NOMS National Offender Management Service

Working together to reduce re-offending

Integrated Drug Treatment System

The First 28 Days: Psychosocial Support

First Wave Model
This document is to be used for First Wave Prisons and will be reviewed before wider roll-out commences

Drug Strategy Unit
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NHS

National Treatment Agency for Substance Misuse

Home Office

Contents

1. Background and Context

1.1 This document describes how psychosocial services will be delivered for Problematic Drug Users (PDUs) during the first 28 days of custody under the Integrated Drug Treatment System as funding permits. It should be used alongside the CARAT[1] specification, (2004) the CARATs Practice Manual, The Clinical Management of Drug Dependence in the Adult Prison Setting, DIP[2] Guidance and PPO[3] Guidance. This document is aimed at a wide audience including Commissioners, NDPDU, ADCs, and Establishment Drug Strategy co-ordinators, CJIT workers, Offender Managers, Healthcare teams, CARAT workers, managers and providers of treatment services in the community.

1.2 Considerable progress has been made in the expansion of drug treatment in Prisons. A comprehensive framework is now in place to address the needs of drug misusers, but scope remains to increase the volume and improve the quality of treatment.

1.3 To address, this HO/NOMS/DH jointly developed a proposal for improved drug treatment for prisoners early in custody, based on NTA Models of Care (2002). Key elements of the new framework are:

- improved volume and quality of clinical interventions with increased use of maintenance prescription and with detoxification conducted over individually assessed periods of time;
- structured CARAT intervention during the first 28 days of clinical intervention;
- closer integration of drug treatment services with a particular emphasis on clinical/CARATs; and
- Strengthening links to Community Services including Primary Care Trusts, Criminal Justice Integrated Teams (CJITs), Drug Treatment providers etc.

2. Aim of the psychosocial support during the first 28 days of custody:

2.1 Detoxification and Maintenance programmes are two of the key treatment modalities under MoC and therefore can be seen as interventions in their own right. However they are also a gateway into a treatment journey, for those clients who require ongoing psychosocial treatment /support to remain drug free/stable. Both pharmacological treatment and psychosocial treatment is more effective when they work together in an integrated and harmonised manner.

2.2 The initial 28-day period of arriving into custody is recognised as a critical period of time for PDUs who are considered to be in a vulnerable state.[4] The

[1] Counselling, Assessment, Referral, Advice and Throughcare.
[2] Drug Intervention Programme.
[3] Prolific and other Priority Offenders
[4] There is evidence to suggest a vulnerability of drug using prisoners during the first 28 days of custody, with regard to self inflicted deaths and self-harming behaviours. 50% of self-inflicted deaths occurred

engagement of the client at this point can provide support and be crucial to their continuous treatment journey.

2.3 The main aim of the psychosocial intervention is to:

- provide a 28-day structured care package of psychosocial support for prisoners with problematic drug use which:
  - complements clinical interventions
  - takes into account previous treatment in the community or custody and
  - provides a platform for longer-term drug treatment in prison and on release.

2.4 Referrals to more intensive drug treatment programmes in custody should be made as soon as need is identified however commencement would generally take place after completion of the 28-day psychosocial intervention.

3. Client's[5] Drug treatment Journey

A client's drug treatment journey may take 5-7 years (or more) to complete (NTA Models of Care Update 2005), for some the journey may be a lifetime event. It is important to acknowledge that everyone's journey is different and that therefore flexibility is important rather than a rigid "one programme fits all." Time spent in custody is **part** of a client's treatment journey. It is recognised that there is cumulative benefit from a series of treatment interventions; Prison drug treatment should be seen as one of a 'series' of treatment that some clients with drug problems will undergo. There is evidence[6] to suggest that there is optimised benefit if a client is retained in treatment for a minimum of 3 months so it is important that the 28 day period outlined in this document is not seen as a discrete intervention but as the beginning or continuation of a treatment journey.

4. Client centred treatment

Drug Treatment should be delivered in accordance with identified need; enhanced treatment outcomes are more likely where the client feels s/he is actively involved in the creation of their care plan. Care Plans must therefore be developed with the individual with agreed goals and identified areas of work. Some of these may include referral to services outside the domain of drugs and alcohol i.e. housing, childcare, employment.

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during the first 28 days in custody (DH 2003) with 62% of those who died being problematic drug users (HMP Safer Custody Internal Report 2002).

