



Service Specification

Integrated
Substance Misuse Treatment Service
Prisons in England

Final v0.17

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Document Status

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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and*
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.*

Table of Contents

1	Introduction	5
2	How to use this document.....	7
3	The Model.....	9
4	Guiding Principle.....	11
4.1	Recovery.....	12
4.2	Reducing Harm and Reducing Deaths in Custody	13
4.3	Reducing Reoffending	14
4.4	Equivalence.....	14
4.5	Lived Experience	14
4.6	Vigilance and Responsiveness.....	14
4.7	Balanced system	14
4.8	Discreet Provision and Integrated Systems	15
4.9	Entries and Exits.....	15
4.10	Information sharing.....	15
4.11	Attitudes and Values.....	16
4.12	Supporting Resources	16
5	Core.....	19
5.1	The Service	19
5.2	Service Outcomes	19
5.3	Service Standards	22
5.4	Service Expectations	23
5.5	Screening and Assessment.....	25
5.6	Mental Health.....	26
5.7	Recovery Planning and Review.....	27
5.8	Sentence Planning.....	28
5.9	Interventions.....	28
5.10	Continuity of Medication.....	30
5.11	Peer Led Approaches.....	32
5.12	Drug Testing.....	32
5.13	Access to information and Confidentiality	33
5.14	Supporting Resources	34
6	Benchmarks.....	Error! Bookmark not defined.
7	Setting	38
8	Cohorts.....	39
9	Health and Justice Specification Annex 1	40

1 Introduction

This service specification describes a fully recovery orientated, integrated prison substance misuse treatment service. This covers traditional drugs of abuse, psychoactive substances, illicit abuse of prescribed and over the counter drugs and alcohol.

Partnership working is essential across NHS England, Ministry of Justice (MoJ), Public Health England (PHE), Local Authorities, Her Majesty's Prison and Probation Services (HMPPS) and the providers of substance misuse services both within and outside of prescribed places of detention.

A safe and secure prison system cannot be effectively delivered without competent and productive staff and substance misuse services. Effective substance misuse services cannot be delivered without the full support and partnership of the prison regime and staff. Some of the themes that came out of the consultation on this specification included:

- More substance use/misuse and mental health training for officers
- More focus on supply reduction and the links to demand reduction to deliver a more holistic approach
- Opportunities within the regime to learn new skills; having a structure and purpose, and incentives to maintain progress in treatment and on the recovery journey.

Though these elements are outside of the direct remit of NHS England and this specification, they are a central part of effective treatment, reflecting the importance of partnership working, and deserve noting here.

It is recognised that this is a significant time of change and transition in terms of NHS and Criminal Justice System (CJS) reforms and elements of this specification may change. The commissioners will fully engage with the provider and ensure service user and lived experience involvement during the initial service co-design period (following agreement of what is to be delivered and what outcomes are being sought) and then for the lifetime of the contract to ensure this specification remains relevant to those who need the service.

The relevant developments below describe a timeline to this point from the point of the last Government Drug Strategy;

- In December 2010 the Government launched its drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'. This was a major change to Government policy, the Drug Strategy set out a fundamentally different approach to preventing drug use in our communities and in supporting recovery from drug and alcohol dependence. This has since been superseded by the most recent publication of 'The Drug Strategy'¹ in July 2017,

¹ <https://www.gov.uk/government/publications/drug-strategy-2017>

- In addition, the Government's Alcohol Strategy (2012) set out an ambition to radically reshape the approach to alcohol and reduce the number of people drinking problematically.
- The responsibility for the funding and commissioning of all substance misuse treatment for offenders in England transferred from the Ministry of Justice to the Department of Health (DH) in April 2011 (with some psychosocial responsibilities staying with Local Authorities until 2013). This included funding for Counselling, Assessment, Referral and Throughcare Services (CARATs), drug and alcohol programmes in prisons and Compact Based Drug Testing (CBDT), with the National Offender Management Service (NOMS) retaining the responsibility for Mandatory Drug Testing (MDT). The objective behind this change in funding and commissioning arrangements was to enable integrated substance misuse services to be commissioned that could build on the good work already achieved in custody and enhance continuity of care through the gate.
- In 2013, NHS England published a paper "Securing Excellence in Commissioning for Offender Health"² which stated that NHS England would assume responsibility for commissioning substance misuse services in prisons. The ambition is to improve health and care outcomes, support safer communities and social cohesion and in doing so:
 - Narrow the gap between those in criminal justice and detained settings and the rest of the population in terms of health and care outcomes, through improved support from all health and social care;
 - Reduce the number of people who are detained as a result of untreated health problems, and so support reductions in offending; and
 - Ensure continuity of care post release, and so support reductions in re-offending.

² <https://www.england.nhs.uk/2013/03/offender-health/>

Note to Local Commissioners

This section is for guidance to assist you and does not form part of the final specification. It should be removed prior to publishing.

However it may be useful, as a part of negotiating and co-designing the service, to adapt the content of it to that purpose.

2 How to use this document

This Service Specification represents something of a departure from earlier iterations of the integrated substance misuse service specification. In previous specifications, the text has very much provided a clear steer as to:

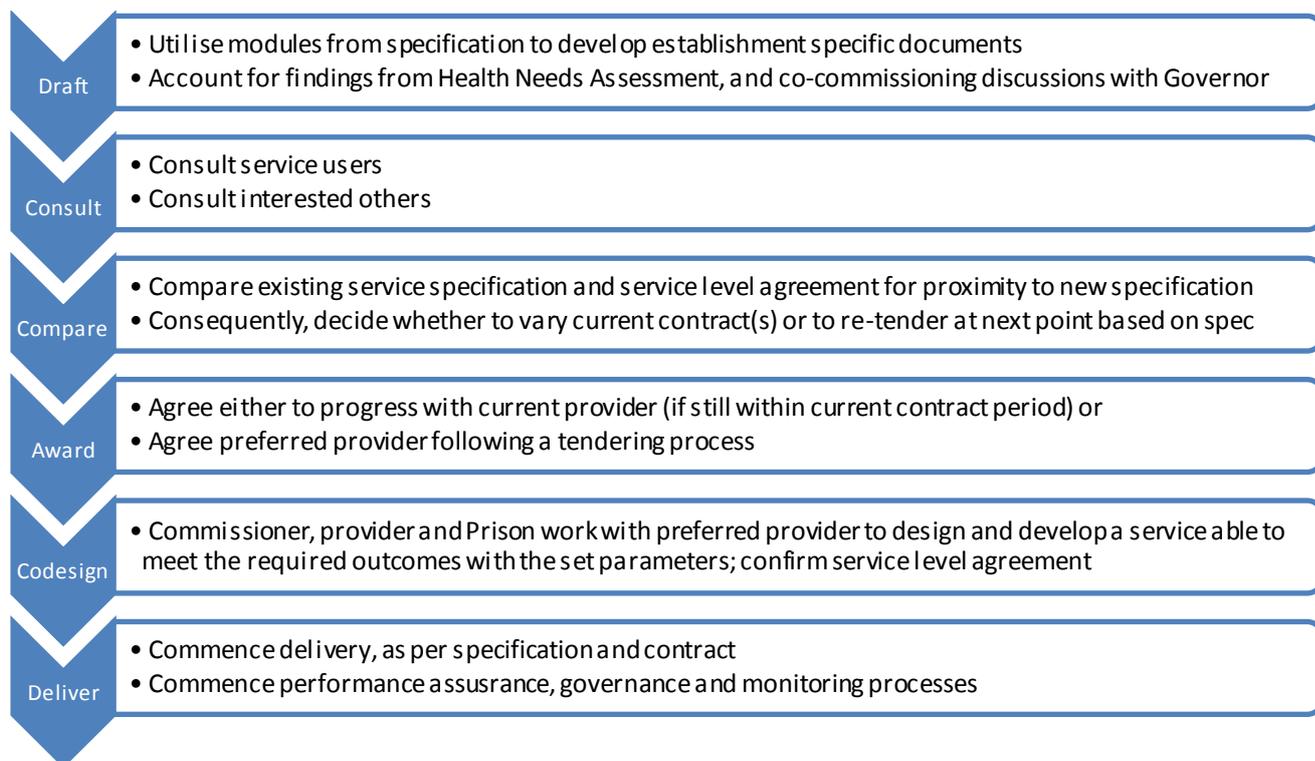
- a. Exactly what should be provided, in what context
- b. How to go about providing it and
- c. How much of it to provide

Following feedback, what we have presented in this document is a modular approach taking account of:

- a. Areas of focus that – nationally – we would expect providers to prioritise; these would be (as a minimum) those listed as part of the ‘Guiding Principles’ at Section 4
- b. The outcomes that are required from any provider, and evidence of their ability to deliver those outcomes
- c. The freedom for regional Commissioners to tailor the specification to their needs and the needs of any specific prison population
- d. The opportunity for providers to show their skill, experience and creativity in developing service models that will deliver the required outcomes.

