The First Stage of the Evaluation of IDTS

Prison, Health Care Staff and Primary Care Trusts Perception of Implementing IDTS in the First Wave of Prisons

Prison Health Research

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We would like to thank all the IDTS leads who have participated in the study, especially, for their time and their openness when discussing their difficulties preparing to implement IDTS. Without their contribution, the insight that we have acquired would not have been possible.

AIM OF THE REPORT

The aim of report is to highlight the experiences of the first wave of prisons in implementing IDTS in order to

- inform and guide the next implementation phase.
- to highlight the issues Offender Health need to either consider or address and
- to inform the specification for full IDTS research evaluation.

It is intended for broad readership. However, it may be of particular interest to Governors, PCT and IDTS leads who are preparing to implement IDTS.
SUMMARY

The Integrated Drug Treatment System (IDTS) is a new initiative that aims to radically improve the clinical and psychosocial services offered to substance misusers within prisons. The introduction of IDTS aims not only to increase the volume and quality of treatment available to prisoners, with particular emphasis on early custody, but also to address better integration between clinical and CARAT Services and reinforce the continuity of care between prisons and for those released into the community. At the commencement of the study forty-six prisons were included in the first wave of implementation. The aims and objectives of the study were: to identify the key steps in the first wave of implementation of IDTS; inform both the next implementation phase and the specification for full IDTS research evaluation.

The research combines both qualitative and quantitative approaches. IDTS leads from 38 prisons participated in a telephone interview to explore the following: their perception of IDTS; the level of support that they have received; the key obstacles that delayed implementation; the perceived difficulties when IDTS is implemented and suggestions as to how the second wave of prisons could implement IDTS more effectively. The following six themes associated with the implementation of IDTS were identified: fundamental problems; operational issues; lack of communication; staff-related issues; major concerns and ethical issues.

Findings suggest that prison establishments are embracing IDTS and the vision Offender Health have for the future development of prison healthcare. Ensuring that the vision becomes reality requires determination; dedication; effective communication between IDTS leads, PCTs, Offender Health , CARAT teams, prison drug strategy leads, prison governors and all relevant stakeholders; courage of conviction; the ability to critically evaluate the implementation process; the ability to learn from mistakes and a sense of openness to amendments throughout the whole process of implementation. The fact that IDTS steering group have commissioned this study and IDTS leads have had the ability
to critically evaluate their experiences of implementing IDTS would suggest that the foundations for creating an effective partnership might be in place.
BACKGROUND

‘Prisons are the last bastions of our welfare state to face modernisation.’
De Viggiani et al., (2005)

Prison clinical drug services have, to date, often been under-resourced and have delivered inadequate or inappropriate clinical treatment practices, particularly with regard to substitute prescribing and incorporating maintenance. In many prisons there have often been poor links between prison Counselling, Assessment, Referral, Advice and Throughcare (CARATs) clinical services and community treatment. The introduction of Integrated Drug Treatment System (IDTS) aims not only to increase the volume and quality of treatment available to prisoners, with particular emphasis on early custody, but will start to address better integration between clinical and CARAT Services and reinforce the continuity of care between prisons and for those released into the community (DH, 2006).

IDTS consists of two components; enhanced clinical management of drug dependence, and enhanced psychosocial support. The enhanced clinical management increases the range of treatment options for prisoners, specifically substitute prescribing. The psychosocial input focuses on assessment, advice and throughcare. The aim of IDTS is to integrate the clinical and psychosocial treatment into one system that works to the standards of Models of Care and the Treatment Effectiveness Strategy and is combined into one care plan.

Fifty-three prisons are included in the first and second wave to implement aspects of IDTS. Only nineteen prisons will implement IDTS in full (i.e. enhanced clinical services and enhanced psychosocial support). The remaining thirty-four prisons will implement only the enhanced clinical services.

The implementation of IDTS is a mammoth task and involves considerable preparation, within the prison, before it can go live. This involves structural work, recruitment of staff
(i.e. health care, prison and administrative staff) and training. Preliminary findings reveal that staff have encountered numerous and often unforeseen problems as they prepared to implement IDTS. This has resulted in the majority of prisons finding it difficult to meet the date predicted when they would be able to implement IDTS effectively and safely within their establishment. This aspect of the evaluation study will focus on IDTS leads perception of the implementation of IDTS.
AIMS AND OBJECTIVES

Aim

To identify the key steps in the first wave of implementation of an Integrated Drug Treatment System (IDTS) and to inform both the next implementation phase and the specification for full IDTS research evaluation.

Objectives

1. To describe and examine critically the progress of implementation and operation of IDTS in the first wave prisons, to include those aspects that appear to be associated with successful implementation and any apparent obstacles or impediments to progress and to make recommendations for the second phase of implementation.

2. To determine whether funding has been sufficient to implement all aspects of IDTS.

3. To identify health care and prison staff perception of IDTS.

4. To identify health care staff views as to whether or not they will have sufficient staff and resources to provide the service to every prisoner/client that requires it at reception.

5. To identify the current reality of continuity of care, with respect to drug treatment, in prison and the community.

6. To explore the views of staff on how well IDTS is being/will be implemented and possible areas for improvement.

7. To explore staff perception of how the implementation of IDTS might affect the regime of the prison.
8. To identify health care staff perception about whether the integration of CARATs and clinical services can occur

9. To identify if any aspect of the psychosocial support model is being left out and why?

10. To identify the level of support and guidance received whilst preparing to implement IDTS.

11. The findings from the study will be used to inform and guide the next implementation phase.
METHOD

Data Collection

The research combined both qualitative and quantitative approaches and collated data from the first wave of prisons preparing to implement aspects of IDTS. The study focussed on the forty-six prisons that were preparing to implement IDTS when the study commenced (i.e. twenty-nine prisons implementing the enhanced clinical services only and seventeen prisons implementing enhanced clinical services and enhanced psychosocial support). The key person responsible for organising the implementation of IDTS, within each prison, was identified and arrangements were made to conduct a semi-structured telephone interview at their convenience. During the interview a range of variables was collated to identify the following: the extent to which IDTS has been/will be implemented; the difficulties encountered whilst preparing to implement IDTS and information about new staff, their roles and responsibilities. In order to assure participants of their anonymity, none of the telephone interviews were tape-recorded and neither the participants nor the prisons are identifiable in the study.

Inclusion Criteria

All prisons (n = 46) implementing aspects of IDTS, at the commencement of the study, will be asked to participate in the study. This includes 29 prisons implementing the enhanced clinical services only and 17 prisons implementing enhanced clinical services and enhanced psychosocial support.

Integrated Drug Treatment Interview Schedule

Information was collated during the telephone interview to ascertain the following:

1. The key person’s specific roles.
2. The date IDTS has been/will be implemented.
3. Their views about the level of support/guidance they have received.
4. Their view of the SOR Action Planning Tool kit.
5. Identification of any unexpected costs when preparing to implement IDTS.
6. Documentation of numbers of staff who will be employed to implement IDTS.
7. Specific roles, qualifications and responsibilities of staff employed.
8. Identification of specific recruitment problems.
9. Identification of what clinical interventions are now provided, in line with the new treatment guidelines.
10. Establish the current reality of continuity of care, in prison and the community, for those with drug problems.
11. Identification of the number of clients that could be cared for at any one time.
12. To establish whether or not their resources will enable them to provide the service to every prisoner/client that requires it at reception (if not, identify how they will address this issue).
13. Key obstacles that have delayed implementation of IDTS and how they have been overcome.
14. Perceived difficulties when IDTS is implemented.
15. Criticisms of IDTS.
16. What they have found helpful when preparing to implement IDTS.
17. Their views about how the next wave of prisons could implement IDTS more effectively.

Data was analysed and descriptive statistical data is reported, covering the key variables in the interview schedule. Thematic analysis was used to analyse the qualitative data.

Findings from the study will be used to inform both the next implementation phase and the specification for full evaluation of IDTS.

Sample

Thirty-eight out of the forty-six prisons (83% of the whole sample) preparing to implement IDTS participated in the study. Thirty-five were male prisons and three were
female prisons. Fourteen (82%) of the seventeen prisons preparing to implement IDTS in full (i.e. enhanced clinical services and enhanced psychosocial support) participated in the study (male n = 11; female n = 3). Twenty-four (83%) of the twenty-nine prisons preparing to implement only the enhanced clinical services, participated in the study (all were male prisons).

Fifteen were local prisons, nineteen were training prisons, two were open prisons and one was a young offender prison. Thirty-five were public prisons and three were private prisons. Interviews were conducted during the 12th June 2007 and 19th October 2007. Interviews ranged between thirty and eighty minutes. The mean length of the interviews was sixty minutes. Twenty-two of the IDTS leads were recruited from prison health care; Ten were senior discipline staff; four were recruited from external agencies and two were PCT leads responsible for the implementation of IDTS within the prison.
FINDINGS

Placing the Time-Frame into Context

Interviews were conducted whilst the following issues were occurring:

- The merging of PCTs.
- Transitional process - (i.e. Prison healthcare services being transferred to Primary Care Trusts).
- Contractual issues - (e.g. ‘Agenda for Change’).

The above issues undoubtedly created additional obstacles and delays for the first wave of prisons preparing to implement IDTS (refer to sub-themes ‘PCT’ and ‘Recruitment’ for more information). The reader must be mindful of these difficulties as the findings are presented.

Views about IDTS

Findings reveal that the implementation of IDTS is multi-faceted and complex. Thus, before presenting the difficulties preparing to implement IDTS it is necessary to highlight the conflicting perceptions about IDTS within establishments.

