) and CARATs; and,
 - The Substance Misuse Triage Assessment form – used in prisons only.
- 5.23 The DIR has three main roles, which are to:
- Facilitate and improve standards of continuity of care for drug users, and minimise duplication of assessment, especially when they are moving between custody and community but also when information is passed between case managers and/or treatment providers;
 - Support the monitoring and research functions around DIP, in line with the programmes' and other related performance management frameworks;
 - Be the Substance Misuse Triage Assessment form used for all CARAT clients (and clinical clients where Integrated Drug Treatment System (IDTS) is in operation), whether or not they are likely to become clients of the CJIT in their home area of residence.
- 5.24 Data fields gathered by the DIR include:
- Problem substances
 - Regularity of substance misuse
 - Treatment modalities in prison
 - Referral to community drug services on release
 - Offence

Prison Health Performance & Quality Indicators

- 5.25 There is one specific PHPQ indicator dedicated to prison substance misuse treatment – PHPQI 1.19. It takes the traffic light rating given to the Integrated Drug Treatment System clinical provider by the National Treatment Agency for Substance Misuse quarterly review (4th Quarter, January–March 2009).
- 5.26 The Royal College of GP's Quality Practice Award, an outcome-focussed workforce approach, is being piloted in HMP New Hall. The 12 modular reflective practice toolkit has been adapted from the GP QPA, which is open to practices with high-performing systems. The QPA culminates in an external audit by a multi-agency team.

Care Quality Commission and World Class Commissioning

- 5.27 The Care Quality Commission is the new integrated regulator for health and adult social care, established as part of the NHS Next Stages review. The audit processes the QCA develop will potentially contribute to quality outcomes.
- 5.28 Similarly, the World Class Commissioning assurance handbook outlines a five-stage process that is designed to concentrate on outcomes.
- 5.29 Although there are often discernable differences in the effectiveness of one treatment modality over another (ref PDTSRG Evidence Base Paper), other factors can have an equal or more profound influence on treatment outcomes. These include:
- Operational Governance** – Poor financial and administrative governance can mean that resources are wasted and fewer people can access and enter treatment;
 - Inequality** – Treatment systems may provide a good service to some clients (e.g. white males), but fail to reach a significant proportion of the wider population (eg women, Black and Asian drug users, people with learning disabilities or serious mental health problems)
 - Staff quality, competence and motivation** – Some services are not good at retaining clients in treatment. Rigid and outmoded approaches can cause clients to leave prematurely, whilst innovation in services, however, can engender positive outcomes⁶
- 5.30 The World Class Commissioning System recognises this need for a broad outcomes perspective. It therefore incorporates health outcomes, competencies and governance. It is important to set and measure outcomes that cover all of the above. Outcomes that concentrate on client response to treatment will, for instance, fail to detect a service's failure to bringing into treatment some individuals from under-represented communities.

⁶ Simpson D, Joe G and Rowan-Szal G (2007). Linking the elements of change: Program and client responses to innovation, *Journal of Substance Abuse Treatment* 33, 2, 111-120

Prison Surveys

5.31 Surveys offer a good means of measuring the range of prisoners' problems and needs on reception and how these change over time. In the case of the mental and physical health of the population, surveys are the only pooled source of information. Each primary care trust conducts a health needs assessment on the level of health care need in the prison, but this information is never reported or combined. The disadvantage of surveys is the cost and time associated with conducting them. Examples of key surveys are outlined below:

- **Survey of physical health:** The last survey of the physical health of the prison population was conducted in 1994, prior to the NHS taking on the responsibility for commissioning health care for prisons. It showed that prisoners have worse physical health than their equivalents for age and gender in the general population (Bridgwood & Malbon 1995).
- **Survey of mental health problems:** The last major survey of prisoner mental health problems was the ONS survey Psychiatry and Morbidity Among Prisoners In England and Wales, conducted in 1997. It showed that prisoners have more adverse mental health problems than an equivalent member of the population (Singleton et al. 1998).
- **Newly sentenced prisoners survey:** The Home Office commissioned a cohort study of 1,457 newly sentenced prisoners from 49 prisons in England and Wales, between November 2005 and November 2006. The prisoners are being followed for four years. Some of the information collected by the cohort study is the same information as for the ONS prison Survey of Psychiatry Morbidity. A draft document from this study suggests increased prevalence of psychosis and substance misuse in the prison population since the ONS survey in 1997.

Outcome Studies – Community-based

National Treatment Outcome Research Study (NTORS)

5.32 This study recruited 1,075 clients from 54 treatment programmes during 1995. Forming the largest prospective longitudinal cohort study of treatment outcome for drug users to be conducted in the UK, NTORS investigated problem drug users in four treatment modalities: specialist inpatient treatment, rehabilitation programmes, methadone maintenance and methadone reduction.

5.33 NTORS investigated treatment outcomes in existing services under day-to-day circumstances. Such studies are rare because of the high cost involved and the degree of effort and organisation required to implement, coordinate and sustain data collection systems over a number of years.

- 5.34 The main outcome measures used were:
- Substance misuse behaviour (including substance type, frequency and quality of use)
 - Health (psychological and physical health problems)
 - Social functioning (employment, accommodation and crime)
 - Harm (injecting and sharing injecting equipment)

Drug Treatment Outcomes Research Study (DTORS)

- 5.35 Funded by the Home Office, DTORS seeks to update existing knowledge on the effectiveness of drug treatment in England. Within the context of changing patterns of drug use and an expansion in criminal justice referrals, this study aims to measure the outcomes experienced by those seeking drug treatment.
- 5.36 The study comprises of three key elements: a quantitative study of outcomes, a qualitative study of treatment-related issues, and a cost benefits analysis. This is a three-year study, which is currently ongoing. Outcome measures used include:
- Levels of drug use
 - Offending
 - Social circumstances
 - Physical and mental health problems
 - Risk taking behaviours

6. Additional desirable outcome indicators

- 6.1 Some key factors identified in Section 4 of this paper are not measured via the tools set out in Section 5. These are set out below.
- 6.2 *Children and families* - The well-being of children and families is an important aspect of the 2008-18 Government Drug Strategy *Protecting families and communities*.
- 6.3 The outcomes should be both immediate, (i.e. successful re-integration of families upon release) and longer term (children safeguarded). Treatment activities most likely to achieve these objectives and therefore bring about desired outcomes are:
- Inquiry as to whether patient has child care responsibilities
 - Use of multi-agency working to the fullest extent where patients are parents
 - Document information given to patient when take-home doses
 - Involvement of families in treatment wherever appropriate
 - Number of parents accessing parenting support interventions
 - Common Assessment Frameworks completed where there is a substance misuse link and
 - Involvement in Safeguarding children board , and children and young people's services involvement

- 6.4 The Review Group evidence base paper identified three interventions and provisions that have proven reducing re-offending potential:
- Opioid substitution
 - Enhanced life skills
 - Sober living communities

All of these three depend to a substantial extent on the design of services that integrate with community provision and facilities.