As a part of the development of the detailed specification, and the selection of providers, we would expect those with lived experience to be included and supported in their involvement at each step.

The process that we would expect to see would be:

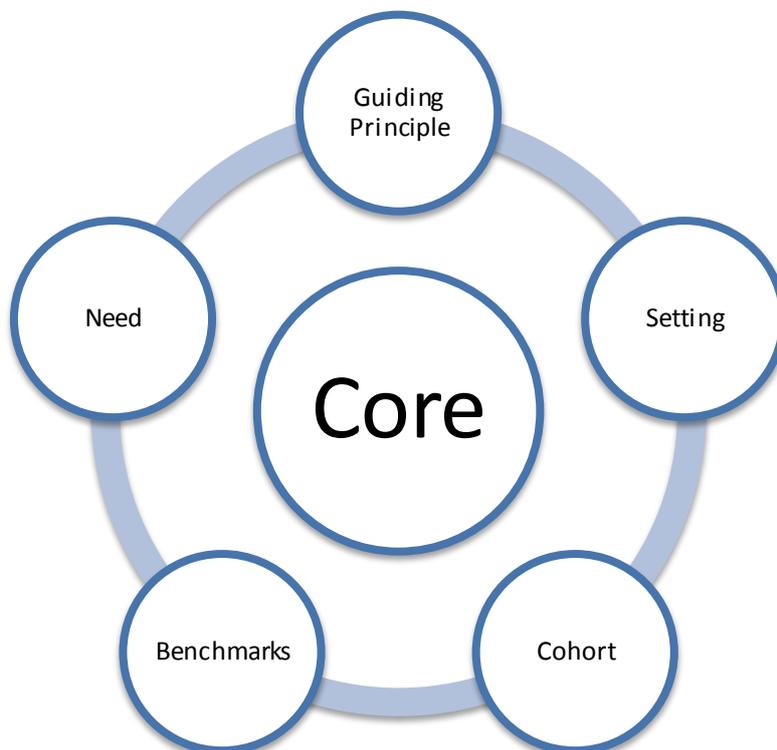


This specification also has a suite of annexes which are relevant to all Health and Justice specifications and are not service specific. These annexes form part of the overall specification and ensure that the providers within an establishment, and nationally are all working to the same standards.

As a part of the process of exploring the specification, co-design and agreements between parties, a number of documents will need to be in place (which will vary according to Commissioner, Provider, Prison and regional / local approaches); further details of these will be included in other documents, such as the standard contract.

3 The Model

The Integrated Substance Misuse Service Specification is structured to enable the flexible use of concepts presented through six main considerations;



- a. At its centre – a **core framework** document that clearly articulates the required outcomes, objectives and standards of the service and the expected minimum levels of governance.
- b. The context of an overarching **guiding principle**, which aims to define the basis upon which activities in the specification are delivered (safe, recovery focused, service user centred, integral peer support approaches, and provided within a cohesive multi-disciplinary framework). The guiding principle element of the specification will also include signposting towards pre-existing reviews and recommendations (e.g. the Patel report: Reducing drug related crime and rehabilitating offenders³³)
- c. Full account of the **setting** within which delivery takes place, especially where this impacts on the type and/or duration of intervention that can be offered (e.g. Remand or Reception Prison as opposed to Category B Sentenced)
- d. A thorough examination of **need**, including (but not limited to) quantitative and qualitative analysis, including consultation and patient involvement; a comprehensive

³³ <https://www.gov.uk/government/publications/the-patel-report-reducing-drug-related-crime-and-rehabilitating-offenders>

understanding of need is a cross-cutting issue across all elements of the specification, and the flexibility offered by this specification places the emphasis on *an establishment based service designed around the needs of both the cohort (i.e. the shared and unique needs of the men and women it is seeking to serve) and the setting*, as evidenced through comprehensive health needs assessments⁴.

The review and update of the specification – and its' implementation from 2017/18 onwards – is an important turning point to take into account

- The changing pattern of substance use/misuse in prisons, including psychoactive substances, illicit alcohol and tobacco and the misuse of prescribed and over the counter medications
 - The changing profile of men and women in prison, such as the aging population of former heroin users
 - The different physical and mental health needs of women in custody, their social and family circumstances, and the forthcoming changes to the Women's Estate.
 - Service users, and their full and active involvement in the design and planning of services, service delivery and peer support and service evaluation
 - Requiring all stakeholders to ensure all substance misuse services (including all drugs and alcohol) are commissioned and provided as services that are fit for purpose and take account of prison reforms – such as the change of role of some establishments to become Reception Prisons.
 - Co-commissioning which sees Governors working closely with health commissioner to improve healthcare services in their prisons, including helping offender with substance misuse issues.
 - The introduction of Smoke Free prisons
- e. Full and proper account of relevant **benchmarks** (e.g. clinical guidelines, available evidence base etc.)
- f. Shows a clear understanding for the specific needs of the **cohort** (e.g. remand prisoners, women, sentenced prisoners, BAEM, older prisoners etc.)

It is proposed that the central Core Specification is the primary document – prefaced by the guiding principle statement – with guidance, signposting and linkages explicitly made to appendices / annexes / external sources to cover need, setting, cohort and standards. These can then be utilised as appropriate by Commissioners and Providers in specifying the required service and evidencing delivery.

This model should ensure

- Requirements are delivered, whilst allowing for local flexibility and personalisation of the treatment and support offer to enable individual needs to be met
- Existing standards (e.g. clinical guidelines) are not repeated or interpreted for the specification; but they are signposted to

⁴ <https://www.gov.uk/government/publications/prescribed-places-of-detention-health-needs-assessment-toolkit>

- Rather than telling providers how they should be doing their job, commissioners will be able to look for competence, creativity and innovation in evidencing the ability to deliver the required outcomes. Once assured of the ability of the provider to deliver effectively against the 'must do' elements of the specification, commissioners / Governors, providers and service users can work in a process of co-design to develop a bespoke service tailored for the setting and cohort, focussed on achieving the desired outcomes

4 Guiding Principle

Adapted from 'Drug Misuse and dependence; UK guidelines on clinical management' 2017⁵

The purpose of health care in prison, including care for drug and alcohol problems, is to provide an excellent, safe and effective service to all prisoners equivalent to that of the community – whether the aim is stabilisation, crisis intervention or recovery from dependence.

Screening, assessment and treatment for problem drug and alcohol use should address the wide range of substance use/misuse, and other, often related, physical and mental health needs identified, and should address any identified disability. It should have a public health perspective and focus on reducing harms and promoting recovery.

Care should be delivered by professionals and allied staff who are suitably competent, properly supervised and operating within a clear quality and clinical governance framework supporting safe and effective delivery. Routine sharing of necessary information should support integrated care delivery.

Treatment should be regularly reviewed. There should be access to suitable psychosocial interventions to support treatment and recovery. Where medication is indicated, its provision should be suitably optimised, particularly in those with difficulties achieving stability.

Clinicians should be broadly aware – though active engagement with service users and custodial colleagues – of the main types of drug use for those coming into prisons and used whilst in prison (including traditional drugs of abuse, psychoactive substances, illicit use of prescribed drugs and misuse of over the counter drugs), and emerging trends in drug and alcohol use and harms. They will also need to keep abreast of changes in prescribing practices that may affect risks of misuse of prescribed drugs or from polypharmacy. Clinicians should be able to adapt evidence-based treatments from the wider community where appropriate to the prison estate and regime, and be able to work with security staff and supply reduction and safer custody initiatives to help reduce harm and to manage risk, particularly the risk of death in custody and self-inflicted harm.

Management of risk for those with problems with substance use/misuse includes a good understanding by practitioners of the risks from inadequately addressed co-morbidities, from

⁵https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/628634/clinical_guidelines_2017.pdf

unnecessary or unsupervised polypharmacy, from inadequately addressed intoxication or withdrawal, and of delayed symptoms of intoxication or withdrawal that may affect risk of self-harm and suicide, particularly in the first weeks following reception into custody. They also need a clear understanding of the nature of dependence and of risks of relapse in the period after release. This is particularly important for those with heroin dependence who have become drug-free during imprisonment who are not in receipt of opioid substitution treatment, who then have a very substantially increased risk of overdosing and dying soon after release (Larney et al 2014, Degenhardt et al 2014).