Positive Perception of IDTS

‘It’s [IDTS] brilliant.’
Participant 32

Many leads believed that IDTS is a clinical solution to drug dependency and when fully implemented will result in a national standardised drug treatment within prison establishments. They also stressed that the introduction of IDTS would enable substance
misusers to move around the prison estate more successfully, reduce self harm, suicide and drug-related fatalities during early release.

Several leads described it as the missing link in treatment as it assesses and reduces risk, provides individual care and clinical packages for substance misusers. Others stressed that it is the first real attempt to link with the community and ensure continuity of care for those who are substance-dependent. It was also suggested that the introduction of IDTS might help to reduce the amount of illicit drugs that are smuggled into establishments.

Leads also stated that the introduction of IDTS has resulted in the first serious attempt to integrate services. Whilst they found this a challenging task, (e.g. addressing negative attitudes and encouraging disciplines to communicate with one another) the majority of leads see this as a positive step forward for both clients and staff.

Many leads stressed that IDTS would be more in line with services provided in the community. In addition, many believed that better communication and true integration would help to ensure that those who are substance-dependent are cared more effectively as well as help staff to value, respect and understand each discipline’s specific roles whilst caring for clients; reduce the unnecessary duplication of recorded information; improve morale; increase job satisfaction and career prospects.

One lead suggested that once IDTS has been successfully implemented, the next step in addressing substance misuse in prisons, would be to introduce a ‘needle exchange’ service within establishments.

The following is a summary of the perceived strengths of IDTS for discipline, clinical and CARAT staff.

**Discipline Staff**

According to many IDTS leads very few discipline staff are receptive to IDTS. However, this might be related to the fact that the majority of discipline staff have not been
informed about IDTS (refer to sub-theme ‘Lack of Communication Between Healthcare Staff and Discipline Staff’ for details). Those that were receptive to IDTS thought prisoners would receive better treatment and care. Others thought it would help to prevent gate deaths.

**Clinical Staff**

Clinical staff felt that IDTS would help to provide a better service for clients; providing real treatment rather than just symptomatic relief. Others stated that the policy is very complex but it tries to link with the community and provide continuity of care and is the first real attempt to deal with these issues. Many stated that working with the CARAT and drug strategy team meant that they would share a common goal, which had never occurred before. Clinical staff perceived IDTS as an opportunity to develop new skills and increase job satisfaction.

**CARAT Staff**

CARAT staff felt that the implementation of IDTS would improve the quality of care that clients received and would help to address some of their clients additional needs, for example, the psychosocial element of IDTS. Others believe that integration with healthcare would help to ensure that they do not work in isolation, increase their knowledge, develop new skills and make them feel part of a larger team.

**Negative Perception of IDTS**

“They [Offender Health] fail to realise 80,000 are in custody and the majority are substance misusers.’

*Participant 29*

Several leads believe that the introduction of IDTS has been a ‘knee-jerk reaction’ in response to the 198 prisoners, or former prisoners, who sued the Home Office for failing to provide appropriate medical treatment during detoxification. Whilst the majority
acknowledge the importance of providing appropriate services, many establishments feel that they have been bulldozed into implementing IDTS with little concern for the possible implications. Specifically, the clinical risk if not done correctly; the unmet need of the current prison population who are substance-dependent and the legal implications if these issues are not addressed.

The following is a summary of the perceived limitations of IDTS for discipline, clinical and CARAT staff.

**Discipline Staff**

As stated previously the majority of discipline staff had not been informed about IDTS. However, many of those who were aware of IDTS thought it was too policy-driven, not practical enough and presented a security issue.

**Clinical Staff**

For many the main concern was the lack of knowledge and experience of caring for and treating substance misusers. This lack of knowledge and skills and the level of expectation to implement the service evoked anxiety and fear of treating them.

**CARAT Staff**

One lead who was from a CARAT background stated that IDTS was two years too late as it is heavily focused on opiate users and stressed that trends are changing dramatically and focus and treatment should now be more on stimulant and alcohol abuse. There was serious concern that IDTS will dominate so much of their time that ‘throughcare’ might get neglected. Many were concerned about the increased workload and their ability to fulfil all of the tasks required of them.
Difficulties Recruiting Participants

Recruitment of participants was extremely difficult. One regional lead forbade all IDTS leads, within their region, to participate; another PCT lead forbade two prison IDTS leads to participate in the study. These instances were resolved, but only after negotiating with official bodies outside the prison such as the Department of Health or the PCT lead within the Primary Care Trust.

It was also difficult to identify IDTS leads within many prisons as prison staff were often unaware of who was responsible for the implementation of IDTS. Once the IDTS lead had been identified, many were uncertain whether they would be able to participate and all sought permission, which was often a lengthy process. On two occasions the PCT lead stated that they would represent the prison IDTS lead even though the prison IDTS lead stated that they wanted to participate in the study.

Telephone interviews had to be arranged well in advance due to the IDTS leads’ workload. On several occasions interviews had to be re-arranged due to unexpected circumstances. On one occasion for example a disturbance on the wing occurred when the interview was taking place. Another had to be re-arranged due to unexpected involvement in the early release of prisoners, announced by the government.

None of the IDTS leads refused to participate in the study. However, eight IDTS leads (prisons n = 8) failed to reply to requests to participate in the study, despite, numerous attempts to contact them, via their colleagues, letter, telephone, answering machine, email and fax. It is possible that the establishments that did not participate in the study might be experiencing the most difficulties and their specific problems and needs might not be identified in the study. In an attempt to acquire an insight into this specific concern a decision was made to identify the RAG (red, amber, green) status of the establishments that did not participate.

RAG status refers to the ‘traffic light system’ used in the Statement of Readiness Action Planning Toolkit (refer to pg 35 for details about the Toolkit and traffic light system).
The goal is to achieve green as this demonstrates that the establishment has attained an appropriate standard to implement IDTS effectively. The RAG status and the difficulties each establishment was experiencing are documented in a quarterly summary report throughout the implementation process. The RAG status of establishments that participated in the study and those that did not is discussed below.

The RAG Status of Establishments

Those That Participated in the Study

To ensure that the study has encapsulated and reflects the experiences of the majority of first wave prisons preparing to implement IDTS, a decision was made to identify the RAG status of all prisons around the time-frame when the interviews had been conducted (i.e. 12th June and 19th October 2007). This was identified in the ‘IDTS: Progress, Summary Report’ dated 4th September 2007. Findings revealed that the study has identified the experiences of establishments from all of the three categories (i.e. red n = 3, amber n = 24 and green n = 11).

Those That Did Not Participate in the Study

One female and seven male prisons did not participate in the study. The male establishments consisted of one local, four training and two open prisons. Four of the establishments received prisoners from one local/dispersal prison that participated in the study. The RAG status for all eight establishments was as follows: green n = 2; amber n = 4 and red n = 2. It is encouraging that only two of the establishments were experiencing significant delays. Moreover, a review of their specific difficulties documented in the quarterly summary has revealed that these had been identified in other prisons that participated in the study and have been highlighted in the current report.
IDTS Leads

The majority of IDTS leads were very positive. They are enthusiastic and highly motivated individuals who came from various backgrounds and disciplines (e.g. healthcare, CARATs, probation, social work, and discipline staff). Their knowledge about substance misuse varied dramatically, ranging from those who had no knowledge, to others who had a clinical background and up to thirty years of experience working in the field. Regardless of their background and knowledge about substance misuse all had experienced numerous difficulties and obstacles over which they had little control.

Initially, it is possible to question why some Governors had recruited a senior member of their discipline staff, with no knowledge of substance misuse, to be their IDTS lead. It could be argued that all IDTS leads should be recruited from healthcare. Whilst the majority of IDTS leads recruited from healthcare had knowledge of substance misuse and were receptive to IDTS, some had little or no knowledge of substance misuse. This issue was especially pertinent to training prisons and was highlighted by the IDTS leads as a specific training need (refer to sub-theme: ‘IDTS Training’). Of concern were the two healthcare IDTS Leads who stated that they thought IDTS was unsafe and had very little commitment to it. In contrast, all of the discipline staff who were recruited as IDTS leads were extremely positive about IDTS and its implementation.

**Discipline Staff Recruited as IDTS leads**

*‘If it works in black and white (referring to prison officers) it will work in colour.’*

Discipline officer recruited as an IDTS lead

Whilst all the IDTS leads had the same goals and objectives, there appeared to be distinct differences in the way in which IDTS leads involve discipline staff during the implementation phase. Discipline staff recruited as IDTS leads, stressed the importance of involving and communicating with discipline staff whenever major changes occur within an establishment. Findings suggested that discipline staff recruited to implement
IDTS had adopted this approach, whilst implementing IDTS and were more likely to involve and inform discipline staff during the implementation phase. For example, several had sent them on CARAT courses so that they would be more flexible when IDTS was implemented. It was felt by these IDTS leads that effective communication with discipline staff during the early stages of implementation would ensure that they are more receptive to IDTS and the prisoners who are administered methadone.

**Protected Time to Implement IDTS**

There was a huge variation in the amount of protected time allocated to IDTS leads preparing to implement IDTS. Fourteen (37%) were employed full time to do the implementation, compared to twenty-four (63%) who had additional responsibilities. Some (n = 6) had no protected time and were expected to implement IDTS, in addition to their normal workload.

**Date to Implement IDTS**

Twenty leads (53%) felt that they had not been given enough time to implement IDTS. Many described the intense pressure placed upon them to implement it in October 2007 and stated that they would have felt better equipped if they had been able to implement IDTS in January 2008.