- 6.5 There are potential benefits to be drawn from the alignment of drug treatment service outcomes with the objectives of companion services, particularly where such services provide a very important health or social care need for some of the same service users. Mental health and learning disabilities services are perhaps the best example of this:

Outcome (PSA 16)	Data Source
Adults with learning disabilities in settled accommodation	Care Quality Commission special data collection
Adults with learning disabilities in employment	Care Quality Commission special data collection
Adults in contact with secondary mental health services in settled accommodation	Mental Health Minimum data set
Adults in contact with secondary mental health services in employment	Mental Health Minimum data set

- 6.5 *The alignment of outcomes from different health, social care and offender management sectors is likely to become a far more common theme over the coming years. This theme is explored in section 7 below.***

7. The likely configuration and nature of services in 2011

- 7.1 Recent and current legislative and strategic developments will influence the configuration and priorities of drug treatment services in 2011. The most significant of these are: Equality, Children & Families; Restructuring; and Integration

7.2 Equality

With the change in equality and human rights legislation there is now a legal as well as moral imperative for government agencies, the National Health Service and all treatment providers to ensure equality of access and service.

- 7.3 Both the Department of Health and Ministry of Justice now have a Single Equality Scheme (SES)⁷ The SES sets out the Departments' public commitment and plan for action across the six equality strands of ethnicity, gender, disability, age, sexual orientation and religion or belief. The SES also incorporates the Human Rights programme. This scheme will cover the period 2009 – 2012.
- 7.4 Outcome metrics will need to measure and promote equality, and form an increasingly important part of any future quality assurance process.
- 7.5 Children and families**
As referenced earlier in this paper (sections 2.1 and 6.2), the well-being of children and families is a key element of the 2008-18 Government Drug Strategy *Protecting families and communities*. The 2007 UK Clinical Guidelines also underlined this ethos:
"Greater emphasis has been put on child protection issues and clinicians' responsibilities to maximise opportunities to identify and prevent harm to both children of drug misusing parents and young drug users themselves"
DH & Devolved Administrations (2007)
- 7.6 Restructuring**
Earlier this year the **NOMS** agency was restructured within the Ministry of Justice, bringing together the headquarters of to enable more effective delivery of services. The two constitute bodies, the Probation Service and HM Prison Service,⁸ remain distinct but have a strong unity of purpose – to protect the public and reduce re-offending. NOMS is responsible for commissioning and delivering of adult offender management services, in custody and in the community, in England and Wales.
- 7.7 Responsibility for delivering a reduction in re-offending and the management of offenders is devolved to 10 regional offices in England and one office in Wales. Each is responsible for commissioning services, developing a reducing re-offending delivery plan and coordinating partnerships in their area. This move to a more regional emphasis will create new relationships across England between Government Offices, Strategic Health Authorities and Directors of Offender Management.
- 7.8 The **NHS** itself is undergoing a significant change in the way it plans and delivers health services. The High Quality for All programme, initiated in 2008, placed primary care trusts, (the national network of local NHS organisations), at the centre of planning and commissioning of services. In spring 2009, each PCT published its strategic plan setting out a five-year plan for improving the health of people locally.

⁷ <http://www.justice.gov.uk/noms-single-equality-scheme.htm>

⁸ <http://www.justice.gov.uk/news/newsrelease270409b.htm>

'Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations. Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health'.
High Quality for All (NHS/DH, 2008)

7.9 Outcomes will be a fundamental area of scrutiny within the NHS by 2011:

'All registered healthcare providers working for, or on behalf of, the NHS will be required by law to publish 'Quality Accounts' just as they publish financial accounts'. NHS Next Stage Review, Final Report, July 2008

7.10 As part of this change, a **Quality and Outcomes Framework** will be established, to include an independent and transparent process for both developing and reviewing indicators. It will be necessary that the outcomes decided upon by the Prison Drug Treatment Strategy Review Group harmonise with and become accepted within this Quality and Outcomes Framework.

7.11 The Government's 2009 Green Paper on the future of **care services**⁹ states:

'We want to build the first National Care Service in England'.

7.12 Among the changes being considered is the pooling of various strands of social care funding. Such pooling would create the potential for the commissioning of large integrated social care services, which may provide important opportunities for the commissioning of wraparound and aftercare services for drug users leaving prison drug treatment services.

7.13 Greater Integration

This move towards a more integrated health and social care provision is currently being piloted by the new integrated care organisations (ICOs). ICOs bring together health and social care professionals from a range of organisations, including community services, hospitals, local authorities and others, depending on local needs. The Wakefield ICO pilot concentrates on services for substance misusers, and includes NOMS prisons and probation agencies, and the police. The aim of ICOs will be to achieve more personal, responsive care and better health outcomes for a local population

7.14 One of the aims of the Drug Strategy, *Drugs: protecting families and communities (2008)* is to deliver new approaches to drug treatment and social re-integration. As part of this aim, **System Change pilots** are testing new approaches that can provide better end-to-end management through the system, including a more effective use of pooled funding and individual budgets, and with

⁹ HM Govt (2009) Green Paper: Shaping the Future of Care Together

a sharper focus on outcomes. This programme covers drug treatment both in the community and in prisons, and the continuity of care for drug-using offenders leaving prison. Four partnerships in particular are working in new ways that have the potential to influence:

- **Partnerships in Essex** are already taking steps to move the responsibility for IDTS and CARATs funding and commissioning to Essex Drug and Alcohol Partnership (EDAP). They are also exploring aligning of related commissioning of DIP service.
- **In Hampshire** self-directed support (SDS), tools for the assessment of SDS for substance misusers have been drafted and are ready to be piloted
- **Hertfordshire** is aiming to develop new contracts to support the pilot, especially around wraparound and re-integration services.
- **Lambeth** is currently considering a comprehensive re-tendering of prison and community drug services across the borough

8. Commissioning for a full range of outcomes

8.1 In addition to the opportunities arising from the new developments described in section 7, the PDTSRG may want to explore the potential of outcome-based commissioning.

8.2 Although there are often discernable differences in the effectiveness of one treatment modality over another (ref PDTSRG Evidence Base Paper), other factors can have an equal or more profound influence on treatment outcomes. These include:

Operational Governance – Poor financial and administrative governance can mean that resources are wasted and fewer people can access and enter treatment;

Inequality – Treatment systems may provide a good service to some clients (e.g. white males), but fail to reach a significant proportion of the wider population (eg women, black and Asian drug users, people with learning disabilities or serious mental health problems)

Staff quality, competence and motivation – Some services are not good at retaining clients in treatment. Rigid and outmoded approaches can cause clients to leave prematurely, whilst innovation in services, however, can engender positive outcomes¹⁰

8.3 It is important to set and measure outcomes that cover all of the above. Outcomes that concentrate on client response to treatment will, for example, fail to detect a service's failure to bring some people into treatment in the first instance (such as drug users with learning disabilities).