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

4.1 Recovery

"Recovery is difficult and I'll be in recovery for the rest of my life. I take every day at a time."

Service User, HMP Birmingham

For some people, 'recovery' might be characterised by 'what life was like before'; for others, what life was like before was not good enough and will have contributed to their physical and emotional decline and reliance on (and dependence on) substances. It is important for any individual to feel that their aspirations in relation to recovery are being worked towards, with appropriate encouragement and ambition.

Recovery oriented treatment works from the premise that freedom from dependency is the desired end state of the treatment pathway. Being healthy, being present⁶ and living a productive life are key elements of recovery and though 'abstinence' may support this it does not necessarily define 'recovery'. Service provision should acknowledge the appropriateness of both abstinent and maintenance oriented approaches to recovery, and denying a patient access to medication for the treatment of a clinical condition is not justifiable.

For medication-assisted recovery, which is the most suitable option for some people, this may be a short or rapid journey with supported, peer-related recovery activities both during and following structured treatment interventions; for others it will be a considerably longer journey and abstinence may never be achieved. As a journey, the focus on recovery should

⁶ 'Being present' is a term used to describe an awareness of the current moment and having focus - what is happening now, rather than over-concentration on elements of the past or the future that can inhibit recovery processes by distraction.

begin at first contact / assessment. Services should be expected to think and work holistically and take a person-centred approach in order to support service users to rebuild their lives after dependency.

It will enhance treatment benefit if psychosocial interventions are used alongside methadone/buprenorphine assisted recovery, to assist with the process of personal change, growth and the building of 'recovery capital'. Treatment and recovery will sometimes involve a period of medication-assisted recovery utilising, amongst other things, opiate substitution therapy or detoxification in concert with psychosocial interventions and other recovery focused support both in custody and on release.

Recovery, as a goal, is a concept applicable to numerous substances and conditions – including mental health, dependence on illicit drugs, alcohol or misuse of prescribed and over the counter medication. It is characterised by increasing voluntary control over ones condition, and building protective personal and social assets (or 'recovery capital'). Recovery capital can be thought of as the internal and external resources necessary for an individual to achieve and maintain recovery from substance misuse as well as make behavioural changes. Some of these resources will include improved personal and social relationships, education and employment, personal fulfilment, appropriate accommodation, giving back to others and individual growth.

Recovery pathways are only possible to a certain extent within secure and detained settings, where the freedom to make active choices and progress with personal growth and development is constrained; although the opportunities for this should be maximised within the constraints imposed by the regime, categorisation, and population flows/pressures. Delivering a holistic approach to both tackle demand of drugs and to reduce supply of drugs through robust security measures is needed to support recovery. Further opportunities to experience, develop and maintain recovery will be experienced on release back into the wider community. That is why continuity of care through the gate is crucial to maintain the good work that has happened in custody.

Further details on the sections below are available as part of the Appendix

4.2 Reducing Harm and Reducing Deaths in Custody

Across Europe, illicit opioid users are 10 times more likely to die than their peers of the same age group and gender, and 6100 deaths were attributed directly to opioid overdose in 2012. Poisoning deaths in the UK involving heroin and/or morphine have significantly increased in recent years.⁷

7

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations>

4.3 Reducing Reoffending

A reduction in the likelihood of substance related offending should be a central aim of any treatment intervention and could add value for prisons to identify drug trends.

4.4 Equivalence

Patients within secure and detained settings should receive the same level of healthcare as those people in 'mainstream society' – both in terms of the range of interventions available to them and the quality and standards of those interventions.

Taking into account the substantial health inequalities likely to be faced by most, if not all, patients within secure and detained settings, it is imperative that any provision is not only equitable to community provision, but that it takes bold and innovative steps to improve the health of the most vulnerable and reduce health inequalities.

4.5 Lived Experience

Examples of this within a custodial setting include the use of peer mentors, listeners and treatment interventions – provided by those in custody – and mutual aid groups (Narcotics Anonymous, Alcoholics Anonymous, Cocaine Anonymous etc., or SMART Recovery and others from 'outside' coming in to facilitate peer support groups).

4.6 Vigilance and Responsiveness

Substance misuse, and the patterns and impacts that changes in substance availability and popularity has on individuals, families?, local communities and prison communities, has the potential to be personally and systemically devastating.

Examples of this include dependence on or diversion of prescribed and over the counter medication, especially where this is 'in possession' medication, or the recent increase in the availability of Psychoactive Substances.

4.7 Balanced system

A balanced treatment system combines the opportunity to overcome dependence and reduce harm in full coexistence. There is not one path or one timeline for the journey to the end of dependency, and as such services need to be flexible and person-centred to meet:

- The differing presenting needs of clients – in terms of substances used, physical and mental health needs, ability to maintain safety and reduce harm, ability to consider and begin / maintain a process of substantial change, the need for specialised interventions (such as dealing with a history of loss, bereavement, abuse etc.)

- The over-riding need to ensure the reduction of deaths in custody or after custody
- The different needs of the system – in terms of regime issues within the setting, safety and security, changes to presenting needs and emerging drug use patterns – accepting that treatment is an integral part at the heart of a prison regime
- All of this should be considered within the context that for opioid dependence the national and international evidence suggests that patients exposed to Opioid Substitution Therapy (OST) in custody are significantly less likely to die in the 4 weeks following release⁸

4.8 Discreet Provision and Integrated Systems

Treatment systems are – usually – either specified and commissioned as

- Stand-alone, specialist substance misuse treatment provision or
- An element of a more comprehensive healthcare contract

4.9 Entries and Exits

From the moment of entry, induction needs to set the tone for what will follow; safety and harm minimisation, stabilisation, ambition, enquiry, introducing the concept of recovery and providing encouragement that things can be better going forwards are all important parts of the early engagement phase

Exit from treatment should be visible to patients from the moment they engage in provision, and can usefully include peer support approaches to model the success that can be achieved in recovery.

4.10 Information sharing

Further advice regarding information sharing within the remit of this specification can be found in the accompanying Health and Justice specification Annex (please see section 9 of this document).

The design and delivery of the service must be underpinned by the National Data Guardian's Caldicott Principles⁹, These are;

- **Principle 1 - Justify the purpose(s)**
Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed by an appropriate guardian.
- **Principle 2 - Don't use patient-identifiable information unless it is absolutely necessary**
Patient-identifiable data items should not be used unless there is no alternative.

⁸ IDTS Mortality Study <http://onlinelibrary.wiley.com/doi/10.1111/add.13779/full>

⁹ Caldicott Manual

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/344441/cgmanual.pdf

- **Principle 3 - Use the minimum necessary patient-identifiable information**
Where use of patient-identifiable information is considered to be essential, each individual item of information should be justified with the aim of reducing identifiability.
- **Principle 4 - Access to patient-identifiable information should be on a strict need to know basis**
Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see.
- **Principle 5 - Everyone should be aware of their responsibilities**
Action should be taken to ensure that those handling patient-identifiable information, (both clinical and non-clinical staff) are made fully aware of their responsibilities and obligations to respect patient confidentiality.
- **Principle 6 - Understand and comply with the law**
Every use of patient-identifiable information must be lawful. Someone in each organisation should be responsible for ensuring that the organisation complies with legal requirements.
- **Principle 7 - The duty to share information can be as important as the duty to protect patient confidentiality**
Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies

The multi-agency and modular structure of the service means that Principle 7 will be a significant element of information governance and information sharing undertaken across the service.

4.11 Attitudes and Values

- Services should have a focus on working with people rather than doing 'to' them, and aim to develop a service which is responsive to people and their needs, rather than being process-driven.
- Focus can be as much on an individual and community assets as on finding a seeking to address perceived deficits; respect for an individual's ability to guide and navigate their own recovery can be a therapeutic tool in its own right.
- Compassion; for example, working with a focus on encouragement and ambition, rather than managing addiction as a behavioural issue where medicines are, at times, withheld to attempt to regulate behaviour
- A desire to prevent initial harm and further harm through prevention approaches (primary and secondary), a wider educational ethos and a focus on wellbeing.