**Identifying the IDTS Leads’ Specific Tasks**

The IDTS leads stated that they were often required to oversee and manage all aspects of implementation ranging from structural work; applying for additional funding; writing protocols; communication with outside agencies (e.g. PCTs and steering committees); encouraging integration between health care staff and CARATS and recruitment (i.e. health care, prison and administrative staff) of staff. Arguably, such tasks would suggest that IDTS leads not only have to have an understanding of substance misuse but also require effective management, leadership, problem solving and communication skills in
order to deal with the multi-faceted problems that they might encounter whilst preparing to implement IDTS.

Specific training needs for IDTS Leads

Leads stated that they would have found it helpful and would have felt less overwhelmed whilst preparing to implement IDTS, if they had had received training in the following areas: managing large projects; financial management of large projects; writing protocols and substance misuse.

Lack of Seniority/authority

Twenty-nine leads (76%) encountered major obstacles as they prepared to implement IDTS. Many stated that they did not have enough authority to deal with some of these problems. They explained that the lack of authority compounded their difficulties when dealing with staff within the prison and outside agencies (e.g. health care staff, discipline staff, senior staff, steering committees and PCTs etc.) who were either resistant to change or impeded the lack of progress (refer to sub-theme ‘Support’ for more details). Others stated that they felt they were unable to voice certain issues. For example, one lead felt that IDTS should not be tendered out, but was unable to state this as he was employed on a short-term contract by the PCT who were responsible for the implementation of IDTS within the prison.

Recruitment of IDTS Leads

Many IDTS leads had short contracts and had been told that either their contract would end or their position would become redundant prior to IDTS being fully implemented. Many felt that initially there would be numerous difficulties when IDTS went live and believed that their input during that period would be crucial to ensure successful implementation.
Prison Establishments

All prisons had difficulties or concerns as they were preparing to implement IDTS. However, some concerns were specific to the type of prison establishment and are listed below:

Local Prisons

- Local prisons would go live before the training prisons. This would mean that IDTS prisoners within the local prisons when stable, would not be able to be transferred to an IDTS training prison, possibly creating a bottleneck.

- They would not be able to receive prisoners from court due to this bottleneck.

- They might be overwhelmed by demand due to the volume of prisoners, arriving at reception, suffering from substance misuse.

Training Prisons

- Training prisons might receive unstable prisoners from the local prisons and might need to return them.

- Safety issues – concerns about prisoners working on machinery having been prescribed methadone.

- An increase in bullying due to methadone being used as a currency, for example, IDTS clients forced to regurgitate their methadone.

- A lack of knowledge about substance misuse amongst healthcare staff.
Young Offender prisons

They questioned whether IDTS is suitable for young offenders. Some staff believe IDTS might be the easier option but possibly not the most beneficial for young offenders – encouraging abstinence rather than methadone maintenance.

Private Prisons

- Difficulties acquiring funding from PCTs or Home Office. (refer to sub-theme: Finances for more details).

Data analysis produced six themes and several sub-themes that relate to the IDTS Leads experience of preparing to implement IDTS and are listed in table 1.
Table 1

Table of Themes Identified Amongst IDTS Leads Preparing to Implement IDTS

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<thead>
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<td>• Buildings not fit for purpose.</td>
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<td></td>
<td>• Lack of funding to provide appropriate facilities.</td>
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Theme 1: Fundamental problems

‘This shaky system (prisons) has to try to manage serious, often intransigent problems in dreadful circumstances.’

Smith, 1999

It is recognised within the literature that many prison establishments are overcrowded, lack space and are often not fit for purpose (Her Majesty’s Inspectorate of Prisons, 2000a; Smith, 1999). These were predominant issues for the IDTS leads and have presented numerous difficulties whilst preparing to implement IDTS. The physical environment was of most concern and is discussed below.

Physical Environment

Many IDTS leads explained that a considerable amount of money was being spent on building new facilities that would eventually re-house healthcare and provide facilities for IDTS within their establishment. Others described how major structural work and renovations were currently being conducted to house IDTS. All were enthusiastic and envisaged that their working environment, the conditions in which they would treat prisoners and the quality of care prisoners received, would improve dramatically once they were re-housed. Other establishments were less fortunate. They needed either additional funding to build new facilities or did not have the space to build. Consequently, they had to prepare to implement IDTS in these restrictive conditions.

A combination of a lack of funding to build new facilities; no space to build and the numerous delays that have occurred for those who are dependent on major structural work being completed, has resulted in many IDTS leads preparing to implement IDTS in facilities that are often too small or not fit for purpose. The fact that some CARAT teams have reported that they often have to conduct 1:1 sessions either sitting on the stairs or on open landings, highlighted the current difficulties these staff have in providing basic
provisions for substance mis-users prior to the implementation of IDTS (refer to theme 6: ‘Ethical Issues’ for more information).
Theme 2: Operational Issues

Numerous operational issues and concerns were identified when preparing to implement IDTS and are listed under the following sub-themes: regime, estates and finances which are discussed below.

Finances

Costing for IDTS

‘It is [IDTS] the most resource hungry process I have ever been involved in.’

Participant 12

IDTS leads explained that costing for each prison had been based on data that did not reflect the current population within the prison, which had increased dramatically for some establishments. They believed that this had resulted in a huge short-fall on the amount that they had been given to implement IDTS. This short-fall was partially addressed by using their clinical under-spend, from the previous year.

PCTs

Difficulties accessing IDTS funding from the PCT was a major stumbling block for many leads and has possibly been the most instrumental in delaying implementation within some establishments (e.g. refer to theme 5: ‘Major Concerns’ for details).

Home Office

IDTS leads from private prisons stated that the Home Office had not informed them of the exact amount that they would receive to implement IDTS. In addition, they had also
delayed funding to implement it and the leads were concerned that this would delay implementation as they were unable to either recruit or send staff on training.

**Estates**

*Health Care Hatches*

The introduction of health care hatches have been problematic for many establishments. Safety and security issues were of the most concern. Leads explained that the initial design had a handle on the hatch that could be used as a ligature point. In addition, many stated that the health care hatch weakened the cell doors and presented a security issue. These concerns were being investigated by Offender Health during the period the interviews were being conducted.

The size of the doors within some establishments was also a problem when fitting health care hatches. On occasions the healthcare hatches were too big for the doors. This issue was especially pertinent to older establishments which tended to have narrower doors. One prison overcame this difficulty by designing a vertical healthcare hatch.

One lead explained that estates had placed the healthcare hatches too high in the cell doors, making it difficult for female staff to observe their clients. One lead misunderstood the IDTS SoR Action Planning Toolkit and had healthcare hatches fitted, even though they were not required in their establishment.

*Dispensary*

One lead also had problems with the dispensing hatches within the purpose-built pharmacy, explaining that they were too small to get a cup through and prisoners could not be seen through the frosted glass. This example demonstrates how the leads have to project-manage every aspect of implementation to prevent such errors occurring.
Difficulties Acquiring Telephone Lines

One prison lead described his difficulty acquiring additional telephone lines due to obstacles being put in place by a private contractor. The lead explained that they would not permit the establishment to lay additional trunking and cabling so that additional phones would be made available to those implementing IDTS. Seven additional phone points were required. However, he was informed that one phone line and fax line would cost £14 per month which was an unexpected cost. Consequently, only one additional phone point was ordered and was situated in the dispensing room. This was an unexpected finding and is potentially a health and safety issue.

Regime

Many leads stated that they and their establishments had two major concerns about IDTS and the impact it may have on the regime of their prison and they are as follows:

Movement of Prisoners

Some leads believe that IDTS will become the regime. That is, the regime will be based around the dispensing and movement of prisoners for medication. This concern was most pertinent for those who had a large prison population.

Key Performance Targets

Many leads believe that IDTS Steering Group paid little attention to other priorities within establishments and this might result in them being penalised if they are considered to be under-performing. Many believe that IDTS will have a negative impact on key performance targets and specifically the loss of purposeful activities hours. They explained that the planned movement of a large number of prisoners being given methadone, would be time consuming. They believe that planning the movement of prisoners and waiting for the group to be administered methadone, might result in many
prisoners being unable to do any purposeful activities. These issues should be explored in more depth during the evaluation process.
Theme 3: Communication

Informing Establishments That They Would be Implementing IDTS

‘Arrangements for prison health care must not undermine the role of the prison Governor as the person responsible for running the prison.’

Longfield and Fairfield, 1999 p382

Several leads stated that their establishment felt that they had been misled about IDTS, as they were initially informed that it would be specifically for prisoners who had been given short-term sentences. Many were concerned that their Governor had never been consulted, prior to being informed that their establishment would be implementing IDTS. Many also criticised the way in which the Department of Health had casually informed them via email about their implementation of IDTS.

Guidance on Implementing IDTS

Every lead said that they were bombarded with information about IDTS. They believed that it could be reduced dramatically and that this would help to ensure that future leads do not miss vital information. In addition, many stated that the documentation and paperwork sent by Offender Health and NOMS was constantly being revised and amended throughout the implementation process. This resulted in the leads having to read and re-read lengthy documentation which was extremely time consuming. Arguably, the second wave of prisons will not be subjected to numerous revisions to documentation made by Offender Health and NOMS as these documents will have had their final revisions.
The implementation of IDTS is a complex process involving a number of different key stakeholders both in prisons and the community. It requires an effective and systematic approach when preparing to implement IDTS. The Action Planning Toolkit has been specifically designed for this purpose and identifies a number of critical areas that need to be addressed and gives a brief description on the required outcomes. The prison IDTS lead is the principal owner of this document and is required to use the toolkit as they prepare to implement IDTS. The Toolkit uses a traffic light system. The ultimate goal is to achieve green for all critical areas as this demonstrates that the establishment has attained an appropriate standard to implement IDTS effectively.