¹⁰ Simpson D, Joe G and Rowan-Szal G (2007). Linking the elements of change: Program and client responses to innovation, *Journal of Substance Abuse Treatment* 33, 2, 111-120

- 8.4 The World Class Commissioning System recognises this need for a broad outcomes perspective. It therefore incorporates health outcomes, competencies and governance. World class commissioning may also provide the basis for outcome-based accountability, an approach to social provision used by Portsmouth and the City of Hull (see *Appendix E*).

9. Conclusion

With the recent restructuring of NOMS and the NHS and the imminent reconfiguration of social care provision in England, the introduction of Local Area Agreements and with the launch of pilot programmes like the Systems Change and the Integrated Care Organisation, we are now entering an era of partnerships. Integrated working is becoming the standard approach to service planning, commissioning and delivery. Much of this work is now undertaken at a local level, via Joint Strategic Needs Assessments, joint commissioning and Local Strategic Partnerships.

We are also at a point of increased concentration on outcomes: the new NHS *Quality and Outcomes Framework* is one such example.

These factors mean that outcome setting is a matter for regional and local organisations and agencies, within the greater context of national public service agreements. Any outcomes framework for prison drug treatment should be matched to these established and evolving systems. In view of the complexity of this picture, coupled with the technical challenges of adjusting and drawing together information management systems, the PDTSR Group may wish to consider the establishment of an Outcomes working group, which will take forward the embedding of key outcomes determined by the PDTSRG.

REFERENCES

All-Party Parliamentary Hepatology Group (2006) [A Matter Of Chance: An Audit Of Hepatitis C Healthcare In England](#). London.

Bridgwood, A. and Malbon, G. (1995) Survey of the physical health of prisoners 1994. A survey of sentenced male prisoners in England and Wales, carried out by the Social Survey Division of OPCS on behalf of the Prison Service Health Care Directorate. London: HMSO

Dolan, K., Shearer, J., Macdonald, M., Mattick, R. P., Hall, H. and Wodak, A.D. (2003) A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence* 72, 59 -65

Dolan, K., James Shearer, Bethany White, Jialun Zhou, John Kaldor, Alex D. Wodak (2005) Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection *Addiction* 100 (6) , 820–828

Farrell, M. & Marsden, J. (2005) Drug related mortality amongst newly released offenders 1998 to 2000. Home Office Online Report 40/05

Gossop, M. (2006) *Treating Drug use Problems: Evidence of Effectiveness*. London: NTA

Gossop, M., Marsden, J., Stewart, D., Kidd, T. (2003) The National Treatment Outcome Research Study (NTORS): 4-5 year follow-up results. *Addiction*, 98, 291-303

Gossop M, Stewart D, Browne N & Marsden J (2002) Factors associated with abstinence, lapse or relapse to heroin use after residential treatment: protective effect of coping responses, *Addiction*, 97, 1259–1267

Gossop M, Marsden J, Stewart D & Treacy S (2001), Outcomes after methadone maintenance and methadone reduction treatments: two-year follow-up results from the National Treatment Outcome Research Study *Drug and Alcohol Dependence* 62, 255–264

Gossop M, Marsden J, Stewart D & Rolfe A (1999) Treatment retention and 1 year outcomes for residential programmes in England, *Drug and Alcohol Dependence* 57, 89–98

Hutchinson, S.,J., Wadd, S., Taylor, A., Bird, S.M., Mitchell, A., Morrison, D.S., Ahmed, S. and Goldberg, D.J.(2004) Sudden rise in uptake of hepatitis B vaccination among injecting drug users associated with a universal vaccine programme in prisons. *Vaccine* 2004;23:210-214

Jones, C., McCann, M. and Nugent, Z. (2002) Scottish Prisons Dental Health Survey, Scottish Health Boards Dental Epidemiological Programme.

Judd, A., Hickman, M., Jones, S., et al. (2005) Incidence of hepatitis C virus and HIV among new injecting drug users in London: prospective cohort study. *British Medical Journal*, 330, 24–25.

Lind et al. (2004) The effectiveness of methadone maintenance treatment in controlling crime: an aggregate level analysis. *Crime and Justice Statistics*; March 2004

Noble A, Best D, Finch E, Gossop M, Sidwell C & Strang J (2000). Injecting risk behaviour and year of first injection as predictors of hepatitis B and C status among methadone maintenance patients in south London *Journal of Substance Use*, 5,131-135

Plugge, E., Douglas, N. and Fitzpatrick, R. (2006) *The Health of Women in Prison Study Findings*. Department of Public Health; University of Oxford

Pratt, D., Appleby, L., Webb, R., Shaw, J. and Piper, M. (2006) Suicide in recently released prisoners: a population-based cohort study. *Lancet* 2006; 368: 119–23

Shaw, J., Appleby, L. and Baker, D. (2003) *Safer Prisons: A national study of Prison Suicides 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness*.

Singleton, N., Meltzer, H., Gatward, R., Coid, J. and Deasy, D. (1998) *Psychiatric morbidity among prisoners in England and Wales*. TSO: London.

Singleton, N., Farrell, M. and Meltzer, H. (1999) *Substance misuse among prisoners in England and Wales* <http://www.statistics.gov.uk/pdfdir/drugs0799.pdf> [Accessed 7 July 2008]

Singleton N, Pendry E, Taylor C, et al. (2003) *Drug-related mortality among newly released prisoners*. London: Home Office Research, Development and Statistics Directorate (Report No. 187).

Weild AR, Gill ON, Bennett D, Livingstone SJM, Parry JV, Curran L. (2000). Prevalence of HIV, hepatitis B and hepatitis C antibodies in prisoners in England and Wales: a national survey. *Communicable Disease and Public Health* 2000;3:121-6

Drugs: protecting families and communities. The 2008 drug strategy. (2008) HM Government

Models of Care for the treatment of adult drug users: Update 2006. (July 2006) National Treatment Agency for Substance Misuse

The UK Drug Policy Commission Recovery Consensus Group. A vision of recovery (July 2008) UKDPC