4.12 Supporting Resources

Recovery

National Treatment Agency – Building Recovery <http://www.nta.nhs.uk/recovery.aspx>

Routes to Recovery via criminal justice: mapping user manual (NTA 2010)
www.nta.nhs.uk/routes-to-recovery.aspx

Medications in recovery: best practice in reviewing treatment – supplementary advice from the Recovery Orientated Drug Treatment Expert Group (PHE 2013)
www.nta.nhs.uk/medicationsin-recovery-reviewing-treatment.aspx

Smoke Free Prisons Guidance (MSO) -

<https://www.england.nhs.uk/publication/minimum-offer-for-stop-smoking-services-and-support-in-custody/>

Reducing Harm, Reducing Deaths

National Treatment Agency – Preventing Drug Related Deaths

<http://www.nta.nhs.uk/preventing-drug-related-death.aspx>

Drug-related Deaths data

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations>

IDTS Mortality Study

<http://onlinelibrary.wiley.com/doi/10.1111/add.13779/full>

Reducing Reoffending

Public Health England – Healthcare for Offenders <https://www.gov.uk/guidance/healthcare-for-offenders>

Public Health England Health & Justice annual review 2015/16

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565232/health_and_justice_annual_review_2015_to_2016.pdf

Public Health England - Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure and detained settings to inform future health interventions and prioritisation in England

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/565231/Rapid_review_health_outcomes_secure_detained_settings.pdf

An evidence review of the outcomes that can be expected of drug misuse treatment in England <https://www.gov.uk/government/publications/drug-misuse-treatment-in-england-evidence-review-of-outcomes>

Equivalence

NHS Commissioning <https://www.england.nhs.uk/commissioning/health-just/>

Prison medicine: ethics and equivalence, British Journal of Psychiatry

<http://bjp.rcpsych.org/content/bjprcpsych/188/1/4.full.pdf>

Lived Experience

Framework for Patient and Public Participation in Health and Justice Commissioning; NHS England, 30 December 2016 <https://www.england.nhs.uk/wp-content/uploads/2017/01/hlth-justice-frmrk.pdf>

Mutual aid framework

www.nta.nhs.uk/uploads/mutual-aid-framework.pdf

Vigilance and Responsiveness / NPS

New psychoactive substances (NPS) in prisons – a toolkit for prison staff *Public Health England, 2016*

[www.nta.nhs.uk/uploads/new-psychoactive-substances-in-prisons\[0\].pdf](http://www.nta.nhs.uk/uploads/new-psychoactive-substances-in-prisons[0].pdf)

Spice: the bird killer *User Voice, 2016*

www.uservoice.org/wp-content/2016/05/User-Voice-Spice-The-Bird-Killer-Report-Low-Res.pdf

Balanced System

Rebalancing Act; how partnership and collaboration can be strengthened to address the health inequalities faced by those in contact with the criminal justice system

<http://www.revolving-doors.org.uk/blog/rebalancing-act>

Entries and Exits

An Inspection of through the Gate Resettlement Services for Short-Term Prisoners

<https://www.justiceinspectorates.gov.uk/ciji/wp-content/uploads/sites/2/2016/09/Through-the-Gate.pdf>

Information Sharing

Health and Justice Commissioning Intentions 2015/16

<https://www.england.nhs.uk/commissioning/health-just/>

NHS England Information Sharing Policy

<https://www.england.nhs.uk/wp-content/uploads/2016/12/information/sharing/policy/v2-1.pdf>

5 Core

5.1 The Service

The service provider will establish and run an integrated substance misuse service. This service will provide specialist support for all those assessed as requiring interventions to address drug or alcohol misuse. Where this is as part of a wider integrated model of commissioning responses to the multiplicity of physical and mental health care needs, this document would represent the substance misuse 'module' of that wider commissioning activity and should be read in conjunction with the other related elements.

It is appropriate in most cases, to design and deliver services which positively identify and encourage asset-based approaches to intervention; focusing on the strengths of the individuals, rather than solely seeking out and focusing on deficits. This can significantly help with encouraging and enabling a culture of recovery.

The substance misuse treatment element is commissioned as part of the overall Offender Health pathway within the prison and as such the model will ensure an integrated, recovery orientated treatment system both within the prison and onwards into the community. The service will focus on delivering person-centred care within seamless, integrated structured clinical and psychosocial substance misuse interventions/services in prison and facilitating arrangements through the gate into the community to ensure effective continuity of care. Close joint working with Governors, other stakeholders and services (and cross-border working with devolved administrations where our patients might reside) is imperative to the success of the delivery in this service. A suitable structure for information sharing must be established.

The substance misuse service is to be made available to drug and/or alcohol misusers including poly-drug misusers, those with problems related to medicines and individuals with co-morbid mental health problems. Substance misuse invariably impacts negatively upon co-morbid Mental Health disorders. Integrated treatment models are required to better meet complex needs of prisoner and improve information sharing between healthcare providers.

Within this document the term substance refers to drugs and alcohol. The provider must meet the unique needs of the establishment and take into account the needs of the population within that establishment (see Section 7 – Need and Section 8 - Setting).

5.2 Service Outcomes

Prospective providers should – above all – have the ability to demonstrate meaningful outcomes.

A number of sources of guidance and review have recommended multiple options for service outcomes and developments moving forwards, including;

- a. "Health Outcomes in Prisons In England: a rapid Review" (October 2016)¹⁰
- b. NHS Outcomes Framework Domains and Indicators¹¹
- c. Service Specification 29 of Section 7a NHS Public Health functions¹²
- d. Health and Justice Outcomes detailed in the Patel Report¹³
- e. NHS England strategic direction for health services in the justice system 2016-2020¹⁴

The outcomes for this specification – detailed below – have a suffix denoting which of the above outcome frameworks that they are drawn from.

The service provider will work in partnership with the commissioners, Governors and other stakeholders to contribute towards the following outcomes and will consider all opportunities to enhance the aims of the service:

OUTCOME 1
Freedom from dependence on drugs and alcohol (c) (d) (e)
Secondary outcomes and processes
1.1 A decisive shift towards person-centred care that provides the right treatment and support (e) 1.2 Successful completion of a treatment intervention in custody and not representing (either in custody or community) within 6 months of release (c) 1.3 Successfully engage in community based treatment following release (c) (d) 1.4 Where transferred to another secure / detained setting, successfully engaged with treatment at receiving establishment (c) (d) 1.5 Percentage starting treatment in establishment within 3 weeks of arrival (c) (d) 1.6 Percentage receiving clinical treatment who are also receiving psychosocial interventions to address substance misuse (c) (d) 1.7 Supporting rehabilitation and the move to a pathway of recovery (e)

¹⁰ Health Outcomes in Prisons in England: a rapid review - <https://www.gov.uk/government/publications/health-outcomes-in-prisons-in-england-a-rapid-review>

¹¹ <https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017>

¹² <https://www.england.nhs.uk/commissioning/pub-hlth-res/>

¹³ <https://www.gov.uk/government/publications/the-patel-report-reducing-drug-related-crime-and-rehabilitating-offenders>

¹⁴ <https://www.england.nhs.uk/commissioning/health-just/#justice>

OUTCOME 2

Preventing people from dying prematurely (b)
Enhancing quality of life for people with long term conditions (b)

Secondary outcomes and processes

- 2.1 Smoking cessation service uptake (within context of smoke free prisons programme) (c)
- 2.2 HIV Testing uptake, as a percentage of the eligible population (c)
- 2.3 Hep C Testing uptake, as a percentage of the eligible population (c)
- 2.4 Hep B Testing uptake, as a percentage of the eligible population (c)
- 2.5 Physical Health Checks uptake (as a percentage of the eligible population) (c)
- 2.6 Reduction in substance related harm within the establishment (d)
- 2.7 Treating and caring for people in a safe environment; protecting them from avoidable harm (b)

OUTCOME 3

Supporting Recovery
Helping people recover from episodes of ill health or following injury (b)
Enhancing quality of life for people with long term conditions (b)
Improve the health of the most vulnerable reduce health inequalities (e)

Secondary outcomes and processes

- 3.1 Increasing focus on self-management approaches (a)
- 3.2 Focus on strengths and assets – not just deficits
- 3.3 Proactive early intervention which models recovery as an end goal (a) (e)
- 3.4 Increased and enhanced access to peer approaches (12 step, SMART Recovery etc.) as well as establishment based peer support (mentors, listeners, peer advocates) (a)
- 3.5 Improved health, social functioning and relationships, including the use of Health Champions (or equivalent) (d)
- 3.6 Reduced likelihood of a return to dependent substance misuse on exiting the establishment, including access to mutual aid and recovery communities and wrap around services (d)
- 3.7 Improved care co-ordination of patients through joint working with healthcare and mental health services (d)
- 3.8 Assessment, care plan review and service delivery actively seek to identify and address vulnerabilities and health inequalities (e)
- 3.9 Supporting rehabilitation and the move to a pathway of recovery (e)