Many leads questioned the traffic light system used in the toolkit. They argued that some targets could never be green. They also stated that there were too many abbreviations, which made it difficult to read. Twenty-three leads (61%) thought the toolkit was not very clear and thought it was too long, ambiguous and needed a level of knowledge to decipher it. In contrast fifteen leads (39%) used positive terminology stating that it was crystal clear, an excellent piece of work and a brave attempt to pin down something so complicated.

**Support**

Sixteen leads (42%) were happy with the support that they had received, compared with twenty-two (58%) who were not. Those who had felt that they had received inadequate support tended to criticise their regional steering committee, local implementation group and PCT as discussed below.
Regional Steering Committees and Local Implementation Groups

‘Major players are not used to playing on one side.’
Participant 9

Many stated that meetings were poorly organised and that not all stakeholders would attend. On occasions this would mean that certain decisions could not be made, creating delays in the implementation process. Leads also stated that the committees often consisted of members from multiple agencies who seemed to have different agendas, resulting in difficulties in communication with the IDTS caught in the middle. Some leads also described their frustration that members of the steering committees and local implementation groups had never visited their establishment to see the difficulties they faced, despite numerous invitations. This issue was also relevant to PCTS.

The majority of leads felt that their concerns were often ignored and that they were put under intense pressure to implement IDTS in October 2007, even when they were not fully prepared, since, for example, they had neither recruited nor trained staff (refer to theme 4: ‘Staff-Related Issues’ for details). One lead described how he, his Governor, the clinical lead and head of healthcare were humiliated, shouted at and bullied by members of a regional committee because they were experiencing delays in the implementation process. Others stated that when they attended meetings they felt intense pressure to say that they were on target with implementation due to the fear of recrimination.

In contrast, those who felt supported by their steering committees and/or local implementation group stated that their contribution was invaluable. Interestingly, a handful of names were repeatedly mentioned when asked who they felt had supported them the most. It is possible that their contribution has made a huge impact on the effective implementation of IDTS within many establishments.
Other Prison Establishments

Many leads have developed a support network with leads within other prisons. These networks tended to occur in clusters. Those involved in such networks had found them extremely helpful and often found them more supportive than the local implementation groups.

Governors

All leads stated that their Governor was supportive of them and IDTS. Their level of involvement varied dramatically. One Governor initiated an away day for healthcare and CARAT staff which focused on the integration of disciplines and learning to work together.

PCTs

A few prison leads found their PCT to be supportive. The majority did not and often described them as unhelpful and obstructive. Others stated that their PCT had initially been supportive but the relationship had become strained and had deteriorated rapidly whilst preparing to implement IDTS. These issues were a major concern for the majority of leads and are discussed in more detail in Theme 5: ‘Major Concerns.’

Lack of Communication between Healthcare Staff and Discipline Staff

‘Health is not just about healthcare. A healthy prison regime will have a considerable effect on health and requires the full involvement of the prison service.’

Longfield and Fairfield, 1999

Findings revealed that often no arrangements had been made to inform discipline staff about IDTS despite the impending start date. Consequently, many discipline staff were informed about IDTS from an uninformed third party within their establishment. It is possible that such individuals served to exacerbate fears and concerns, about IDTS,
amongst prison officers. One lead described how some discipline staff within his establishment formed a rebellious group who were challenging the introduction of IDTS within the prison. Interestingly, the lead stated that they had managed ‘to crush them’ rather than ‘educate them’. It is therefore, necessary to ask the following question:

If healthcare staff had fears, concerns and anxieties about implementing IDTS, why would discipline staff be any different?

It may be that more effective communication with discipline staff during the early stages of implementation might have helped to ensure that they were more receptive to the implementation of IDTS.
Theme 4: Staff-related Issues

Numerous staff-related issues were identified when preparing to implement IDTS and are listed under the following sub-themes: recruitment, retention of staff, training, negative attitudes and are discussed below.

Recruitment

Issues associated with recruitment were of serious concern for the majority of leads and are as follows:

*Releasing of Funds*

Both public and private prisons experienced difficulties in accessing funds to advertise and recruit staff and this was instrumental in delaying implementation for some establishments (refer to sub-theme ‘Finances’ for details).

*Difficulties Recruiting Staff*

Many leads had difficulties in recruiting nurses. Several had advertised nationally, on more than one occasion, with little success. There were few applicants for the posts and of those invited for interview, many did not attend; the majority of those interviewed were of poor quality. This was extremely frustrating and time-consuming for the leads. One lead had difficulty in recruiting a pharmacist and had to entice one by offering additional incentives (e.g. paying for his mileage to and from the prison). Others had difficulties in recruiting escort and clerical staff.

Some establishments have had a serious problem with recruitment for many years and experience difficulty in maintaining the primary care structure. The leads stated that the location of their establishment seemed to be exacerbating this problem. They believe that the severe difficulty in recruiting staff means that they cannot implement IDTS safely. A
combination of the delays in receiving funding, the lack of interest in the advertised posts and the lack of suitable applicants, created numerous problems and delays whilst preparing to implement IDTS (e.g. refer to sub-theme ‘Training’ below).

**Training**

Difficulties in recruiting staff had a direct impact on IDTS training within establishments (refer to sub-theme ‘Recruitment’). The lack of newly-appointed staff resulted in some healthcare departments being too short-staffed to release staff to attend the IDTS training, especially when staff had to attend two day courses.

**IDTS Training**

Many leads found it difficult to attend IDTS training due to their increased workload (refer to ‘Protected Time to Implement IDTS’). Several also stated that the training was sporadic and they were often informed of courses at short notice. Many leads said that they would have preferred training to be more local as it would be more cost effective and might help to ensure that more staff could attend the courses. Some also stated that it would have been helpful if there were training in conducting IDTS group work. Several leads, predominantly in training prisons, stated that they and other members of their staff would have benefited from additional training in substance misuse.

**Retention of Staff**

**Retention of IDTS Leads**

Retention of IDTS leads appeared to be a problem for some prisons. In one extreme case a PCT lead stated that the newly recruited prison lead, who had considerable experience in substance misuse, resigned after three weeks stating that he felt that he could no longer continue in post as it would compromise him professionally.
Retention of Nurses

There were concerns about the lack of job satisfaction for nurses who have to administer methadone. Many suggested that retaining nurses in these posts may be difficult once IDTS is implemented.

Negative Attitudes

IDTS leads reported that some members of staff within healthcare had negative attitudes towards substance misusers and IDTS, as follows:

Negative Perception of Substance Misusers

Numerous leads stated that many of their healthcare staff disliked caring for substance misusers. Some used negative terminology when referring to them, such as ‘dick heads.’ The leads explained that when such negative attitudes prevailed, it is not possible to assume that all nursing staff would respond appropriately to prisoners who were substance misusers. This issue may be a partial explanation as to why many IDTS leads experienced difficulties recruiting healthcare staff to implement IDTS (refer to sub-theme ‘Recruitment’ for details).

Negative Attitude to IDTS

Two IDTS leads did not agree with IDTS, did not want to implement it and did not want to go on IDTS training (refer to ‘IDTS Leads’ for more information). As stated above, one lead resigned after three weeks, informing the PCT lead that he could no longer continue in the post as it compromised him professionally. Two nurses asked to be conscientious objectors and refused to be trained in IDTS. Some CARAT staff also believed that IDTS compromised them professionally and believed that the focus should be on abstinence and not methadone maintenance. Some discipline staff also voiced their concerns about methadone maintenance, believing that prisoners would be more aggressive and difficult to manage.
Theme 5: Major Concerns

Twenty-nine leads (76%) encountered major obstacles as they prepared to implement IDTS (e.g. Buildings not fit for purpose; difficulties recruiting and training staff etc.,). However, issues surrounding protocols, PCTs, the transfer of prisoners, capping and the possible legal implications surrounding IDTS created the most anxieties. Many leads stated that they would like Offender Health to address some of the following concerns:

Protocols

It’s [writing protocols] like keep re-inventing the wheel.’

Participant 5

The majority of leads believe that protocols, procedures and policies should be standardised whenever possible. However, they acknowledged that some might need to be amended slightly to ensure that they were appropriate for their establishment. Many argued that standardising protocols would save a considerable amount of time for the leads, enabling them to focus on other aspects of implementation.

Some leads had no experience of writing protocols and expressed this as specific training need (refer to sub-theme ‘IDTS Training’). Those who lacked experience in writing protocols were also concerned about the possible legal implications, if ever the protocols were to be scrutinised, for example, if an IDTS client died whilst in custody. Writing some protocols was especially difficult for those who had very little knowledge about substance misuse (refer to ‘IDTS Leads’ for details), resulting in the leads becoming dependent on others to write them. This presented its own difficulties, for example, one lead was unable to find anyone within the PCT to write the clinical protocols. Another was waiting for the project lead to be employed. A CARAT manager refused to write any protocols for one lead as they had not received additional funding to do these tasks. Delays also occurred when the leads had to wait up to three months for outside agencies to sign protocols.
Several leads suggested that the following protocols should be standardised:

- Clinical protocols
- Information sharing protocols
- Transfer protocols
  - Offender Management Unit (OMU)
  - Offender Categorisation and Allocation department (OCA)
- CARATS/IDTS
- CARATS/Healthcare
- IDTS Drug Intervention Programmes (DIP)
- IDTS/Offender Management Unit (OMU)
- IDTS/Offender Assessment System (OASys).