[5] Client: For the purpose of those undergoing support under the IDTS and in line with Models of Care all prisoners, who require access to drug treatment, will be referred to as "clients"

[6] NTA – Effectiveness Review – June 2005

5. Creating a treatment culture

There is evidence to show that treatment outcomes are enhanced if the service characteristics/environment is user friendly. Delivering drug treatment in a prison setting can prove challenging. However every effort must be made to ensure a treatment culture/therapeutic environment is promoted. This includes:

- Inducting all staff involved on the treatment ethos of the prison with awareness of giving positive and not negative messages
- Ensuring all staff engaging in the delivery of treatment have the required competencies.
- Development of an agreed joint care plan between the client, clinical staff and the key worker.
- Access to appropriate facilities to engage in assessment/1:1 work/groupwork which respect confidentiality
- Using the keyworker role to ensure that treatment is planned, co-ordinated and delivered.
- General promotion of a treatment ethos i.e. use of appropriate leaflets, posters etc

6. Throughcare

Many of the clients engaged in the 28-day psychosocial support will be on remand or serving short sentences and may also be subject to transfer. This makes the role of effective throughcare (between community and prison and/or between prisons) essential; the keyworker role is vital to throughcare taking place.

7. Flexibility and prioritisation

7.1 The 28-day psychosocial support must be flexible to meet the varying needs of the different clients. The phases outlined later in this document need to be delivered to suit the identified needs of the individual and their circumstances, it is important to remember that some clients may be stabilised and ready to engage within the first few days in custody whilst others may need more time to stabilise and engage in further treatment.

7.2 The minimum interventions are outlined in Phase 1 and must be available for those who are in custody for the full 7 days. A degree of prioritisation of interventions may have to take place where someone is going to be released earlier or is due in court. As a minimum every client engaged in the IDTS must be offered the following:

1. Assessment/Assessment review and Care-planning/release plan (may be just an initial care plan)
2. Harm Reduction/Risk of Overdose
3. Referral to CJIT or other community treatment

7.3 Prolific and Other priority Offenders (PPOs)

In line with the CARAT PPO Guidance[7], identified Prolific and other Priority Offenders (PPOs) must be prioritised for psychosocial interventions including those delivered within the first 28-days.

8. Competencies and Training

The skills/competencies to deliver psychosocial interventions within the first 28-days are no different to that required of CARAT workers currently. What will be needed is familiarisation with this framework.

9. Complementary Therapy

9.1 Complementary therapies are popular with service users and are increasingly employed in drug treatment services. These include acupuncture, reflexology, homeopathy and massage. While the evidence base at present does not provide strong support for such therapies, they may improve client satisfaction and treatment retention[8].

9.2 It is not possible to fund complimentary therapies through IDTS funding. Approval for the use of complementary therapies rests with the Primary Care Trust (PCT) responsible for the provision of Healthcare within the individual establishment.

10. Peer support

Use of peer support particularly from those who have themselves engaged in the 28-day psychosocial support may be useful in engaging and motivating clients during the early stages. (Further guidance on setting up such support mechanisms will be available by August 2006).

11. CARATs

11.1 The aim of CARATs (Counselling, Assessment, Referral, Advice and Throughcare service) is to provide a low-threshold, low/medium intensity, non-clinical drug treatment service to prisoners in order to reduce the harm caused by drugs. CARATs workers act in a key working role and provide care co-ordination in order to ensure that there is continuity of care between what is provided in prisons and what is provided on release within community settings.

[7] CARAT PPO Guidance – January 2006

[8] Models of Care 2002

11.2 CARATs provide services at tiers 2 and 3 within the Models of Care approach to drug treatment. The service identifies and assesses prisoners before providing advice, information, one-to-one, group work and referral to other appropriate services, including structured drug rehabilitation programmes. Where additional needs have been identified such as housing, employment, benefits, etc. CARATs will refer to appropriate services inside the prison establishment including resettlement, probation teams, Criminal Justice Integrated Teams[9] (CJITs) or other community provision to prepare for release.

11.3 The 28-day framework described in this document will provide the psychosocial interventions required to fit the needs of clients during this critical period. It will serve to enhance and boost current CARAT services during the first 28-days. (For detailed information about the CARAT service please refer to the CARATs Practice Manual). CARATs currently provide some elements of the services outlined in this document but this is determined by local priority and capacity. Additional funding together with the framework outlined in this document will enable the delivery of a consistent and enhanced common psychosocial service, for the first 28-days, across the estate.