OUTCOME 4
Improved throughcare; focus on entry and exit continuity of care (d) to support recovery and reduce re-offending (e)
Secondary outcomes and processes
<p>4.1 Effective linkages evidenced with wider care pathways and community structures / services related to accommodation, employment and education (a) (e)</p> <p>4.2 Successfully engage in community based treatment following release (c) (d)</p> <p>4.3 Where transferred to another secure / detained setting, successfully engaged with treatment at receiving establishment (c) (d)</p> <p>4.4 Percentage starting treatment in establishment within 3 weeks of arrival (c) (d)</p> <p>4.5 Ensuring continuity of care, on reception and post release, by bridging the divide between healthcare services provided in justice, detained and community settings (e)</p> <p>4.6 Effective use of drug rehabilitation requirement (DRR) and the alcohol treatment requirement (ATR) (e)</p>

OUTCOME 5
<p>Strengthening the voice and involvement of those with lived experience (d) (e)</p> <p>Engaging people with lived experience in the delivery of services and mutual aid networks (d) (e)</p>
Secondary outcomes and processes
<p>5.1 Increased and enhanced access to peer approaches (12 step, SMART Recovery etc.) as well as establishment based peer support (mentors, listeners, peer advocates) (a)</p> <p>5.2 Consistent engagement with those with lived experience throughout the commissioning, planning, delivery and service review aspects of service delivery, including financial and other support to enable individuals to engage to the level that they would expect</p> <p>5.3 A decisive shift towards person-centred care that provides the right treatment and support and forums for service users (e)</p>

5.3 Service Standards

- Individual needs-led recovery care planning and key working for all clients must be part of a care planned approach to care. There will be one care plan for both clinical and psychosocial interventions, and inclusion or strong linkage to other

care plans (such as education, work or community interventions) should be considered.

- The service provider will be required to offer a programme of integrated recovery focused substance misuse structured interventions and services (including harm reduction) for any prisoners entering into the establishment who are screened as having a substance misuse need or who self-refer.
- The Service Provider must have a named Single Point of Contact (SPOC) in the establishment for all relevant professional bodies, and maintain a single point of contact for secure email; and a fax number for referrals within each establishment.
- All client contacts must be noted on SystemOne or any successor IT system. This includes all psychosocial interventions and contacts by external drug and alcohol services, who should be facilitated access to the system, after signing up to the relevant information sharing protocols.

5.4 Service Expectations

The service(s) will be available to prisoners within the specified prison.

The service provider will deliver efficient, effective individualised interventions/recovery focused services that meet the needs of all service users and contribute to the service outcomes outlined above. In doing this the service must:

- Support and enable service users to reduce their dependency on drugs and/or alcohol to enhance their chances of recovery
- Work closely with the prison, prison healthcare services and mental health services to enable service users to improve their physical and mental health
- Work with Security departments to ensure Supply and Demand strategies are in place to reduce the supply of drugs and alcohol into prisons and the diversion of prescribed medication
- Engage as an active member of the Establishment Substance Misuse Strategy Board
- Work closely with partners to develop and implement a co-ordinated strategy to address **emerging** needs – such as the increase in availability and use of Psychoactive Substances (PS), supporting activity to reduce their supply and leading on treatment interventions and activities to both reduce demand and address the emergent problems PS cause – both at point of managing the acute symptoms of use and in developing resilience through psychosocial interventions, and developing a coherent strategy to the management of and response to the illicit use of prescribed and over the counter medications – both those smuggled in to the establishment and those diverted from legitimate prescribing activity within the establishment. Service providers should also be familiar with systems to understand and report harms from PS¹⁵

¹⁵ <https://report-illicit-drug-reaction.phe.gov.uk/>

- Develop and monitor an appropriate Workforce Plan incorporating minimum standards, staffing levels, supervision requirements, development planning, contingency staffing arrangements etc.¹⁶
- Design and resource an appropriate range and variety of therapeutic interventions and/or therapeutic communities to reflect both the presenting needs of the population, the model of intervention being offered, the type of prison and length of sentence, and the stated ambitions of service users expressed either informally or through structured user involvement processes
- Reduce the risk of re-offending following release through robust through care and release planning, including active engagement with Community Rehabilitation Companies (CRCs) and the National Probation Service (NPS).
- Accounting for diversity and carrying out Equality Impact Assessment
- To ensure that the information made available to service users is accurate, appropriate and factually correct. Such information should be accessible and meaningful in terms of context, language, literacy level and understanding – meeting the Accessible Information Standard. Advice and information should be provided by a variety of methods including oral, written, audio-visual aids and face to face.
- Establish and maintain professional and appropriate working relationships with prison governors, discipline officers, Voluntary, Community and Social Enterprise groups (including Mutual Aid and Self-Help Groups) and all other staff working in partnership in the prison to ensure the efficient and effective operation of the substance misuse service and recovery focused services/interventions
- Establish and maintain clear and effective pathways between prisons, prisons and community substance misuse services, from reception to release.
- Allocate prisoners to pathways dependent on need to ensure the right service is delivered at the right time ensuring selection; de-selection criteria and sequencing are appropriate to individual need and length of time in prison.
- Pro-actively work to re-engage service users who have ‘dropped out’ of treatment prematurely or who have never engaged with treatment previously.
- Prescribe in accordance with relevant guidance
- Undertake therapeutic drug testing in accordance with relevant guidance, and take part in HMPPS quality assurance programme

The Service Provider must work in partnership with the full range of health or social care organisations in the community and in prisons to support service users and/or their families to achieve the Service Outcomes.

Partnership working requires the Provider to work collaboratively with all departments throughout the establishment and should include their arrangements for partnership working with Security Departments, Safer Custody Teams, and Offender Management Units etc. and through the gate, CRCs/National Probation Service, Local Authorities and other recovery focused services.

¹⁶ <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/03/health-justice-competence-framework.pdf>

The Service Provider will liaise with and work collaboratively with all commissioned services working within the prison which include:

- Sexual Health In Reach Services
- Integrated Clinical Assessment & Treatment Service (ICATS)
- Dental and Oral Health Services
- GP services
- Podiatry Services
- Occupational Therapy Services
- Mental Health In Reach and Forensic
- Opticians
- Pharmacy Services
- Any other Specialised Services

Representatives from the Service Provider must attend relevant establishment and /or partnership meetings to improve the effectiveness of the service and to facilitate the smooth running of the prison – including any ACCT processes where applicable.

The Service Provider will be required to work in close collaboration with any persons appointed by the Commissioners to undertake an evaluation of the Service.

The Service Provider must ensure all health and social care professionals involved in the service user's care or associated care are kept fully informed of the service user's progress.

5.5 Screening and Assessment

The Service Provider must undertake an appropriate level of screening for substance misuse and those identified as needing structured treatment must then receive the comprehensive substance misuse assessment

Examples of screening/assessment activity:

- Undertake a clinical assessment to ensure that any clinical issues requiring immediate attention are managed appropriately. Ensure that they are managed in the appropriate location according to their needs (i.e. Stabilisation Unit or Healthcare)
- The screening will include the use of the Alcohol Use Disorder Identification Test (AUDIT)
- Identify the service user's immediate and long term needs and goals to aid recovery
- Identify relevant family issues that may have a bearing on the service user's recovery and re-integration
- Establish which other agencies are involved with the service user
- Identify any need for and make referrals to other prison services (e.g. mental health)

- Ensure that the service user has read and understood how information about them will be handled and shared
- Determine whether or not the service user consents to have their information submitted to the National Drug Treatment Monitoring System (NDTMS) and any other future relevant authority data collection initiative – supporting their understanding that the information will help with the delivery and co-ordination of care and will be kept safely and confidentially
- Assess risk of Self Harm and/or harm to others
- Establish whether any risk management plans are currently in place and develop risk management plans according to need. It is not possible to provide an exact formula to assess risk. Rather, staff must assess risk based upon reasoned judgement and their in-depth knowledge of the service user.¹⁷ Though primarily developed for mental health care programme approach purposes, the Sainsbury risk assessment tool can be modified to suit the client group and setting¹⁸
- Establish whether the individual is a primary carer for children, or for a vulnerable adult

5.6 Mental Health

It is essential that addictions services are involved with those with comorbid mental health problems; however, those patients and their care also need to be integrated with forensic mental health services.