*Criticising Other Protocols*

Several participants had replaced a previous lead (refer to ‘Retention of IDTS Leads’). When this occurred they often criticised the protocols already prepared and made significant amendments to them. Leads also had a tendency to criticise other establishments IDTS protocols if they had an opportunity to read them. However, one prison capitalised on these issues by selling their protocol to other establishments.

*Capping*

> ‘We [prison] don’t know what’s coming [demand for IDTS].’

*Participant 18*

Twenty-seven leads (71%) believe that they will be overwhelmed by demand once IDTS was implemented. Many stated that this issue could be addressed if the number of IDTS clients cared for within an establishment were restricted, especially when they first go live. This is termed as ‘capping.’ The study has identified that some prisons were permitted to cap the number of IDTS prisoners they cared for and others were not. Those who were to have their numbers on IDTS capped were the least anxious about
implementing IDTS. However, many leads questioned why some were receiving preferential treatment. The majority of leads believe that every prison should be capped, especially when they first go live. They argued that if the numbers did not get capped, many prisons will become overwhelmed and find it difficult to provide all aspects of IDTS (e.g. group work). Others questioned whether refusing to cap prisons was safe practice.

**Transfers**

‘It’s a joke, we need transfer policies.’

*Participant 30*

Issues surrounding the transfer of prisoners evoked much controversy. According to IDTS leads, transfer issues are particularly problematic for prisons that cover a large area or feed to, or receive prisoners from several other prisons. Many leads argued that Offender Health has paid little attention to transfer issues and suggested that this could have serious implications if these issues continued to be ignored.

Transfer protocols were also relevant to IDTS prisoners who attend court. One establishment had a protocol in place to ensure that their IDTS clients are returned to their establishment. It was not possible to identify whether all prisons have a similar protocol in place.

The majority argued that the co-ordination of prison transfers, especially during the early stages of implementation is crucial to ensure effective implementation for the following reasons:

- To ensure that establishments do not become overwhelmed with IDTS prisoners.
- To prevent the bottle-neck occurring, which was a concern among many local prisons (refer to ‘Prison Establishments’).
• To manage the number of IDTS prisoners transferred to establishments that are capped (refer to sub-theme ‘Capping’).

• To ensure safe practice.

Legal Implications

The current study has identified several issues which may have legal implications such as, consistency and continuity of IDTS care across establishments; responsibility and lack of guidance for those already detained. Each issue is discussed separately.

Consistency and Continuity of IDTS Care Across Establishments

The possible lack of consistency and continuity of IDTS care across establishments was of concern. Leads were specifically concerned about the legal implications if the following scenarios occurred:

• If a recently detained prisoner could not be transferred to a prison that provides IDTS.

• If a local prison is unable to transfer an IDTS prisoner to an IDTS training prison.

Responsibility

Several leads said that they were uncertain who would ultimately be responsible if litigation occurred, e.g. PCT, prison, contracted health care.

IDTS Protocols

Issues surrounding protocols was of serious concern to most leads. Many were concerned that their IDTS protocols would be scrutinised if a death in custody occurs.

Several leads stated that IDTS focuses on substance misusers who arrive at reception, paying little attention to those who are already detained. This approach may have legal ramifications, as it possible to question why recently detained prisoners should have priority over those who are already detained.

Primary Care Trusts

‘The NHS has limited stomach for taking on such difficult problems [prison health care], particularly when it has severe problems of its own.’

Smith, 1999

The Merging of Trusts

The first wave of prisons was preparing to implement IDTS whilst many PCTs were being merged. As two PCT leads participated in the study (refer to sample) it was possible to acquire an insight into some of the difficulties that they were encountering as preparations were being made to implement IDTS within prison establishments. The fear of redundancy was a concern for one PCT lead due to the merging of several PCTs. The amalgamation and major restructuring of PCTs and its implications may be a partial explanation as to why PCTs were perceived to be unsupportive.

The majority of prison leads acknowledged that the merging of PCTs had created some of the difficulties. However, they perceived their PCTs lack of engagement was due to their lack of interest in prison healthcare.

Difficulties in Accessing IDTS Funding

Difficulties in accessing IDTS funding from the PCT was a major stumbling block for many leads and may have been the most instrumental in delaying implementation within some establishments (e.g. refer to sub-theme: ‘Recruitment’). Several believed that PCTs
delayed releasing funds in order to make their own accounts look healthier. One lead stated that it is recognised that Governors, in the past, had neglected prison health care and diverted funding to other areas of the prison which they perceived to be of higher priority. Several leads believed that their PCT seemed to be adopting the same principle and this could have a negative impact on prison healthcare if it is not addressed from the outset.

In contrast a few leads stated that their PCT was extremely supportive and had even released additional funding to implement IDTS. One PCT had overcome numerous obstacles and red tape to enable the prison establishment to convert their clinical under-spend to capital funding so that they could build appropriate facilities to implement IDTS effectively (refer to sub-theme ‘Red Tape’ below for details). When such positive interactions occurred, healthcare IDTS leads often described a sense of feeling valued and belonging to the National Health Service.

**PCTs - Red Tape**

As stated previously many establishments needed additional funding either to renovate or build new facilities in order to implement IDTS effectively (refer to theme 1: ‘Fundamental Problems’). In an attempt to overcome this issue, some IDTS leads asked their PCT if they could convert their clinical-underspend, from the previous year, into capital funding so that they could build or renovate health care facilities in preparation for the implementation of IDTS. On most occasions PCTs refused and said that the clinical-underspend was for the commissioning of services and that it was the Governor’s responsibility to provide the facilities for the provision of services. However, one PCT overcame these obstacles by agreeing to convert the clinical underspend into capital spending thus, ensuring that IDTS was implemented most effectively.

**PCT and Recruitment Issues**

The majority of prison leads stated that their PCT had created numerous obstacles when they tried to recruit staff. For example, one PCT refused to release funds to advertise
nationally, even though they were aware that the prison lead had difficulty in recruiting (refer to theme ‘Recruitment’). Another PCT placed a blanket ban on appointing staff and gave no explanation. This was of concern to the prison lead as he needed to recruit staff to implement IDTS. One prison lead informed Human Resources within the PCT that they had difficulties in recruiting suitable applicants, only to be told that they should recruit anybody that applied.

**PCTs Lack of Understanding of Prison Establishments**

Many prison leads stressed that prison healthcare is a unique working environment and functions within the constraints of the prison regime. They argued that to facilitate major healthcare changes, it is crucial that those employed by the PCT, must have an understanding of prison healthcare and prison regimes. However, findings suggest that many who were responsible for the implementation of IDTS within the PCTs made major decisions despite neither visiting the prison nor knowing much about prison healthcare nor the prison regime. Prison leads perceived such disregard of fundamental issues as arrogant and foolhardy.

**Strained Relationships Between the PCT and IDTS Lead**

A few prison leads found their PCT to be supportive but the majority did not, describing them as unhelpful and obstructive. Others stated that their PCT had initially been supportive but the relationship had become strained and had deteriorated rapidly whilst preparing to implement IDTS. Some described how their PCT had meetings before meetings; which always excluded the IDTS lead. One prison lead has resorted to taking a witness to every meeting he attends with the PCT.
PCT Tendering IDTS

‘Things are occurring behind closed doors.’
Participant 6

Tendering IDTS was a contentious issue for some prison leads. Some felt too vulnerable to voice their concerns as they were employed by the PCT responsible for the implementation of IDTS. Several leads argued that tendering this service was not viable. This issue is pertinent to the establishments who envisage that they will have only a few IDTS clients. Prison leads believed that the retention of IDTS staff using an external provider model may be problematic. Others were concerned about staff sickness in tendered services and had developed a contingency plan if this were to occur. Several argued that it would be better if prisons were in control of staffing. Other prison leads voiced their concerns about the conflict of interest surrounding PCT’s commissioning of services and tendering of contracts.

Risk Factors

‘First overdose [referring to methadone] and all hell will be let loose.’
Participant 25

First night Prescribing

One GP contacted the British Medical Association voicing his concerns about first night prescribing. This issue was being addressed by Offender Health whilst the interviews were being conducted.

Deaths in Custody

Many leads voiced their concerns about the possibility of additional deaths in custody occurring once IDTS is implemented. They were specifically concerned about the cocktail of illegal substances which prisoners may have access to during time in custody.
which may potentially be used combined with the daily dose of prescribed methadone. This was a concern of one lead who stated that their establishment had a serious drug problem. Others believe that the implementation of IDTS will result in an increase of methadone being smuggled into establishments. One lead was concerned that a judicial review concerning IDTS might be conducted if a handful of deaths occur within prison establishments.
Theme 6: Ethical Issues

‘Prisoners have a right to health care equivalent to that available to the rest of the population; that health care in prison should be delivered to the same standard as the base population.’

Health Advisory Committee, 1997 pg 6

Issues surrounding confidentiality, the standard of care substance misusers might receive and the lack of guidance for those already detained, have been identified as ethical issues and are discussed below.

Confidentiality

Prior to the implementation of IDTS, some CARAT staff have had to conduct 1:1 sessions either sitting on the stairs or on open landings due to the lack of space within their establishment (refer to theme 1: ‘Physical Environment’). In addition, some CARAT staff voiced their concerns that some 1:1 sessions may have to be held through the health care hatches, once IDTS is implemented, due to their increased workload and the limited time prisoners will be available.