PSA targets 2007-2010 relating to prison and drug treatment

PSA	Relevant Indicators for mental health, offenders and health inequalities	National Indicators	Number Local Areas with LAA
<p>PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs</p>	<p>Indicator 1: Percentage change in the number of drug users recorded as being in effective treatment. It also includes clinical drug treatment in prisons. Indicator 2: The rate of drug related offending, defined as those in contact with the CJS who are identified as misusing Class A drugs (currently heroin and cocaine/crack).</p>	<p>NI 20 Assault with injury crime rate NI 38 Drug-related (Class A) offending rate NI 39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm NI 40 Number of drug users recorded as being in effective treatment NI 41 Perceptions of drunk or rowdy behaviour as a problem NI 42 Perceptions of drug use or drug dealing as a problem</p>	<p align="center">74/150</p>
<p>PSA Delivery Agreement 16: Increase the proportion of socially excluded adults in settled accommodation and employment, education or training</p>	<p>The most socially excluded adults are in settled accommodation Indicator 1: Proportion of former care leavers aged 19, who had left care aged 16 or over, who are in suitable accommodation. Indicator 2: Proportion of offenders under probation supervision living in settled accommodation at the end of their order or license. The most socially excluded adults are in employment, education or training Indicator 5: Proportion of former care leavers aged 19, who had left care aged 16 or over, who are in employment, education or training. Indicator 6: Proportion of offenders under probation supervision in employment at the end of their order or license.</p>	<p>NI 143 Offenders under probation supervision living in settled and suitable accommodation at the end of their order or licence NI 144 Offenders under probation supervision in employment at the end of their order or licence NI 145 Adults with learning disabilities in settled accommodation NI 146 Adults with learning disabilities in employment NI 147 Care leavers in suitable accommodation NI 148 Care leavers in education, employment or training NI 149 Adults in contact with secondary mental health services in settled accommodation</p>	<p align="center">2/150</p> <p align="center">10/150</p> <p align="center">10/150</p> <p align="center">29/150</p> <p align="center">9/150</p> <p align="center">30/150</p>

		NI 150 Adults in contact with secondary mental health services in employment	
PSA Delivery Agreement 23: Making Communities Safer	Indicator 2: Continue to make progress on serious acquisitive crime through a focus on the issues of greatest priority in each locality and the most harmful offenders – particularly drug misusing offenders (ties into PSA 25 – by targeting drug use also target related crime). Indicators 5 and 6: Reduction in re-offending rates (ties into PSA 25 – targeting drug related crime).	NI 15 Serious violent crime NI 16 Serious acquisitive crime NI 17 Perceptions of anti-social behaviour NI 18 Adult re-offending rates for those under probation supervision NI 19 Rate of proven re-offending by young offenders NI 21 Dealing with local concerns about anti-social behaviour and crime issues by the local council and police NI 26 Specialist support to victims of a serious sexual offence NI 28 Serious knife crime rate NI 29 Gun crime rate NI 32 Repeat incidents of domestic violence NI 34 Domestic violence – murder	
PSA Delivery Agreement 18: Promote better health and wellbeing for all	Indicator 1: All-age-all-cause mortality (AAACM) rate. By 2010 increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women. Indicator 2: Gap in AAACM rate between Spearhead Group and national average. Reduce health inequalities by 10per cent as measured by life expectancy at birth. Indicator 3: Smoking prevalence – to reduce smoking rates to 21per cent or less by 2010 Indicator 5: proportion of people with depression and/or anxiety disorders who are offered psychological	NI 120 All-age all cause mortality rate NI 123 Stopping smoking NI 136 People supported to live independently through social services (all adults)	86/150

	therapies.		
PSA Delivery Agreement 19: Ensure better care for all	The Prison PCT partnership should ensure that all of the indicators in this PSA are adhered to for the prison population.	NI 126 Early access for women to maternity services NI 127 Self-reported experience of social care users	
PSA Delivery Agreement 8: Maximise employment opportunity for all		NI 151 Overall Employment rate (working-age) NI 152 Working age people on out of work benefits	
DH DSO	Ensure better health and well-being for all	NI 119 Self-reported measure of people's overall health and wellbeing NI 121 Mortality rate from all circulatory diseases at ages under 75 NI 122 Mortality rate from all cancers at ages under 75 NI 125 Achieving independence for older people through rehabilitation / intermediate care	10/150
DH DSO	Ensure better care for all	NI 124 People with a long-term condition supported to be independent and in control of their condition NI 128 User reported measure of respect and dignity in their treatment NI 129 End of life care – access to appropriate care enabling people to be able to choose to die at home NI 131 Delayed transfers of care NI 132 Timeliness of social care assessment (all adults)	10/150

		<p>NI 133 Timeliness of social care packages following assessment</p> <p>NI 135 Carers receiving needs assessment or review and a specific carer's service, or advice and information</p>	
DH DSO	Better value for all	NI 134 The number of emergency bed days per head of weighted population	
PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs	<p>Indicator 1: Percentage change in the number of drug users recorded as being in effective treatment. It also includes clinical drug treatment in prisons.</p> <p>Indicator 2: The rate of drug related offending, defined as those in contact with the CJS who are identified as misusing Class A drugs (currently heroin and cocaine/crack).</p>	<p>NI 20 Assault with injury crime rate</p> <p>NI 38 Drug-related (Class A) offending rate</p> <p>NI 39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm</p> <p>NI 40 Number of drug users recorded as being in effective treatment</p> <p>NI 41 Perceptions of drunk or rowdy behaviour as a problem</p> <p>NI 42 Perceptions of drug use or drug dealing as a problem</p>	74/150

Treatment Outcomes Profile

Treatment Outcomes Profile

Client ID: _____ D.O.B. (dd/mm/yyyy): ____/____/____ Name of keyworker: _____

Gender: M F Treatment stage: Treatment start Review
 TOP interview date (dd/mm/yyyy): ____/____/____ Treatment exit Post-treatment exit

Section 1: Substance use (Please use NA only if information is not disclosed or not answered.)

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average	Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	<input type="text"/> units/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Opiates	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Crack	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
d Cocaine	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
e Amphetamines	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
f Cannabis	<input type="text"/> spliffs/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
g Other problem substance?	<input type="text"/> g/day	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

Name: _____

Section 2: Injecting risk behaviour (Please use NA only if information is not disclosed or not answered.)

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and 'N', and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Inject with needle or syringe used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				Enter 'Y' if any yes, otherwise 'N'
c Inject using a spoon, water or filter used by someone else?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Section 3: Crime (Please use NA only if information is not disclosed or not answered.)

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
b Drug selling	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Theft from or of a vehicle	Yes <input type="checkbox"/> No <input type="checkbox"/>				Enter 'Y' if any yes, otherwise 'N'
d Other property theft or burglary	Yes <input type="checkbox"/> No <input type="checkbox"/>				
e Fraud, forgery and handling stolen goods	Yes <input type="checkbox"/> No <input type="checkbox"/>				Enter 'Y' or 'N'
f Committing assault or violence	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Section 4: Health and social functioning (Please use NA only if information is not disclosed or not answered.)

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28
c Days attended college or school	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-7	<input type="text"/> 0-28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

Record accommodation items for the past four weeks

e Acute housing problem Yes No Enter 'Y' or 'N'

f At risk of eviction Yes No Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0-20

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Prison Drug Treatment Strategy Review Group

Outcome Model 2010

Prison Drug Treatment Strategy Review Group 2010

Outcomes Framework

This paper concentrates on outcomes. It may be suitable for adaptation into a Payment by Results (PbR) framework. A separate piece of work will be required to summarise and extend standards, and give formal guidance to commissioning groups on the creation by of weighted scorecards.