Service users with co-morbid mental health and substance use issues often have multiple and complex needs, which require a comprehensive, coordinated, seamless, multi-agency response¹⁹. The Service Provider must:

- Operate from a position of “No Wrong Door”; wherever a service user presents – to substance misuse services, mental health services or via some other intervention, it is incumbent upon providers to meet immediate needs and bring appropriate provision to the client, not ‘send’ the client to another intervention; there should be no ‘hand offs’
- Should be able to evidence jointly run group interventions, and co-attendance at Complex Care Meetings
- Contribute to the development of clear pathways and joint assessments with mental health and primary care services to ensure high levels of joint working for those identified with a multiple needs

¹⁷ <https://www.rcpsych.ac.uk/pdf/Camden%20risk%20assessment%20and%20management.pdf>

¹⁸ <http://www.bcpft.nhs.uk/documents/policies/c/1393-care-programme-approach-appendix-4-sainsbury-s/file>

¹⁹ working with people with co-occurring mental health and alcohol/drug use conditions https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

- Ensure substance misuse advice and support is provided to mental health agencies that are responsible for co-ordinating care delivery for service users with severe and enduring mental illness
- Contribute to the development of a mental health and substance misuse comorbidity protocol for prisons and comply with the protocol once agreed.
- Ensure Mental Health issues are assessed and care delivery is coordinated or managed for service users with common mental health and substance misuse problems – often through joint care planning
- In consideration of clients with suspected or diagnosed Personality Disorder, services should be skilled enough to assess the cause of any concurrent substance misuse and the need to offer meaningful intervention (e.g. cognitive behavioural therapy, trauma therapy, coping strategies) and to enable further assessment and intervention

5.7 Recovery Planning and Review

Recovery planning must be instigated from very first client contact. The service provider must work with the service user (and other parties as necessary) to develop and agree a suitable recovery plan on the basis of the comprehensive substance misuse assessment.

At the recovery planning stage, service users must receive an induction, which must include:

- Details about the service
- Maintaining safety, reducing harm
- Details of service user involvement, peer support and carer support
- General expectations
- Code of conduct
- The complaints procedure as set out by the prison establishment
- Emergency planning process in relation to unexpected transfer or release

This induction will be revisited after a period of stabilisation and at regular periods (at least every 3 months), in line with national guidance thereafter, to ensure clarity and understanding.

The Service Provider must ensure suitable and appropriate care co-ordination and review throughout a Service User's treatment journey. As part of this, the Service Provider must ensure provision of recovery plan reviews at suitable intervals, as well as updating the comprehensive substance misuse assessment at regular intervals.

Celebrating success in recovery can mark a significant milestone for service users to recognise achievement and distance travelled. It is fundamental for SUs and also inspirational for other patients and can encourage strengthened links between family and friends.

5.8 Sentence Planning

The Service Provider will work with Offender Supervisors in the Community Rehabilitation Companies (CRC's) and National Probation Service (NPS) to contribute to sentence plans or other individual management boards for prisoners with substance misuse problems.

The Provider must also work closely with CRCs in resettlement prisons (and NPS in respect of high risk offenders allocated to them to manage) to help them to deliver resettlement services to offenders. This is particularly important during the development of an individual resettlement plan for each prisoner to meet their immediate needs upon entering custody, and in the 12 weeks prior to their release to help deliver the resettlement plan and associated services. Release planning must begin immediately and be a continual part of the care planning process.

The Service Provider must develop strong links and clear referral pathways with local community substance misuse providers, Voluntary, Community and Social Enterprise organisations that provide recovery focused services to ensure continuity of care for service users being transferred between community to custodial settings and vice versa.

The Service Provider must develop robust plans and mechanisms for continuity of care for clients on their release from custody to whichever region or local authority they are returning to. The plans should form part of an overarching recovery, treatment and/or care plan, which is discussed with the service user and community providers at the earliest opportunity, and the resettlement plan developed by the CRC providing the through the gate service at the prison.

The release plan must include details of their local treatment provider in case of unexpected or early release and the prison SPOC for the community substance misuse provider to contact. There must be explicit arrangements detailed for the continuation of medicines, including liaison with community pharmacy and other primary care providers, especially where there is a prescription provided on release.

5.9 Interventions

In working towards delivering the service outcomes and aims, the service must, as a minimum offer the following interventions as appropriate for each individual establishment:

- Advice, information and use of brief interventions model to help prevent and minimise problematic substance misuse or dependency
- Consistent key-working and care planning (comprising regular meetings with a nominated professional) to help enhance the service user's recovery. Ideally each individual should have a named nurse and a named recovery co-ordinator to jointly work in ensuring appropriate co-ordination of care
- Substitute prescribing services offering a range of pharmacological interventions and supervised consumption with a focus on recovery from substance dependency and the provision of evidence based drug and alcohol testing equipment and facilities. This should include provision of first-night prescribing and ensuring the required

observation for those undergoing titration or detoxification. Where therapeutic/alcohol testing is undertaken to support treatment programmes, service providers will be required to take part in the HMPPS Quality Assurance Programme.

- Protocols and Standard Operating Procedures will be developed for all elements of the pathway / provision
- There should be an appropriate skill mix of prescribers within any team to ensure that those in prescribed treatment do not have to wait to see their GP to amend a prescription; for example, mirroring activity within community-based services where non-medical prescribers (NMPs) can carry out these functions.
- Clinicians need to have appropriate competencies for their clinical roles and receive training to achieve those competencies. They need to have appropriate certification, such as specialist registration, and take account of any professional revalidation. Clinicians benefit from individual or peer supervision, personal development plans, mentoring or other forms of professional support. Clinicians have an obligation to update their knowledge and skills base according to emerging evidence and developments in professional practice. Appraisal is mandatory for all clinicians working in the NHS and is good practice in other settings. An appropriately skilled and qualified clinician should be available to the service to provide advice, information and assistance in line with Medications in Recovery: Re orientating Drug Dependence Treatment National Treatment Agency (NTA) 2012. NICE Guidance (2007) and the Department of Health Clinical Management of Drug Dependence in the Adult Prison Setting (2007), Drug Misuse and Dependence UK Guidelines on Clinical Management (2017) & RCGP Safer Prescribing In Prisons: Guidance for Clinicians (2011) and any succeeding guidance
- Clinical stabilisation, for all substances and detoxification from substances of dependency, to include symptomatic prescribing as required,
- A rolling programme of evidence based suitable care planned interventions, structured psychosocial interventions (of at least medium intensity, rather than advice and information type approaches), and individually tailored according to service user need. To include programmes for those actively working towards abstinence and programmes suitable for those receiving pharmacological interventions
- Relapse prevention advice and support, including the use of medicines to support this (e.g. Naltrexone, Acamprosate)
- Overdose prevention and harm reduction advice
- Liaison with appropriate services e.g. acute medical and psychiatric health services (such as ante natal, mental health or clinical hepatology services), social care, housing services and other generic services
- Proactive aftercare / release planning
- Naltrexone prescribing for clients leaving custody opiate free where indicated and clinically advised²⁰
- Ongoing advice and support to help sustain long term recovery
- Mutual aid / peer support groups to model recovery
- Appropriate interventions for increasing and high risk drinkers as defined in Models

²⁰ <http://www.hra.nhs.uk/news/research-summaries/naltrexone-enhanced-addiction-treatment-neat/>

of Care for Alcohol Misuse 2006 (MOCAM).

- Naloxone is a potentially life-saving medicine when used in settings associated with opiate misuse and overdose. Systematic reviews conclude that pre-provision of naloxone to heroin users can be helpful in reversing heroin overdoses. There is also evidence for the effectiveness of training family members or peers in how to administer the drug. Commissioners should agree with prison health and community providers how best to facilitate support for naloxone provision on release, to ensure that where it is considered necessary to maintain safety an approach is agreed as a part of Release Planning and subsequent community treatment engagement.²¹
- Prison wing based treatment options to be available where appropriate; e.g. recovery wings, or offering appointments on all wings – though this should not distract services (where this is the chosen approach) from reducing stigma through normalizing placement of those with addiction problems within the general population
- Supportive activity and active patient management in liaison with prison smoking cessation provision, providing (where trained) smoking cessation interventions to patients within substance misuse services and further group / relapse prevention as a part of the smoke free prisons programme. Support to smoking cessation provision should also include increased psychosocial support (alongside smoking cessation advisers), and joint work to prevent and manage any misuse of nicotine replacement therapy (NRT).
- Joint working with Mental Health for clients with diagnosed or non-diagnosed co-morbidity
- Joint working with Health Care, Mental Health and prison discipline staff in relation to self-harm (actual, threatened or risk of) and active contribution to ACCT review
- Qualitative information provided to inform Risk Management procedures including: Parole Boards, Multi-Agency Public Protection Arrangements (MAPPA), ACCT, Jigsaw, Home Detention Curfew (HDC), and Release on Temporary Licence etc.
- Supporting families and friends of service users by direct support, engagement within the visits centre, signposting, liaison and referral of families to community based family and carer services

5.10 Continuity of Medication

Continuity of medication should form part of a care plan which includes arrangements in the event for a planned or unplanned release from prison. Medicines used to treat substance misuse are listed as critical medicines that require prompt continuity to minimise harm from omitted doses (*NICE Physical health in Prisons*). Release planning will require arrangements for ongoing access to OST that minimises the risk of harm post-release in line with national clinical and professional guidance.