Standard of Care /Equivalence of Care

The negative attitudes and terminology used by some healthcare staff when referring to substance misusers is of concern (refer to sub-theme: ‘Negative Perception of Substance Misusers’). The fact that some health care staff disliked caring for substance misusers, refused to be IDTS trained, requested to be conscientious objectors when combined with the IDTS leads who believe IDTS was unsafe and did not want to implement it (refer to sub-theme ‘Negative Attitudes Towards IDTS) is of concern and an ethical issue. Moreover, it is necessary to question the standard of care substance misusers might receive within these establishments.
Lack of Guidance for Those Already Detained

As stated previously, several leads said that IDTS focused on substance misusers who arrive at reception, paying little attention to those who are already detained. This lack of guidance created an ethical dilemma and uncertainty for some establishments. Several leads stated that some detained prisoners were already requesting IDTS prior to its implementation. They also stressed that they were uncertain of the protocol when such requests were made. Many leads were concerned about the volume of newly detained prisoners who will require IDTS and stressed that if all substance misusers within their establishment requested IDTS, it would be overwhelmed before it began. However, ethically, it is necessary to question why recently-detained prisoners should have priority over those who are already detained. It is possible that there might be legal ramifications surrounding this issue and demonstrates the importance of providing guidance and clarification about it.
Methodological Considerations

The Importance of Dialogue between IDTS Steering Group, NOMS & Offender Health and Those Implementing IDTS

In order to ensure successful implementation nationally, it is crucial that effective communication and dialogue occurs between IDTS Steering Group, Offender Health, NOMS Interventions Group and those who are preparing to implement it. As each wave of prisons implement IDTS, this form of communication is crucial, as it will help to guide, inform and perfect the service. However, many leads stated that they were anxious about making certain disclosures for the fear of recrimination. The evaluation process could bridge this gap, enabling them to voice their concerns, provided that the establishments and those involved in the development of this service are assured of their anonymity.

Strengths and Limitations of the Study

One of the limitations of the study is that it was not possible to ask all participants every question in the IDTS interview schedule for the following reasons:

- The telephone interview took approximately one hour to conduct. Due to work commitments sixteen participants were unable to allocate an hour to participate. A decision was made to include these participants in the study and just focus on key questions in the interview schedule.

- Some participants allocated one hour, but discussed important issues/concerns in depth. When this occurred the researcher would explore these issues using qualitative research methods. Adopting this approach resulted in the researcher being unable to ask some questions in the interview schedule due to the limited time-frame whilst conducting the interview. However, the researcher ensured that all key questions in the interview schedule were asked. Arguably, adopting this
approach could also be considered a strength of the study as it has identified important issues that were not asked in the interview schedule, but will need to be addressed when full evaluation of IDTS is conducted.

Another limitation was that eight prisons (17% of the first wave of prisons) that are preparing to implement IDTS did not participate in the study. It is possible that they might be experiencing the most difficulties and their specific problems and needs might not be identified in the current study.

An unexpected strength of the study was that it has identified the numerous difficulties encountered during the transition when PCTs were made responsible for the physical and mental health of prisoners.
DISCUSSION

Findings revealed that the implementation of the Integrated Drug Treatment System is a mammoth, multi-faceted and complex task that affects many aspects of a prison establishment. It requires a dramatic shift in attitude towards substance mis-users and the care they receive, as well as commitment amongst those who are preparing to implement it.

The first wave of prisons also had the additional difficulties of preparing to implement IDTS during the transitional period of Primary Care Trusts being restructured, combined with the commissioning of prison health care services being devolved to Primary Care Trusts. These issues undoubtedly created additional obstacles, uncertainties and delays. It is possible that the next wave of prisons may also experience some of these difficulties if they have not been resolved.

IDTS Leads Perception of IDTS

Whilst the majority reported positive responses towards IDTS, all leads voiced some concerns. It is encouraging that the majority were receptive to IDTS and understood, accepted and welcomed its implementation. However, it is crucial that their concerns are acknowledged and not ignored by Offender Health. Issues surrounding clinical risk, unmet needs and legal implications should be a consideration throughout the whole implementation process.

IDTS Leads

The IDTS leads play a pivotal role in the implementation process. Yet, often this is not reflected in the time allocated to implement it, for example, 63% (n = 24) of the leads had additional responsibilities. In extreme cases, some were expected to implement IDTS in addition to their normal workload. This may be a partial explanation as to why many felt that they had been given an unrealistic ‘time frame’ to implement it. This issue
could be addressed in the next wave of implementation if all leads were given protected time to implement IDTS. The majority would have liked the position to have been a full time post. As the interviews were conducted prior to their implementation date it was not possible to determine how long they actually needed to be in post. This should be explored in the next stage of the evaluation.

Seventy-six per cent (n = 29) of leads had encountered major obstacles as they prepared to implement IDTS and many felt that they did not have enough authority to deal with these problems. It is possible that the first wave of prisons recruiting IDTS leads were unaware of the size of the task, the specific skills required and the difficulties that might be encountered whilst preparing to implement it. Findings suggest that management skills might be more crucial than clinical skills when recruiting leads in the future.

Some Governors are giving little attention, or importance, to those who are recruited as their IDTS lead. The fact that the study has identified two leads who did not agree with IDTS and did not want to implement it, supports this view. Arguably, recruiting leads who are opposed to IDTS does little for the credibility of the Governor and his/her establishment. Moreover, it is possible that these leads might be neither committed nor motivated to overcome obstacles to ensure effective implementation.

Findings suggest that in order for implementation to be effective, it is necessary to identify, acknowledge and address the specific needs of the leads. Based on this assumption the following recommendations are made:

RECOMMENDATIONS

• Leads must be receptive to IDTS and its implementation.

• They need appropriate authority or seniority to deal with senior staff and outside agencies.

• They must have effective management, communication and leadership skills.
• They must be competent at writing protocols and applying for additional funding.

• They need protected time to implement IDTS.

• They should be given a realistic time-frame to implement it.

• They must continue in their posts until IDTS has been successfully implemented within their establishment.

• Governors should be more actively involved throughout the implementation process.

**Theme 1: Fundamental Problems**

A combination of a lack of funding to build new facilities, lack of space to build and the numerous delays that have occurred for those who are dependent upon major structural work being completed, has resulted in many leads preparing to implement IDTS in facilities that are often too small or not fit for purpose. It is possible that the next wave of prisons will be faced with similar difficulties, requiring leads to find innovative ways to implement IDTS most effectively. Those who are there to support the IDTS lead and their establishment, must be mindful of these difficulties and the potential problems this may cause.

**Theme 2: Operational Issues**

**Finances**

The costing of IDTS and difficulties accessing IDTS funding was of concern for many leads within public and private prisons and undoubtedly created delays whilst preparing to implement IDTS. It is possible that other services within prison healthcare are also
experiencing similar difficulties and the magnitude of this problem should be explored in more depth in future research.

In contrast, some PCTs were extremely supportive and released additional funding to implement IDTS. There was one instance of a PCT attempting to convert the clinical underspend into capital spend to ensure that IDTS was implemented most effectively. The fact that several leads had made this request but only one PCT had agreed to do it demonstrates the lack of consistency in the decision making process and the need for Offender Health to provide guidelines on this issue for the next wave of implementation.

**RECOMMENDATIONS**

- Costing for each prison should be based on accurate up-to-date figures and should be addressed prior to the next wave of implementation.

- The National Offender Management Service should ensure that it and or respective PCTs release funds earlier to private prisons during the next wave of implementation.

- PCTs should ensure that they release funds earlier to public prisons during the next wave of implementation.

- Consideration should be given to the conversion of clinical under-spends into capital-spends for establishments who do not have an appropriate physical environment to conduct IDTS effectively.

- Offender Health should provide guidelines on converting clinical to capital spend during the early stages of implementation.

- Offender Health should focus its attention on PCTs and the commissioning of prison health care services.
The introduction of healthcare hatches has been problematic for many establishments, with safety and security issues being their biggest concern. It is possible that these issues have now been addressed as Offender Health were investigating them during the period when the interviews were being conducted. The size of the cell doors and health care hatches created additional problems within some establishments. The introduction of dispensing hatches has also created difficulties and emphasised the importance of the lead project-managing every aspect of implementation.

The study has identified that whilst preparing to implement IDTS, some leads have difficulties in dealing with private contractors within establishments. The magnitude of this problem should be explored in more depth in the next stage of evaluation.

RECOMMENDATIONS

- Prison leads must establish whether healthcare hatches are required within their establishment.

- Leads must ensure that the standardised healthcare hatch is not too large for their cell doors.

- They must ensure that healthcare hatches are positioned at an appropriate height for female staff to observe clients.

- Leads should oversee the design of dispensing hatches, to ensure that they are fit for purpose.
Theme 3: Communication

*Guidance on Implementing IDTS*

Every lead stated that they were bombarded with information about IDTS. Many stressed that it should be severely reduced to ensure that future leads do not miss vital information and that the Action Planning Toolkit would be improved if there were fewer abbreviations.

**RECOMMENDATIONS**

- The amount of paperwork and size of documents sent to IDTS leads should be reduced wherever possible.
- There should be fewer abbreviations in the Statement of Readiness Action Planning Toolkit.