Payment by results will also require an understanding of the challenges to frontline staff associated with the culture shift. These practitioners will need to be cognizant of those areas in the care pathway that their interventions affect, and focussed on the use of feedback in their performance reports to make changes that take service users forward on their journeys of recovery.

The ambition of shifting toward effective measurement of a balanced treatment system focussing on recovery will require the ability to mine individual and aggregated data across data sets, and to manage information sharing effectively.

Current sources of outcome information

There are many sources of information that may be used to build outcome measures. They include:

- National Drug Treatment Monitoring System (NDTMS)
- Drug Interventions Programme data (DIRWeb and DIMIS)
- Mental Health Minimum data set (MHMDS)
- Supporting People data
- DWP data
- Offender assessment and sentence management (OASys)
- Police National Computer
- Medicines Management Prescribing Reports (PACT data)
- Contract reviews (outcomes agreed locally and contained within contacts or service level agreements)
- Accredited treatment programme placements and completions
- NOMIS data
- Department of Work & Pensions Labour Market System (LMS)
- HMRC Job Entry data
- Staff satisfaction surveys
- Service User Satisfaction surveys
- Clinical Governance (CQUINS , CQC data)
- Service Audit
- Quality Outcome Framework

There are four primary outcomes to this framework:

	Primary Outcome
A	Reduced drug use
B	Reduced re-offending
C	Improved health, social functioning and relationships
D	Increased employment and enhanced workforce skills

Each of these outcomes may be measured via a range of sub-outcomes and outputs, set out in the framework on pages 3 and 4 (below). These sub-outcomes and outputs have been specifically identified in view of the evidence for their effectiveness and by the findings of the national PDTSRG service-user consultation.

Sub-outcome and outputs

Outcome monitoring would be via national and local data sources, and where possible both will be encouraged.

	Sub-Outcome /Output	Suggested Measurement	Evidence Base	Service User (table 2, page 6)
1	Reduced drug use	<u>National</u> per cent of service users receiving care planned intervention (DIRWeb & OASys) TOP tracker reports <hr/> <u>Local</u> per cent reduction in +ve screens for class A drugs (Clinical & compact-based drug testing) per cent reduction in self-injecting per cent reduction in shared injecting	Table 1: S, T & U (page 5)	10, 11, 12
2	Reduced drug supply	<u>National</u> Randomised Mandatory Drug Test data <hr/> <u>Local</u> Clinical Audit (medicines management) Security Information Reports Police Community perceptions reports	Cosden (2010)	16, 28, 29
3	Equality of service	<u>National</u> DIRWeb; NDTMS; NOMS PMS Diversity Report <hr/> <u>Local</u> Service Audit Local ethnicity reporting	Legal Requirement	17, 18, 19

	Sub-Outcome /Output	Suggested Measurement	Evidence Base	Service User (table 2, page 6)
		Equality Outcome Objectives (local/partnership report)		
4	Effective reintegration following release	<p><u>National</u> DWP data / P2W data; Supporting People data; PNC: Reduction in the number/frequency of reconvictions from the predicted rate Reduction in the seriousness of reconviction Increased time to reconviction after release</p> <p>Mental Health Minimum Dataset</p> <p><u>Local</u> NOMS prison performance data Sentence Plan audit HMIP Audit</p>	Table 1 D G Ba & Ca	25, 26 30, 31
5.	Continuity of Community Treatment	<u>National</u> DIRWeb; NDTMS	Table 1 D & G	27, 33, 34, 35, 36 38, 39
6	Enhanced skills for independent living (Life Skills)	<u>Local</u> per cent of care plans incorporating Life Skills*; per cent of service users receiving Life Skills assistance Service users' rating of self-efficacy** per cent of Service users with budget plan	Table 1 Ba	32, 37

	Sub-Outcome /Output	Suggested Measurement	Evidence Base	Service User (table 2, page 6)
7	High quality drug treatment	<u>National</u> DIRWeb performance data; NDTMS data Treatment Planning review; TOP tracker reports	Value-scoring Table 1 Modalities (page 5)	
		<u>Local</u> CQUIN framework CQC reporting Service User Survey; Service Audit Real time client feedback Skills Consortium data HR Records Staff satisfaction survey	Gossop (2006) Simpson (2006) LSH & TM (2003)	1, 2, 3, 4, 5, 14, 15, 20
8	Reduction in drug-related deaths following release	<u>Local</u> Clinical audit of prescribing against NICE (CQC administered) Medicines management audit (CQC) Local audit of drug-related death (General Mortality Registers) Death in custody review action plans	Table 1, J & K Davoli (2007)	6, 7, 8, 9,
9	Peer support	per cent increase in service users accessing peer support groups per cent increase in service users involved in formal peer support per cent increase in service users involved in informal peer support	NICE (2007) Table 1 B	21, 22, 23 24
10	Facilitated support from	<u>Local</u> per cent increase in service users reporting positive relationships	Table 1	40, 41

	Sub-Outcome /Output	Suggested Measurement	Evidence Base	Service User (table 2, page 6)
	family (where drug free)	with family and carers	V W X	
11	Family knowledge of (a) support; and (b) dependence	<u>Local</u> Service user's family audit Referrals to local family services(where commissioned)	Table 1 V W X	42
12	Increased support for families and carers	<u>Local</u> per cent increase in reported access to support for families and carers of service user per cent of service users with parental / guardian responsibility accessing family support services per cent Service Users subject to Common Assessment Framework	Table 1 Y	43, 44, 45
D Increased employment and enhanced workforce skills				
13	Entry to Progress to Work programme	<u>National</u> DWP data / P2W data; <u>Local</u> Evidence of volunteering in workplace setting Completion of literacy course Completion of vocational training course	Table 1 Ba	31, 32 & 33

* Client evaluation support tools (CEST Forms)

** Social satisfaction questionnaires and Holmes Rahe scores

Table 1: Scoring matrix for evidence of effectiveness (PDTSRG 2009)

Intervention Code	Treatment Type	Reduced Drug Use	Reduced Use Prison	Reduced Reoffending	Total Value
A	12-step Programme	2			2
B	<i>Peer support</i> meetings	3			3
C	Therapeutic Communities	2		2	4
D	Case Management	1			1
E	Brief Interventions	3			3
F	Drug-focused counselling	1			1
G	Intensive support on release	3		3	6
H	Psychodynamic	1			1
I	Harm reduction (Group)				0
J	Opioid substitution	3	2	3	8
K	Naltrexone	2			2
	Opioid detox without psychosocial support				0
Cognitive Behavioural Therapy					
L	For stimulant use	1			1
M	For cannabis dependence				0
N	For methadone maintenance clients			0	0*
O	For generalised drug dependence			1	1
P	For women drug users	1		0	1
Contingency Management:					
S	For stimulant use	3			3
T	For methadone	3			3