The period immediately following release is a time of considerable vulnerability. For people leaving prison receiving opiate maintenance, contact should be established with a

²¹ The ACMD's 'Consideration of naloxone':
www.gov.uk/government/uploads/system/uploads/attachment_data/file/119120/considerationof-naloxone.pdf

community service at the earliest opportunity after reception, so that release planning can be facilitated (such as an appointment already scheduled for attendance following release and how to manage an unplanned release). Close working between the prison drug treatment and community treatment providers, including community pharmacy services, is central to the securing of good integrated care.

The options used would depend on local agreed pathways, the individual's safety/clinical considerations and take account of where they will be accessing pharmacy and community services when they are released.

- Unless the dose has been arranged to be administered or supplied in the community on the day of release or transfer, people in prison should have their dose of opioid substitution therapy (OST) before they leave to cover their OST during the first 24 hours after leaving the prison.
- Prior to a planned release all prisoners on substitute medication will have short term substitute medication needs and continuity of care issues addressed - including liaison with community services. FP10's or FP10MDAs can be used where required in line with national guidance²²
- Supply of Short term OST on release or FP10/FP10MDA risks will be balanced against the risk of releasing the person with no planned access to enable OST continuation - Where a decision is made to release a person without access to a supply of OST that could result in omitted doses, the reason for releasing the person without plans for continued medication should be clearly recorded in their clinical record and access to prompt re-assessment on release planned.
- Prison substance misuse providers should take the lead in making plans for medicines continuity at the point of release, though good liaison and planning systems are also required within community provision to ensure the effective and rapid engagement of patients leaving custody.

A range and choice of substance misuse rehabilitation programmes to support the following:

- A focus on the individual's strengths and assets as a way to achieve recovery, rather than a focus on 'correcting deficits'
- Abstinence from drugs and/or alcohol (and working towards abstinence)
- Reducing risk in the number of prisoners drinking above NHS guidelines
- Reducing risk of drug or alcohol related offending
- Enhancing Recovery Capital and Relapse prevention
- Increasing motivation in prisoners previously unwilling to engage with substance misuse services/interventions
- Tailored interventions designed to improve social functioning and enhance life skills
- Tailored interventions to address other underlying issues (loss, trauma, abuse)
- Therapeutic drug and alcohol; testing to ensure compliance with treatment and psychosocial interventions

²² <http://www.rpharms.com/unsecure-support-resources/professional-standards-for-optimising-medicines-for-people-in-secure-environments.asp>

5.11 Peer Led Approaches

The Provider will work with the Prison Establishments to select, train and retain peer supporters/recovery champions and ensure adequate supervision and records of attendance. Selection would ideally be based upon recovery progress and attitude as well as risk / offence.

The Service provider will liaise with the establishment / Governor to ensure that processes are in place for the training and weekly wages of peer supporters (likely to be in the region of £1100 per peer supporter per annum). Further elements may include;

- Accredited training and qualifications
- Input from a clinical professional as part of training and supervision
- Work hours paid once training/qualifications completed
- Peer supporters could be offered progression opportunities within the service/organisations
- Offer support to continue peer mentoring on release e.g. references, linking with community services
- NCVO/Mentoring and Befriending Foundation Approved Provider Standard

Family, friends and carers

The Service Provider will work in partnership with local carer's agencies to ensure family friends and carers access the range of support available. The service will include a lead family liaison role which will enhance community services to enable prisoners to maintain, develop and build upon family relationships, especially with children under the age of 18.

5.12 Drug Testing

- Testing for substances must be undertaken on first night entry / reception, prior to initiating prescribing and on a risk assessed basis thereafter. Staff should be suitably trained and competent to interpret test results
- Testing will be undertaken for therapeutic purposes only, and not Mandatory Testing, to ensure compliance with treatment programmes and prescribed medications
- The provider must ensure that testing complies with Quality Assurance processes, legislation and relevant Prison Service Instructions (PSI) or Prison Service Orders (PSO)
- Positive tests must be shared with other parties where there are concerns that not doing so will harm the individual or jeopardise the security and safety of the prison and or staff or other offenders.

5.13 Access to information and Confidentiality

The Service Provider must comply with any Prison Information Sharing Agreement and the Data Protection Act 1998 as well as PSO 9015; Information Assurance (and subsequent documents that supersede these).

Information collected and recorded by the Service Provider (or sub-contractors) in regard to service users who attend and/or engage with treatment will be made available, within stated and agreed parameters, agreed data sharing arrangements and paying due regard to NHS England Information Sharing Policy, to members of the Commissioners or other persons appointed by the Commissioners.

There must be representation from Substance Misuse Service Manager and/or service delivery manager at security committee meetings and a reciprocal arrangement with Medicine Management Meetings, where the robust sharing of information should be facilitated. Any relevant Terms of Reference should be amended if required

Particular attention should be paid to suspected illicit drugs (including prescription and over the counter drugs) used by prisoners. Such intelligence and information should be acted upon, and may include reviews of prescriptions and/or risk assessments for in-possession medication, and drug/alcohol testing where appropriate. Where a prisoner provides a positive drug test whilst receiving a clinical intervention, for non-prescribed substances, the information about any substances should be shared with relevant prison security departments through a security information report (IR), for the purposes of monitoring and reacting to the availability of illicit substances circulating in the establishment. **Clinical and patient identifiable data is not required for this purpose.**

Prison Security departments should refer any prisoner who provides a positive MDT test into treatment services.

The provider must provide each service user with a copy of the provider's privacy notice. This should tell people:

- who you are;
- what you are going to do with their information; and
- who it will be shared with.

These are the basics upon which all privacy notices should be built. However, they can also tell people more than this and should do so where you think that not telling people will make your processing of that information unfair. This could be the case if an individual is unlikely to know that you use their information for a particular purpose or where the personal data has been collected elsewhere.

5.14 Supporting Resources

The GMC's Good medical practice guidelines (2013) www.gmc-uk.org/guidance/good_medical_practice.asp

British National Formulary www.medicinescomplete.com/mc/bnf/current (requires registration)

Summaries of Product Characteristics (SPCs) and Patient Information Leaflets (PILs) www.medicines.org.uk/EMC

Professional Standards for optimising medicines for people in secure environments – Prisons, Young Offender Institutions and Secure Training Centres (Edition 2); Royal Pharmaceutical Society (RPS), 2017 <http://www.rpharms.com/unsecure-support-resources/professional-standards-for-optimising-medicines-for-people-in-secure-environments.asp>

Smoke Free Prisons 'Minimum Service Offer' – NOMS, PHE and NHS England <https://www.england.nhs.uk/publication/minimum-offer-for-stop-smoking-services-and-support-in-custody/>

Details of testing and treatment for hepatitis C are available from the National Institute for Health and Care Excellence (www.nice.org.uk)

European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction (2011). Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC http://ecdc.europa.eu/en/publications/Publications/111012_Guidance_ECDC-EMCDDA.pdf

European Association for the Study of the Liver (2015) EASL recommendations on treatment of hepatitis C 2015. Journal of Hepatology 63: 199-236 www.easl.eu/medias/cpg/HEPC-2015/Full-report.pdf

ICO Guidance: What you should include in Privacy Notices. <https://ico.org.uk/for-organisations/guide-to-data-protection/privacy-notice-transparency-and-control/what-should-you-include-in-your-privacy-notice/>

6 Benchmarks

The Provider must evidence their ability to manage a clinical service with due regard to;

- 6.1 A full breakdown of the workforce required to deliver the service, including expected numbers of staff carrying out different roles and their minimum levels of qualification. Consideration should be given to cover arrangements in the event of absence, to ensure as far as possible continuity of provision
- 6.2 The appropriateness and safety of the setting
- 6.3 A comprehensive range of interventions, from advice, information and harm reduction, through to structured psychosocial interventions (especially where a medical or prescribed intervention is indicated and offered)
- 6.4 Availability of provision - including operating at lunchtimes, evenings and weekends where required
- 6.5 Extensive and visible access to peer support and Mutual Aid Groups - available to all prisoners
- 6.6 Taking account of the regime, access to education and employment, and prioritising safety and security
- 6.7 The provider will be able to evidence their ability to provide a high quality, safe and accessible service across a range of settings. This will include the production / updating of a service-level Health Impact Equality Assessment
- 6.8 In carrying out the Services the Provider will be “exercising public functions” for the purposes of section 149(2) of the Equality Act 2010. As such, the Service Provider must pay due regard to the Public Sector Equality Duty under section 149(1) of that Act and to deliver the Services accordingly. The Equality Act 2010 relates to service users and employees.
- 6.9 The Service Provider must record structured treatment activity and performance information on an appropriate clinical and case management database, agreed with the Commissioner. This will include collation of data by equality profiles on service users and outcomes and the ability to report this as a part of performance and governance monitoring processes
- 6.10 The Provider must ensure full, accurate and timely reporting of activity through NDTMS and SystmOne (or any successors thereof)
- 6.11 The Provider will need to ensure they hold the appropriate licenses (controlled drug, CQC registration etc.) in order to deliver services.
- 6.12 The Provider must evidence the policies, procedures and protocols that are in place to manage the service and its staff (e.g. Safeguarding, Health & Safety, Incident Management, Performance & Capability etc.).