11.5 CARAT workers must ensure that they use the CARAT casework file to record all interventions and notes pertaining to the psychosocial elements of this 28-day period.

12. The Key Worker Role

12.1 Crucial to the success of the 28-day psychosocial support intervention is the role of the key worker. This will be a CARAT worker whose predominant role will be to draw up and ensure delivery and ongoing review of the care plan and that those involved in the client's care both in the community and in prison are kept informed. Good practice would be that the key-worker is also responsible for undertaking assessments and 1:1 interventions. This would normally involve regular meetings between the keyworker and the client where progress against the care plan would be discussed, reviewed and goals revised as appropriate.

12.2 The main components of the key-worker role are:
A dedicated and named CARAT worker will be allocated to each client on the 28-day psychosocial support intervention within the first 24-hours of entry into custody (or first working day after a weekend/BH) and will stay in this role during the stay at that establishment.
The key worker will be responsible for ensuring the clients care plan is drawn up with the client, clinical staff and others as appropriate e.g. resettlement; and is then delivered and reviewed regularly
The key worker will not be responsible for the delivery of all elements of the care plan but will be responsible for coordinating assessment information and care for client

[9] See CJIP/DIP guidance 2003 (to be updated 2006)

Key working will also play an essential role in maintaining motivation and engagement throughout treatment interventions
Within the first 28-day period a minimum of one key working session per week is required.
CARAT teams must follow the normal guidance for transfer by notifying the receiving CARAT team (and relevant CJIT) and transferring the CARAT file.
Where the transfer is planned and occurs within the first 28-days the CARAT team in the receiving prison must be notified to enable a key worker to be nominated prior to transfer.
CARAT teams in receiving establishments must have a system in place to enable identification of those within the first 28-days and allocate a key-worker as required.

12.3 Key working sessions to review progress over the 28 days
These should be conducted once a week, as a minimum, to review the progress the client is making and be used to make any changes that may be required to the care plan. These sessions should also make full use of motivational interviewing techniques to ensure client remains motivated and engaged. These sessions may also be used to continue building a therapeutic relationship with client, providing information and advice etc.

13. Psychosocial treatment:

13.1 Structured Psychosocial Interventions:
"…are **clearly defined** psycho-social interventions, delivered as part of a client's care plan, which assist the client to make **changes** in their drug and alcohol – using behaviour"(MoC Update 2005 out for consultation).

13.2 Psychosocial treatment for substance use disorders is a broad "umbrella" term that brings together under its folds a varied group of non-pharmacological interventions for effective management of drug abuse. The fundamental basis of these interventions is that they do not involve prescribing medicines in themselves but that they serve to support any pharmacological treatment. Specifically, psychosocial interventions can enhance pharmacological treatment effectiveness[10] by increasing medication compliance, retention in treatment, and acquisition of skills that reinforce the effects of medications.. Other than this goal of strengthening pharmacological effectiveness, psychosocial treatment can serve longer-term goals of either total abstinence, or maintenance regimes, with reduction of harm as the aim.

13.3 Staying drug free for a long period of time may be difficult for a substance misuser living a particular life style, often in a drug using "sub-culture", where the primary preoccupation revolves around drugs. Thus, long-term abstinence, or maintenance, also necessarily implies, ultimately, a change of life style and

[10] Amato 2004; Gerra 2003; McLellan 1993

adoption of a more productive life style. A prisoner in custody who is removed from their normal lifestyle for a period of time can capitalise from this period of temporary removal from the drug revolving lifestyle by being in an environment where s/he can begin to learn some skills which will in the long term assist in the adoption of a different lifestyle. Prisons also offer an environment where access to drugs is greatly reduced compared with the community.

14. Integrated Drug Treatment System (IDTS)

14.1 The development of an integrated working system consisting of CARAT teams and healthcare will reduce the current duplication of assessment and provide enhanced drug treatment to the client. A communication strategy will ensure that leaflets and other publicity information will be developed to inform prisoners of the new service, what it means for them and the ongoing support they will receive. In addition other related services e.g. GPs, Drug Treatment providers, Probation etc, will be provided with information.