*Regional Steering Committees and Local Implementation Groups*

Many leads felt that both their regional steering committee and local implementation groups had failed to support them effectively. The majority of leads felt that their concerns were ignored and that they were put under intense pressure to implement IDTS in October 2007, even when they were not fully prepared. One lead and his Governor were humiliated and bullied by members of a regional committee because they were experiencing delays in implementation and, for fear of recrimination, others felt pressurised into saying that implementation was on target. Steering committees and local implementation groups who undermine the Governor; evoke such fear, anxiety and disregard for the leads’ concerns are hardly likely to provide appropriate support and guidance for prison establishments preparing to implement IDTS. In contrast, those who felt supported stated that their committee’s contribution was invaluable. Difficulties in dealing with regional steering committees and local implementation groups should be explored in more depth in the next stage of evaluation.
RECOMMENDATIONS

- All stakeholders should attend meetings.

- Steering committees and local implementation groups should visit the establishment they are supporting on a regular basis. Provisions should be made so that these dates are documented.

- Steering committees and local implementation groups should provide the conditions whereby leads feel supported throughout the implementation process.

- Governors should not be undermined in front of their officers.

Communication between Healthcare Staff and Discipline Staff

Discipline staff recruited as IDTS leads stressed the importance of involving and communicating with discipline staff whenever major changes occurred within an establishment and had adopted this approach when implementing IDTS. Many leads stated that discipline staff are concerned and have anxieties about the implementation of IDTS and effective communication with discipline staff, during the early stages of implementation, may help to allay many of the fears and concerns that they have. Good communication within an establishment would not only ensure that discipline staff were more receptive to IDTS and to the prisoners who are given methadone, but could also improve morale. Adopting this approach may help to ensure effective implementation in the next wave of prisons preparing to implement IDTS.

RECOMMENDATIONS:

- Discipline staff should be informed about IDTS in an appropriate manner and at the earliest opportunity.
• A question and answer forum should be provided to enable discipline staff to voice their concerns about IDTS.

• Discipline staff should receive a question and answer information pack about IDTS.

**Theme 4: Staff-related Issues**

*Recruitment*

Issues associated with recruitment of healthcare staff were of serious concern for the majority of leads. A combination of the delays in receiving funding, the lack of interest in advertised posts, and the lack of suitable applicants created numerous problems and delays whilst preparing to implement IDTS. These issues could be addressed in the next wave of implementation if funding is made available sooner and recruitment occurred earlier than in the first wave of prisons. Some establishments have had a serious problem with the recruitment of healthcare staff for many years and experience difficulty in maintaining the primary care structure. They believe that the severe difficulty in recruiting staff means that they cannot implement IDTS safely. These prisons may require special attention and support and perhaps additional incentives are required to recruit staff within these establishments. These issues need to be explored in more depth if Offender Health is to ensure that IDTS is implemented effectively in all establishments.

**RECOMMENDATIONS**

• The Ministry of Justice, Department of Health, NOMS and PCTs should ensure that funding is accessible at an earlier stage than in the first wave of prisons.

• Recruitment should commence at an earlier stage in the next wave of implementation.
• Offender Health should focus on the specific needs of establishments which are experiencing intense difficulty in recruiting healthcare staff.

Training

Difficulty in recruiting staff has had a direct impact on IDTS training within establishments. Clearly, if the staff had not been recruited, they could not be trained. Difficulty in accessing funds either from PCTs and or DH/NOMS exacerbated these problems. This finding supports the view that the Home Office and PCTs should ensure that IDTS funding is more easily accessible for leads preparing for implementation. Many leads found it difficult to attend IDTS training due to their increased workload. The fact that some leads are unable to attend such courses supports the view that they need to be given protected time to implement IDTS.

Findings suggest that attention should be focused on the courses that are provided, their content, their location and the way in which information about them is disseminated to IDTS leads. This issue could be explored in the evaluation process.

RECOMMENDATIONS

• An evaluation of IDTS training should be conducted.

• IDTS training should be more localised.

• Training for newly recruited staff should commence at an earlier stage in the next wave of implementation.

• Offender Health should provide guidance on how to respond to health care staff who refuse to attend IDTS training.
Retention of IDTS Leads

The retention of IDTS leads was a problem for some prisons. It is suggested that this issue could be partially addressed if leads had protected time to implement IDTS, were appropriately supported and given appropriate time to implement it.

Negative Attitudes

There were several occasions when leads reported that some of their healthcare staff disliked caring for substance misusers and used negative terminology such as ‘dick heads’, when referring to them. Others stated that when negative attitudes prevailed, it was not possible to assume that all healthcare would respond appropriately to substance misusers. The fact that many healthcare staff do not like caring for substance misusers, is of concern, especially as it is recognised that many prisoners are substance-dependent. The magnitude of this problem needs to be identified. It is suggested that ‘equivalence of care’ will not be achieved within establishments when such discrimination and prejudice is allowed to continue.

Two leads didn’t agree with IDTS, didn’t want to implement it and didn’t want to attend IDTS training. Arguably, these instances may not have occurred if more attention had been paid when recruiting leads. Some CARAT staff believed that IDTS compromises them professionally as they think that the focus should be on abstinence and not methadone maintenance. The level of this concern amongst CARAT staff needs to be explored in the evaluation process. Some discipline staff believed that methadone maintenance would make prisoners more aggressive and difficult to manage. It is possible that this issue could be partially addressed if discipline staff were informed about IDTS in an appropriate manner at the earliest opportunity.

RECOMMENDATIONS

- The level of prejudice and discrimination towards substance misusers needs to be identified in future research.
• Discipline staff should be informed about IDTS in an appropriate manner and at the earliest opportunity.

• A question and answer forum should be provided to enable discipline staff to voice their concerns about IDTS.

Theme 5: Major Concerns

Seventy-six per cent of leads encountered major obstacles as they prepared to implement IDTS. Issues surrounding protocols, PCTs, the transfer of prisoners, capping and the possible legal implications surrounding IDTS created the most anxieties. Many leads stated that they would like Offender Health to address some of these concerns.

Protocols

The majority of leads believe that protocols, procedures and policies should be standardised whenever possible. However, they acknowledged that some may need to be amended slightly to ensure that they are appropriate for their establishment. Many argued that this could save a considerable amount of time for the leads, enabling them to focus on other aspects of implementation.

RECOMMENDATIONS

• There is a need to develop standardised protocols whenever possible.

Capping of IDTS Prisoners

Seventy-one per cent of leads (n = 27) believe that they will be overwhelmed by demand once IDTS is implemented and felt that capping would help to address this issue, especially when they first go live. Many leads questioned why some prisons were capped and others were not. Others questioned whether refusing to cap prisons was safe practice.
Offender Health should provide more clarification on this issue. Difficulties surrounding capping should be explored in the evaluation process.

**RECOMMENDATIONS**

- Senior Prison Service staff should consider issues surrounding the capping of prisons.

**Transfers**

Issues surrounding the transfer of prisoners evoked much controversy. Many leads argued that little attention had been paid to transfer issues and suggest that this could have serious implications if ignored. The leads argued that the co-ordination of prison transfers, especially during the early stages of implementation, is crucial to ensure effective implementation and to ensure that establishments do not become overwhelmed with IDTS prisoners. It will also prevent the bottle necks occurring, manage the number of IDTS prisoners transferred to establishments that are capped, and to ensure safe practice. These issues should be explored during the evaluation process.

**RECOMMENDATIONS**

- Prison Service should consider issues surrounding transfer of IDTS prisoners.

**Legal Implications**

The possible lack of consistency and continuity of IDTS care across establishments was of concern. Others were concerned that their protocols might be scrutinised if an IDTS client died whilst in custody. Several leads were uncertain about who would be responsible if litigation occurred e.g. PCT, prison or contracted health care. Many leads requested clarification on these issues.
Several leads stated that IDTS focuses on substance misusers who arrive at reception and pays little attention to substance misusers who are already detained. They believe that adopting this approach may have legal ramifications, as it is questionable for recently-detained prisoners to have priority over those who are already detained. Such questions demonstrate the importance and urgency of providing guidance and clarification on this issue.

RECOMMENDATIONS

- Offender Health should consider legal implications associated with IDTS.

Primary Care Trusts

Primary Care Trusts have presented the most difficulties for IDTS leads within public prisons. The majority of leads perceived them to be obstructive and unhelpful. Others stated that their PCT had initially been supportive but the relationship had become strained and had deteriorated whilst preparing to implement IDTS. One lead stated that the relationship with his PCT had completely broken down, and he had resorted to taking witnesses to every meeting. As the commissioning of prison healthcare services have only recently been devolved to PCTs it is possible that this issue is not just associated with the implementation of IDTS and requires close monitoring.

The merging of trusts has undoubtedly had a detrimental impact on the implementation process and was highlighted by the two PCT leads who participated in the study. The amalgamation and major restructuring of PCTs, with its implications of mass redundancy, might be a partial explanation as to why PCTs have seemed unsupportive. Whilst prison leads acknowledged that the merging of PCTs’ might have had a negative impact on the implementation process, many perceived their PCT’s lack of engagement was due to their lack of interest in prison healthcare. Such conflicting views emphasise the importance of i) identifying the PCTs’ perspective of implementing IDTS in the evaluation process in order, to avoid bias in reporting and, ii) the need to conduct future
research that will explore PCTs’ perception of being made responsible for the commissioning of prison health care services.

Difficulties accessing IDTS funding from the PCT was a major stumbling block for many leads within public prisons and has been the most instrumental in delaying implementation within some establishments. Several believed that PCTs were delaying the release of funds in order to make their own accounts look healthier. It is possible that other services within prison healthcare are also experiencing similar difficulties: the magnitude of this problem should be explored in more depth in future research. In contrast a few leads stated that their PCT was extremely supportive. When such positive interactions occurred, healthcare IDTS leads often described a sense of feeling valued and belonging to the National Health Service. These positive relationships between prison healthcare and PCTs should be explored in more depth in the evaluation process and in future research.