Intervention Code	Treatment Type	Reduced Drug Use	Reduced Use Prison	Reduced Reoffending	Total Value
	maintenance clients				
U	For opioid detoxification	3			3
Couples / Family interventions:					
V	For opiate detoxification	3			3
W	For methadone maintenance clients	3		2	5
X	Social Network Therapy for opioid detoxification	2			2
Y	Self-help support for carers / families				0**
Other Categorisations:					
Z	Vipassana meditation	2			2
Aa	Higher-intensity (All Treatment Types)***	2		2	4
Beneficial non-treatment factors:					
Ba	Enhanced life skills	3		2	5
Ca	Sober living communities	2		2	4

* Evidence for effectiveness in the treatment of dual diagnosis

** Evidence for improved psychological well-being among carers and families

*** Includes clinical and psychosocial programmes, and combinations of both

Table 2: Themes from service user consultation (PDTSRG 2009)

Effective interventions in criminal justice, health and well being (range and quality of holistic drug treatment/workforce)	
1	People can also find the group work particularly therapeutic
2	A transfer to another prison for a programme would mean clients could miss out on family contact
3	Better information about the full range of treatment
4	Some do not know what addiction means nor there is such a thing as treatment
5	Prison should be of the same quality as the community
6	Requests to switch between maintenance and detox can be ignored
7	Healthcare staff should not make assumptions about people's treatment needs
8	Prescribing should be on the basis of individual needs
9	Naloxone available on release
10	For many prisons there are not enough CARAT workers
11	More one-to-ones, keyworking and counselling
12	A lack of counselling sessions and one to one work and a waiting list
13	Mental health teams would not treat them because they were receiving drug treatment
14	Some uneasiness about CARAT workers who are also prison officers
15	Workers who were quite obviously fresh out of university and reading out of a text book
User experience (including peer support)	
16	Prescribed medication given in cells which may help avoid bullying and targeting
17	Hard for non-English-speaking people to find out what courses are on and access help
18	12-step can be a particular struggle for people with mental health problems
19	Drug treatment at the same time as religious needs such as attending chapel, is unacceptable
20	Concern also about disinfectant measures not being available
21	Unfortunately 12-step is not available in every prison

- 22 Meetings on the wing, led by more confident or experienced service users in the prison
- 23 Education programmes led by peer mentors were also seen as quite positive
- 24 The support that a cellmate can provide though is undervalued.

Resettlement / Reintegration

- 25 A specialist resettlement drugs worker in the DAAT can be a huge asset
- 26 Coming out of prison, you've got nowhere to go...the crack house is somewhere to go
- 27 Reasonable attempts made to ensure continuation of a community prescription on entry to prison and when transferred between prisons
- 28 Cat Ds a problem because of the amount of illicit drugs available
- 29 Difficulties in focusing on recovery because of the amount of illegal drugs in prison
- 30 DIP teams that provide support or activities
- 31 More all-round strategy around release with considerations of family life, accommodation...employment and finances
- 32 Programmes that "help you to help yourself"
- 33 Increased access to work, education and other programmes (during clinical management)
- 34 A wide range of programmes to reduce offending on release would be helpful
- 35 More focus given to resettlement while in prison with housing help and advice
- 36 Residential rehab....ensuring they continued with the progress that they had started in prison.
- 37 More information about entitlements such as community care grants
- 38 DIP and other programmes have meet people at the gate solutions
- 39 Someone to meet you at the gate and take you to some accommodation or a safe place

Families and Communities

- 40 Better information sharing and dialogue with families to facilitate a smoother release from prison
- 41 The support of my family, that's what would prevent me from coming back to prison
- 42 Families can suffer though from a lack of information.
- 43 Families....are also deserving of support for their own needs
- 44 Care should be taken that they are not seen merely as a resource
- 45 More information on administrative concerns [the operation of the prison system] for service users, their family and carers

**Prison Drug Treatment Strategy Review
Group**

Commissioning Sub-Group Report 2009/10

1. INTRODUCTION

- 1.1 Commissioning describes the process of assessing need in a local area, identifying the resources available, planning how to make the best use of the resources, arranging service delivery, reviewing services and then reassessing need. This process should be ongoing and repeated continually to ensure that the services provided are effective, efficient and economical i.e. that the services offered are the 'best value' available and deliver the best possible outcomes.
- 1.2 The current commissioning arrangements for drug users in prison, however, are complex, with multiple agencies involved at a national, regional and local level resulting in fragmented funding streams, commissioning routes, and a lack of consistency of approach within prisons.
- 1.3 The Price Waterhouse Coopers report¹¹ highlighted the key gaps and barriers in the current commissioning arrangements that need to be addressed, including:
- An absence of an overall cross-departmental strategy for dealing with people in prison with drug problems, which balances the objectives and priorities, and sets out a framework for commissioning;
 - A lack of formal authority to make decisions on commissioning priorities across the whole drug treatment pathway and to join up treatment and care interventions for individuals moving from prison to prison – i.e. joint commissioning with authority and responsibility; and,
 - A lack of focus on attempting to join up commissioning to address the services gaps and duplication associated with community based teams and prison based teams.
- 1.4 In light of the above, Lord Patel established an expert Commissioning Sub-Group to consider a range of options to develop a streamlined drug treatment and interventions commissioning system for people in prison, moving between prisons and on release from prison.
- 1.5 This paper summarises the discussions, conclusions and recommendations of the Commissioning Sub-Group.

¹¹ Report to the Department of Health and Ministry of Justice: Review of Prison-Based Drug Treatment Funding (Price Waterhouse Coopers, December 2007)

2. AIM AND PRINCIPLES UNDERPINNING COMMISSIONING FOR PEOPLE IN PRISON AND ON RELEASE

2.1 In order to develop a streamlined commissioning system, the Commissioning Sub-Group began by agreeing on the overall aim and the key principles that a commissioning system should be based on.

2.2 The Commissioning Sub-Group agreed that their overall aim was to agree on a commissioning system to:

Commission a fully integrated drug treatment system in prisons that delivers evidence-based treatment with robust quality measures that meets the needs of the prison population.

2.3 The Commissioning Sub-Group also agreed that any commissioning system must be based on the following principles:

- **PRINCIPLE 1:** A fully integrated drug treatment and interventions commissioning system in prisons must meet the needs, and address the priorities of all the relevant health, social care and criminal justice Government Departments and agencies – there must be a coherent commissioning/partnership structure that all relevant parties can engage with.
- **PRINCIPLE 2:** The way in which drug treatment and intervention services are commissioned in prison must take into account the churn and movement of the prison population – there must be a balance between the needs of the prison population as a whole and an individual’s needs and perspectives.
- **PRINCIPLE 3:** The current health and criminal justice commissioning and funding frameworks for drug treatment and interventions in prisons needs to be brought together into a coherent, multi-disciplinary, streamlined commissioning system and all partners, whether at a national, regional or local level must share a collective responsibility to ensure effective joint commissioning.
- **PRINCIPLE 4:** The options for developing a coherent, multi-disciplinary, streamlined drug treatment and interventions commissioning system in prisons should be considered and a SWOT analysis carried out by the Commissioning Sub-Group of the Prison Drug Treatment Strategy Review Group on the possible options.
- **PRINCIPLE 5:** There needs to be a range of drug treatment and intervention services available in prisons that is needs based and recognises local complexity, diversity, equality and choice.