14.2 Clinical staff will generally have the first contact with the client, following identification of substance misuse issues through the reception-screening tool, and will then initiate an SMTA[11] (using the Drug Interventions Record – minimum up to 6.2) to inform immediate clinical need. Information received from the community on the DIR (or in another formats) will feed into this assessment. The SMTA will be passed to CARATS to inform more detailed assessment and care planning, together with any other appropriate information. Full descriptions of clinical services are outlined in the adult prison guidance[12]; guidance on completing the DIR is contained in the 2005 guidance[13].

14.3 Within 24-hours of entry into custody (or first working day after a weekend/BH), CARATS will appoint a keyworker who will draw up an initial care plan with the client, coordinate drug treatment, and other wraparound services, and provide weekly keyworking sessions; in practice this would generally be the CARAT worker responsible for the completion of the relevant assessments.

14.4 Following a CSMA[14], CARAT and clinical staff will jointly develop and agree a care plan, with the client, by day 5 (initial clinical review will take place on day 5) that meets individual need, is reviewed and revised as necessary. Access to drug treatment programmes [post 28 days], VDT and release planning including ongoing prescribing regimes, will be core components of the plan.

14.5 Apart from the keywork sessions, the bulk of psychosocial interventions will be delivered through a range of structured groupwork sessions detailed below. The majority of these will be relevant for all clients and delivered in

[11] Substance Misuse Triage Assessment
[12] The Clinical Management of Drug Dependence in the Adult Prison Setting (at press)
[13] Using the Drug Intervention Record (DIR) and Activity Form – Field by Field 2005
[14] Comprehensive Substance Misuse Assessment

groupwork sessions by a mix of Clinical and CARAT staff. For those individuals for whom groupwork is not appropriate[15] delivery may be on a 1:1 basis.

15. Standard Sessions

Groupwork must be validated under PSO 4350, delivered to a consistent standard and conducted in appropriate facilities, with group sizes not exceeding 12. Standard sessions, to cover a 90-minute session (including breaks) are currently in development and will be included in the final model. They will cover:

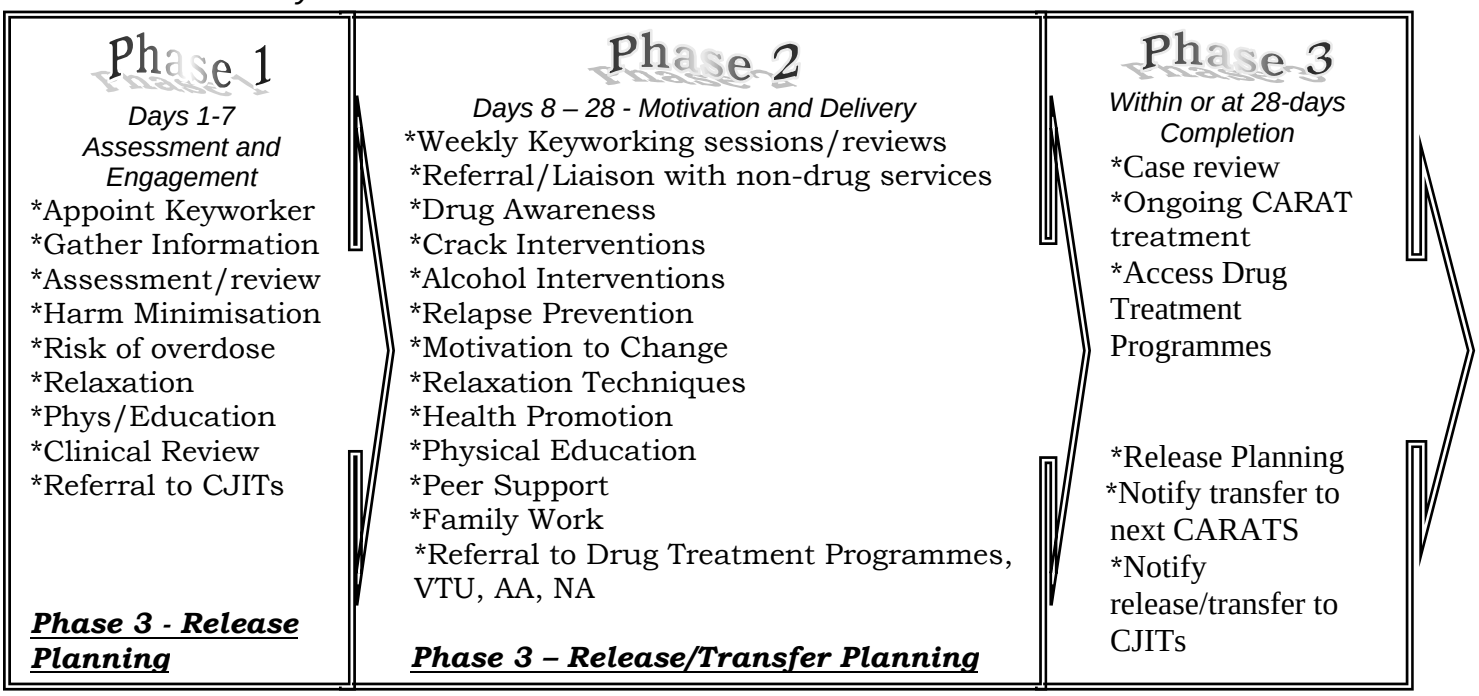
1. Harm Reduction/OD/Safer injecting, BBV
2. Basic Drug Awareness
3. Crack interventions
4. Alcohol interventions
5. Relapse Prevention (basic understanding of cravings and high risk situations and how to manage these)
6. Motivation to change
7. Relaxation techniques
8. Health Promotion: Healthy eating/living