The majority of prison leads stated that their PCT had created numerous obstacles when they tried to recruit staff, ranging from refusing to release funds to advertise nationally when the lead had difficulties recruiting locally, and placing a blanket ban on recruiting when they needed to recruit staff to implement IDTS. Another lead was told by Human Resources, within the PCT, to recruit anybody that applied for the positions, regardless of their suitability. Prison leads found that such responses made them feel disempowered, demoralised and reinforced their belief that PCTs were not interested in prison healthcare.

Many prison leads stressed that prison healthcare is a unique working environment and functions within the constraints of the prison regime. Findings suggest that many PCTs made major decisions despite having neither visited the prison nor knowing much about prison healthcare or the prison regime. Prison leads perceived such disregard of fundamental issues as arrogant and foolhardy.

Tendering for IDTS was a contentious issue for some leads. Several leads thought it was not viable, especially in establishments who envisage that they will only have a few IDTS
clients. Others voiced their concerns about the conflict of interest surrounding PCT’s commissioning of services and the tendering of contracts. Both of these issues should be explored in the evaluation process.

RECOMMENDATIONS

• PCTs should employ a senior member of staff who has considerable experience of prison healthcare and prison regimes to advise them on the implementation of IDTS and future prison health care policies.

• PCTs should ensure that IDTS funding is more accessible to IDTS leads.

• The need to encourage better communication between PCTs and prison health care.

• The need for PCTs to be more supportive of prison leads throughout the implementation process.

• There should be more monitoring of PCTs during the implementation process (e.g. releasing funds, issues related to recruitment, signing protocols and commissioning of services etc).

• The need to identify Primary Care Trusts’ perspective of implementing IDTS during the evaluation process.

• The need to conduct future research that will explore PCT’s perception of being made responsible for the commissioning of prison health care services.
Risk Factors

Issues surrounding first-night prescribing and the possibility that additional deaths in custody might occur once IDTS is implemented, were voiced concerns. The fact that a GP contacted the British Medical Association regarding first-night prescribing demonstrates the level of concern some clinicians have about this issue. It is possible that Offender Health has now addressed the concerns regarding first-night prescribing as discussions were taking place between the British Medical Association and Offender Health during the period IDTS leads were participating in the study.

Many leads voiced their concerns about the possibility of additional deaths occurring once IDTS was implemented. They were concerned specifically about the cocktail of illegal substances that might be used combined with the daily dose of prescribed methadone. This issue is especially pertinent for those within their establishment, who have a serious illicit drug problem. Others were concerned that the implementation of IDTS might result in an increase of methadone being smuggled into establishments, thus increasing the possibility that some IDTS clients may die of a methadone overdose. Other leads questioned whether random drug testing would be able to identify IDTS clients who are also self-administering methadone. Another was concerned about the possibility of a judicial review being conducted if any IDTS clients were to die whilst in custody. Offender Health and NOMS should consider these issues in more depth.

RECOMMENDATION

- Consideration to ways in which illicit drug use in conjunction with methadone can be minimised.

Theme 6: Ethical Issues

Issues surrounding confidentiality, the standard of care that substance misusers might receive and the lack of guidance for those already detained, have been identified as potential ethical issues. According to the Health Advisory Committee (1997) prison
health care should be delivered to the same standard as that received by the general population. It is the case that some CARAT staff currently have to conduct 1:1 sessions either sitting on the stairs or on open landings due to the lack of space; and as clear from the above, many healthcare staff dislike caring for substance misusers, some staff use negative terminology when referring to them and recently detained substance misusers receive treatment before those who are already detained (e.g. IDTS). This suggests that prison healthcare still has a long way to go before it can be considered to be delivering services to the same standard as that received by the general population. The addressing of issues surrounding confidentiality and prejudice towards substance misusers might help to address the ethical concerns identified in the study.
Conclusion

‘Real solutions [improving prison healthcare] are beyond the control of a health service working in isolation from the rest of the prison service.’

Squires 1996

The introduction of IDTS has occurred when the responsibility for the commissioning of healthcare services has recently been transferred to NHS Primary Care Trusts. Whilst the aim of the study is to evaluate the first wave of prisons preparing to implement IDTS it became evident that difficulties surrounding the transfer of the responsibility for the commissioning of healthcare services has intensified and exacerbated the difficulties for those preparing to implement IDTS. Initially, both issues seemed inseparable. However, in order effectively to evaluate the first wave of prisons preparing for implementation it is necessary also to identify which issues and difficulties are associated more with the transfer of responsibility for the commissioning of services rather than difficulties associated with the implementation of IDTS. It is possible that this issue might be pertinent to the commissioning of all prison healthcare services within many prison establishments.

This study is important as it can serve two purposes, i) it can guide and inform the next wave of prisons that are preparing to implement IDTS, and ii) it provides a unique insight into how many PCTs currently relate with prison establishments whilst preparing to implement a major health policy.

In order to evaluate the first wave of prisons implementing IDTS effectively, it is also necessary to understand the complex and difficult relationship many prisons currently have with the PCT that now commissions their health care services. Many prison leads perceive PCTs to be obstructive, unhelpful and uninterested in prison healthcare. In addition, many prison leads were concerned that PCTs despite their lack of knowledge about this unique environment, often disregarded their views and concerns whilst preparing to implement IDTS. Such responses have resulted in many prison leads feeling
disempowered and demoralised. The fact that two PCT leads participated in the study and stated that they felt overwhelmed whilst preparing to implement IDTS highlights the importance of identifying the difficulties both prisons and PCTs are experiencing during this transitional period.

As prison healthcare is undergoing fundamental changes, it inevitable that these will not occur without resistance. However, it is crucial that Offender Health is aware of the potential difficulties that might occur and, as they are identified, must attempt to address them as soon as possible. In the past the NHS has resisted taking responsibility for prison healthcare (Smith, 1999) and might be a partial explanation as to why some prison leads experienced extreme difficulties as they tried to implement IDTS.

Prisons and PCTs might be resistant to these reforms because Governors may be reluctant to lose control over prison healthcare and PCTs might perceive prison healthcare as a financial burden they can ill afford. To help ensure that PCTs and prisons are receptive to one another, it is imperative that Offender Health endeavour to understand both prison and PCTs perspectives regarding this enforced union. It must also encourage, support and motivate this amalgamation rather than criticise and blame those who are resistant to the inevitable changes that are occurring within prison healthcare.

The Department of Health is committed to meeting the healthcare needs of prisoners, stating that prisoners should have access to the same quality and range of healthcare services as the general public. However, findings suggest that PCTs responsible for the commissioning of prison healthcare services seem to have little understanding of this unique environment, which functions within the constraints of the prison regime. Many leads suggested that PCTs fail to realise that the prison population is ‘demographically different from the general population and the circumstances in which they live are clearly different from those of the general population’ (Health Advisory Committee for the Prison Service, 1997) and that no two prisons are alike (Birmingham, 2003), whilst Reed (1997) states that the prison service needs to recognise that expertise in the commissioning and delivery of healthcare is overwhelmingly based in the NHS. It could be argued that the Health Service needs to recognise and acknowledge the important
contribution the prison service can make during the transitional process and whilst preparing to implement new healthcare services. It could be argued that the provision of healthcare services in prison is more complex than just focusing solely on the commissioning of services. The current study has identified that the physical environment, attitudes and the tensions between security and healthcare, all impinge, and have an impact, on the provision of prison healthcare services.

Findings reveal that the implementation of IDTS is a mammoth, multi-faceted and complex task that encroaches upon many aspects of an establishment whilst preparation to implement it is underway. It requires a dramatic shift in attitude towards substance misusers and the care they receive. IDTS leads play a pivotal role in the implementation of IDTS. The majority had to overcome seemingly insurmountable obstacles as they prepared to implement IDTS. Many leads felt that their participation in this study had given them a voice that they felt had been lost during the implementation process.

Many leads embraced IDTS and perceived it as a clinical solution to drug dependency and believe that when fully implemented it will result in a nationally standardised drug treatment within prison establishments. They also perceived that the introduction of IDTS would enable substance misusers to move around the prison estate more successfully, thus enabling them to function more effectively, reduce self harm, suicide and drug-related fatalities during release. It is encouraging that the majority are receptive to IDTS and understand, accept and welcome its implementation but it is crucial that their concerns are also acknowledged and not ignored by Offender Health, DH and Prison Service, NOMS.

Taking these factors into account, it is suggested that IDTS by no means occurs in isolation. In order to understand the complexity of implementing IDTS it is necessary to understand the present difficulties many establishments face during the transitional period as healthcare services are devolved to NHS Primary Care Trusts.

Findings suggest that prison establishments are embracing IDTS and the vision Offender Health has for the future development of prison healthcare. The following elements are
required to ensure that the vision becomes reality: determination; dedication; effective communication between IDTS leads, PCTs, Offender Health, NOMS and all other stakeholders; a courage of conviction; the ability to overcome numerous obstacles; the ability to evaluate critically the implementation process; the ability to learn from mistakes and a sense of openness to amendments throughout the whole process of implementation. The fact that the IDTS Steering Group commissioned this study and IDTS leads have demonstrated the ability to critically evaluate their experiences of implementing IDTS, would suggest that the foundations for creating an effective partnership might be in place. The full evaluation of IDTS will determine whether this union has been successful.
REFERENCES