6.13 Governance and Quality

Governance – previously referred to as ‘clinical governance’ – is an established system in the NHS and the independent healthcare sector to deliver and demonstrate that quality and safety of its services are of a high standard that is continually improving. The expectation of any service delivering care on behalf of NHS England would be that robust governance structures and systems are in place, visible and effective, including (but not limited to);

- A clear iteration of the minimum levels of leadership (both managerially and clinically)
- Evidence of risk management assessment, escalation and review
- A ‘no blame’ culture, and the enablement of ‘whistleblowing’ in a safe and reassuring manner
- The effective management of Serious and Untoward Incidents (SUIs) and ‘near misses’, with clearly articulated and public escalation, reporting and review processes and subsequent shared learning and development activity

NHS England Health and Justice Commissioning are committed to improving the quality of clinical interventions through a systematic approach. The Service Provider, Service and individual clinicians have to take account of both formal and informal governance structures.

The Service Provider and Service should abide by local and national arrangements for governance. Managers of services will ensure quality through appropriate governance arrangements and report to Commissioners on governance as required.

The Service Provider must ensure attendance and contribution at quality boards/governance meetings within the prison establishment.

The Service Provider must follow the NHS England Serious Incident Framework²³, including controlled drug incident process.

Documentation, guidance and resources

- New psychoactive substances (NPS) in prisons – a toolkit for prison staff
Public Health England, 2016
- Routes to Recovery: Psychosocial Interventions for Drug Misuse – a framework and toolkit for implementing NICE recommended treatment interventions.
Commissioned by the National Treatment Agency (NTA) from the British Psychological Society (BPS)
- National Treatment Agency (NTA) Integrated Drug Treatment System: The first 28 days
- Medications in Recovery: Re-orientating Drug Dependence Treatment NTA 2012
- Clinical Guidelines on Drug Misuse and Dependence Update (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health
- NICE Technology Appraisal 114 (Methadone and Buprenorphine for the

²³ <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

- Management of Opioid Dependence)
- NICE Clinical Guidance 51 (Drug Misuse: Psychosocial interventions)
 - NICE Technology Appraisal 115 (Naltrexone for the Management of Opioid Dependence)
 - Joint Commissioning Panel for Mental Health guidance on drug and alcohol services
 - NICE guidelines on coexisting severe mental illness and substance misuse
 - NICE guidelines on physical health of people in prison
 - NTA Models of Care for the treatment of adult drug misusers 2002 and update 2006
 - NICE Clinical Guidance 52 (Drug Misuse: Opioid detoxification)
 - Models of Care for Alcohol Misuse 2006 (MOCAM)
 - NICE Clinical Guidance 100 (Alcohol use disorders: Diagnosis and clinical management of alcohol-related physical complications)
 - NICE Clinical Guideline 115 (Alcohol use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence)
 - NICE Public Health Guidance 24 (Alcohol use disorders: Preventing harmful drinking)
 - Guidance on the Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Novel Psychoactive Treatment UK Network (NEPTUNE). London, 2015.
 - Good Practice in Harm Reduction
 - NICE Public Health Guidance 18 (Needle and syringe programmes: providing people who inject drugs with injecting equipment)
 - NTA Guidance: Clinical management of drug dependence in the adult prison setting including psychosocial treatment as a core part (2006) and its subsequent updates
 - All current relevant Prison Service Instructions (PSIs) and Prison Service Orders (PSOs) and good practice guidance
 - This list is not exhaustive

7 Setting

Note to Local Commissioners

This section should be removed prior to publishing, and replaced with any locally and regionally derived information and evidence (e.g. from Health Needs Assessments) as to the specific needs of individuals dependent upon the setting in which they are seeking / receiving treatment.

NB: The current programme of reform of the prison system in England by the Ministry of Justice and Her Majesty's Prison and Probation Service will impact on considerations of setting, as the custodial estate remodels. Given this ongoing development, the detail below will need to be revisited in 2017/18 to ensure that it keeps pace with the changes in prison configurations.

Within the ethos of co-commissioning between Health Commissioners and Prison Governors, and maintaining the flexibility of this specification to be adapted to local need, this section is where you would consider and iterate the specific needs of the setting within which the service is to be provided, such as;

- Reception Prison
- Open Prison
- Trainer
- High Secure
- Long Term

The impact of the different settings should help providers to consider their service model and the needs to be met through their service offer, and subsequently help commissioners and providers with co-designing the service.

Considerations of setting should also include the appropriateness of the estate to facilitate effective treatment and recovery interventions, such as a healthcare setting which actively promotes recovery, safe and appropriate dispensing facilities, and whether recovery wings and therapeutic communities could enhance the model of delivery.

8 Cohorts

Note to Local Commissioners

This section should be removed prior to publishing, and replaced with any locally and regionally derived information and evidence (e.g. from Health Needs Assessments) as to the specific needs of groups prevalent within the establishment who may have differential access requirements or intervention needs dependent upon their individual characteristics.

Within the ethos of co-commissioning between Health Commissioners and Prison Governors, and maintaining the flexibility of this specification to be adapted to local need, this section is where you would consider and iterate the specific needs of the treatment cohort(s) within which the service is to be provided, such as;

- Women
- Older prisoners
- Sex offenders
- Transgender prisoners
- End of life care

Impact on different cohorts should help providers to consider their service model and the needs to be met through their service offer, and subsequently help commissioners and providers with co-designing the service. Example guidance below; the list is not exhaustive.

Patient Cohort	Relevant guidance
Women	WHO - Women's health and the prison setting ²⁴ Clinks – Health and care services for women offenders ²⁵
Transgender	Care and management of transgender offenders ²⁶ NHS England Health & Justice Transgender Review – <i>not yet published</i>
Personality Disordered	The offender personality disorder pathway strategy ²⁷
Older people	Prison Reform Trust – ‘Doing Time’ – older people in prisons ²⁸ Needs and characteristics of older prisoners ²⁹
Black and Minority Ethnic	The Lammy Review ³⁰ Clinks – BAME needs and resources ³¹
Protected Characteristics	The needs of individuals with any of the Protected Characteristics should be taken into account in line with current legislation, Equality Act 2010 ³² .

²⁴ http://www.euro.who.int/_data/assets/pdf_file/0006/249207/Prisons-and-Health,-18-Womens-health-and-the-prison-setting.pdf?ua=1

²⁵ http://www.clinks.org/sites/default/files/basic/files-downloads/health_and_care_services_for_women_offenders_finalv2.pdf

²⁶ <https://www.gov.uk/government/publications/care-and-management-of-transgender-offenders>

²⁷ <https://www.england.nhs.uk/commissioning/wp-content/.../opd-strategy-nov-15.pdf>

²⁸ <http://www.prisonreformtrust.org.uk/ProjectsResearch/Olderpeopleinprison/>

²⁹ <https://www.gov.uk/government/uploads/.../needs-older-prisoners-spcr-survey.pdf>

³⁰ <https://www.gov.uk/government/organisations/lammy-review>

³¹ <http://www.clinks.org/criminal-justice/black-asian-minority-ethnic-bame>

³² http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

9 Health and Justice Specification

Annex 1

This document should be read in conjunction with the standard annex referenced below.

[Standard Annex to Health and Justice Service Specifications](#)

[Adult Prison Estate](#)

[March 2018](#)

[Publications Reference Gateway 07873](#)