- **PRINCIPLE 6:** In terms of commissioning, drug treatment and interventions provision in prisons should be viewed as far as possible as an integrated system and needs to take into account the community context if continuity of care is to be effectively commissioned.
- **PRINCIPLE 7:** To work toward the commissioning of an integrated end-to-end management system.
- **PRINCIPLE 8:** The performance management of commissioning systems must focus on outcomes, not only activity and process.

3. SUMMARY OF KEY ISSUES FOR CONSIDERATION

- 3.1 In developing a commissioning system, the Commissioning Sub-Group began by reviewing the current system, impact on partnership/joint working approaches, and commissioning for quality and outcomes.
- 3.2 As far as possible, the Commissioning Sub-Group have attempted to ensure that potential new developments are taken into account in the development of a commissioning system, such as the drive toward less central control and greater local decision-making.
- 3.3 The key issues emerging from this review and discussions is briefly summarised below.

The Current Commissioning System

- 3.4 A variety of Government Departments and agencies fund and commission drug treatment and intervention services in prison and on release in the community.

Commissioning in prisons

- 3.5 Commissioning for drug treatment and intervention services in prisons takes place at both a national and a local level. 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 drug treatment and intervention services between the Department of Health and the National Offender Management Service.
- 3.6 The Department of Health funds primary care trusts (PCTs) to commission prison clinical drug treatment and health care at a local level. Funding is agreed annually – in 2009/10, the Department of Health allocated £39.5 million for PCTs to commission clinical drug treatment services on behalf of prison/PCTs partnerships as part of the Integrated Drug Treatment System.

- 3.7 The Healthcare Commission and the Prison's Inspectorate published a report¹² looking specifically at the way prison health generally is commissioned and concluded that there was scope for improvement. They found that:
- The quality of the provision of healthcare in prisons was variable.
 - The assessment of needs for healthcare is paramount and comprehensive assessments for this group have not always driven development and provision of healthcare services.
 - Although PCTs have emphasised the importance of an assessment of health needs to inform their priorities and strategies for commissioning services, the majority of PCTs did not have such an assessment, or had not completed it.
 - Overall, there has been some improvement in the commissioning of healthcare in prisons, but further work was needed to ensure that specific areas, such as access to health services and the assessment of health needs, were addressed.
 - Collecting information about healthcare in prisons was restricted by a lack of IT - the implementation of electronic records was at an early stage and some prisons used a system that was paper-based.
 - PCTs needed to adopt a more structured approach to resources, to clarify where budgets for healthcare in prisons sat within PCTs, so that it was seen to be a priority.
- 3.8 CARAT (Counselling, Assessment, Referral, Advice, Throughcare) services have been commissioned at a national level directly by the National Offender Management Service within a three-year commissioning cycle - in 2009/10, £33 million was available for the mainstream CARATs programme and £6 million was available for the Integrated Drug Treatment System.
- 3.9 CARATs provide psychosocial support and advice to drug users by assessing the nature and extent of their problematic drug use before providing, or referring to, a range of psychosocial interventions. The service is designed to address the needs of low, moderate and severe drug users and to act as a gateway or link to other services within prisons and the community.

Commissioning on release from prison

¹² Commissioning healthcare in prisons The results of joint work between the Healthcare Commission and Her Majesty's Inspectorate of Prisons in 2007/08 (February 2009)

- 3.10 The initial period following release from prison is particularly crucial for receiving treatment for drug use and joining up with services in the community. In the week following release, prisoners are 37 times more likely to die of drug overdose than other members of the public, due to diminished opioid tolerance¹³. Women are 69 times more likely to do so.
- 3.11 During the first 12 months after release, there is a 3-10 fold greater risk of suicide than the general population. Risk is particularly high during the first 28 days, during which about a fifth of all suicides following release from prison occur. Therefore, effective strategic planning and commissioning needs to span prison and community, and remove barriers to coordination on release from prison.
- 3.12 It is important to note that there is no separate provision and commissioning system in the community for drug users released from prison. The commissioning of community services for adults is undertaken via joint commissioning groups drawn from local drug partnerships and are largely funded by three Government Departments:
- **Department of Health** – the largest single contributor: around £400 million for the Drug Pooled Treatment Budget and an estimated £200 million spent annually from local mainstream monies (e.g. NHS and local authority funds), bringing the overall annual estimated spend on drug treatment to around £600 million.
 - **Ministry of Justice** – contributing £42 million overall to the Drug Pooled Treatment Budget to support Drug Rehabilitation Requirements orders.
 - **Home Office** – provides around £108 million to fund the Drug Interventions Programme.

Impact on Partnership/Joint Working Approaches

- 3.13 The various funding and commissioning arrangements can create barriers to local and regional partnership working, potentially stifling innovations across both geographical and organisational boundaries.
- 3.14 It is vital that these issues are addressed – for example, on average, people are held 31 miles from their home location rising to 58 miles for women prisoners and 65 miles for those serving sentences of 4 years or over. Individuals serving lengthy prison sentences (of two years or more) are likely to be more stable geographically, located in one prison for much (or all) of their sentence. Individuals remanded in custody or serving short prison

¹³ Farrell, M. and Marsden, J. Drug-related mortality among newly released offenders 1998 to 2000, Home Office Online Report 40/05

sentences are much more challenging to engage. They are likely to move between prison, hospital and community, as well as moving between different prisons and therefore will be the responsibility of three to four local commissioning partnerships with each change of location.

- 3.15 Partnership approaches that include case management and information exchange should help people to pass seamlessly from treatment provided or funded by any one of the above-mentioned agencies to another, whilst ensuring that robust continuity of care arrangements are achieved. However, this is not always the case and the difficulties arise, for example, because teams use different assessment tools or there is no electronic information system to assist information sharing. The 2008 Drug Strategy¹⁴ highlighted the need to:

'...manage offenders better at crucial times, such as on discharge into the community from prison, when the risks of relapse and re-offending are high by improving the continuity of case management of drug-misusing offenders and reviewing and strengthening links between prisons, local Criminal Justice Intervention Teams and probation services.'

- 3.16 Therefore, there is a need to establish a more integrated approach, which involves all key agencies working with people on release, both health and criminal justice, if they are to make better use of existing resources and to meet needs.
- 3.17 This might include the pooling of budgets and the aligning of priorities to ensure that the different partnership agencies are focusing on the same group of people, and successfully rehabilitating and resettling individuals into the community. Integrated approaches should also deepen and extend joint identification and assessment, improve offender management and information sharing frameworks for those people in the community who present the highest risk of re-offending, especially for those short sentenced offenders released from prison under no statutory supervision.
- 3.18 Therefore, there can be no doubt that developing effective local partnerships is vital to developing an integrated approach, and improving current commissioning practices is critical for delivering an overall strategic approach, which can address all the needs of offenders both in prison and on release into the community (housing, skills, finance).

¹⁴ Drugs: protecting families and communities – The 2008 Drug Strategy (HM Government, 2008)

Commissioning for value for money, quality and outcomes

- 3.19 Commissioning for value for money, quality and outcomes requires partnerships to demonstrate the best use of available resources to ensure their drug treatment and reintegration systems deliver the best possible outcomes for the target group and local population.
- 3.20 Outcome based commissioning allows commissioners to move from a focus on inputs, process and outputs to a focus on outcomes or results for people who receive services. By working with partners to specify clearly required quality and outcomes, and influencing provision accordingly, commissioners can facilitate continuous improvement in service design to better meet the needs of the local population. This is supported by transparent and fair commissioning and decommissioning processes.
- 3.21 The opportunities afforded by outcome based commissioning include the potential to:
- Develop a new way to distribute money and manage for results
 - Develop new thinking and behaviours to energise delivery
 - Be results focused to achieve success
 - Encourage performance, innovation and learning.

The key benefits of any outcomes-based system can be:

- Improved accountability to local community for results
 - A market managed on the basis of outcomes and customer value
 - Alignment and consolidation of performance targets and indicators
 - Acceleration of knowledge based practice and innovation
- 3.22 In the drug treatment and interventions sector, outcome based commissioning will first require clarity about which types of drug treatment and interventions yield what outcomes, and what is therefore required in treatment and reintegration systems to maximise client outcomes. The latter is being considered by the Prison Drug Treatment Strategy Review Group, Outcomes Sub-Group, which is developing a new outcomes framework.

4. DEVELOPING A STREAMLINED COMMISSIONING SYSTEM

- 4.1 The Commissioning Sub-Group carried out a SWOT analysis and considered the pros and cons of a range of options against the established principles (outlined in section 2) and against the following criteria:
- The commissioning system must not jeopardise current funding for drug treatment and interventions or risk disinvestment of any health, local authority or criminal justice mainstream funding.

- The commissioning system must have the capacity and flexibility to enable the commissioning of drug treatment and intervention services at whichever level (national, regional or local) is appropriate for the intervention - some commissioning at a national level may be required to ensure the needs of underrepresented groups are being met e.g. female drug users in prison and people under 21-years of age.
- The commissioning system must link with community commissioning systems to ensure the continuity of care for people released from prison into community treatment services and for those entering prison from the community.
- The commissioning system must be in line with the development of other commissioning systems within the NHS, local authorities and the criminal justice system and not work against them.
- The commissioning system must support a commissioning for outcomes based approach, including health and criminal justice outcomes, and take into account the work carried out by the Outcomes Sub-Group.

4.2 The Commissioning Sub-Group also considered the potential risks that would need to be addressed, including:

- A lack of 'buy-in' by commissioners, and external organisations and partners so the 'status quo' is maintained.
- The requirement for agencies to change their commissioning and working practices, and to work beyond traditional boundaries will present a major challenge.
- The time and effort needed to develop a common understanding of concepts and terminology cannot be underestimated.
- Difficulties in developing appropriate protocols and effective communication between all agencies at both a regional and local level.
- The needs of drug-using prison population and their families may not met.
- Probation Service has statutory duties to discharge that must be taken into account.

4.3 One of the option considered was around the possibility of establishing fewer or possibly a single funding stream (held by either health or criminal justice) which could be used more flexibly to support the whole of the prison drug treatment and interventions pathway, including related support needs both inside and outside prisons.

- 4.4 The Commissioning Sub-Group came to a consensus that all commissioning tasks (e.g. needs assessments, strategic planning, purchasing) should not to be undertaken by one body (either health or criminal justice) or just at one level (either national regional or local). It is more important to have a coherent structure to link these tasks across the health, social care and criminal justice sectors. It is essential that commissioners at all levels use local information and needs assessments to develop appropriate links and agree shared commissioning arrangements with other partners in order to create integrated packages of provision for drug users in prison and on release that avoids duplication.
- 4.5 The Commissioning Sub-Group concluded decision-making around commissioning should be focused primarily at a local level, and more responsibility given to local partnerships, commissioners, prison governors and users and carers.
- 4.6 Maximising local ownership would sustain and improve outcomes in terms of both re-offending and reduction of harm to the individual, their families and their communities. Local areas also require greater autonomy and flexibility to deliver better services by focusing on increasing the access and quality of drug interventions, matched to individual needs, and reducing bureaucracy. Therefore, options around single funding streams were rejected.

5. A STREAMLINED COMMISSIONING SYSTEM

- 5.1 The Commissioning Sub-Group reached consensus on a commissioning system that best promotes collective responsibility, effective joint commissioning and aligned/pooled budgets in order to obtain the best outcomes, efficiencies and value for money, which would also create a more autonomous and accountable system.
- 5.2 It is recommended, therefore, that for the first time in England, the majority of drug funds be jointly commissioned at a local level - this includes the National Offender Management Service's CARATs funding.
- 5.3 This would mean that local health commissioners, potentially within the new consortia of GP practices, and local drug partnerships including local authorities, prison governors, etc..., will share the responsibility for commissioning drug treatment and interventions both in prisons and on release and will have a collective responsibility to ensure effective joint commissioning.
- 5.4 Some commissioning at a national level may still be needed, for example, to ensure the needs of the women's estate and under 21-year-old offenders are addressed and under this system, services can be commissioned based on needs, at whichever level (national, regional or local) is appropriate for the intervention.

- 5.5 As this work programme and recommendations were being completed, major changes to commissioning systems within the NHS were announced. PCTs are to be abolished by April 2013: the main commissioning functions would pass to GP consortia and the public health function would pass to local authority commissioners. Healthcare commissioning will be the responsibility of GP consortiums working with local communities to commission the majority of local health services from the NHS, voluntary sector and private providers.
- 5.6 There is no detail yet about what will happen to local drugs partnerships and where the commissioning of drug treatment will fit - it may be that it would be the remit of GP consortia or be part of the public health remit of the local authority, or it may even be split between the two.
- 5.7 This recommended commissioning system, however, is aligned with the Coalition's programme approach for a more autonomous and accountable system and with the NHS White Paper, *Equity and excellence: Liberating the NHS*.
- 5.8 Moreover, it is vital that a shift is made away from the current fragmented system to a streamlined effective and efficient commissioning system that is reflective of consensus on evidence and good practice, and clearly aligned with outcomes.
- 5.9 Therefore, it is recommended that the Government consider putting in place this revised commissioning system by 2011/12.