16. The Phases

16.1 The 28-day psychosocial intervention can be described in three phases of Assessment and Engagement; Motivation and Delivery; and Completion. The phases described in the client's treatment journey whilst in custody must not be seen as inflexible stages with fixed time allocations. This is a flexible framework used to illustrate the different component stages that most clients undergoing treatment will pass through. The phases will inevitably overlap with many clients being ready for the next phase much earlier or later than the framework demonstrates. The distinction between phase two and three is purely illustrative as phase three particularly for those on remand, or serving short sentences (in this instance in custody less than 28 days), may be encompassed into phase two, the motivation and delivery stage, if they are likely to be released within a couple of weeks of entry into custody.

[15] Some clients may be uncomfortable in group settings especially for example some women and clients from BME groups.

16.1. 2 *The client's phased, psychosocial support, treatment journey during the first 28 days*



16.2 Phase One: Days 1-7
Assessment and Initial Engagement

16.2.1 This phase will be focussed on sound assessments and clinical interventions (see Clinical management of drug dependence in the adult prison setting). The client may be withdrawing during this phase and any contact in the first few days must be kept flexible. CARATs role in the first five days will be crucial particularly as it will entail working with all those involved in the client's care i.e. clinical staff, CJITs, prison staff etc. It will consist of collecting all relevant information and ensuring that continuity is maintained and duplication kept to a minimum. An assessment may have already been undertaken in the community and a DIR received into the prison, which should be used as the basis for assessment in custody. The actual contact with the client however may be low key (more face to face contact with clinical services). This phase will include:

- A nominated CARAT keyworker within 24hrs (or the first working day after a weekend/BH) of prisoner reception
- Involvement in Induction (to publicise the 28 day intervention and CARATs overall)
- 1 initial Key-working session - to commence therapeutic relationship with client; explain IDTS and treatment options in custody. The SMTA should

be initiated by healthcare as part of the IDTS but where this has not been the case then CARATs remain responsible for ensuring its completion.

- 1 case work session collating all assessment details from community and prisons
- 1 CSMA and Care Planning – Care plan in conjunction with healthcare
- 1 Harm Minimisation session and Risk of Overdose session (jointly with healthcare)
- I Relaxation session
- Attendance/input at clinical review

16.2.2 The **SMTA** (using DIR) will be used as a basis for all assessments and the information gathered via this must be shared with all relevant parties subject to the consent of client.

16.2.3 Attendance at clinical reviews
CARAT workers will always contribute to clinical reviews by either written reports or by attendance, which will be crucial where needs are complex. In either case a joint substance misuse care plan is mandatory.

16.3 Phase Two: Day 8-28
Motivation and Delivery

16.3.1 This phase will take place after a client has been stabilised and a CSMA, care plan and clinical review (where appropriate) has been undertaken. For some this may be within a shorter or longer period of time.

16.3.2 The level of psychosocial intervention offered will be:

- Weekly key-work sessions
- Ongoing case reviews
- Delivery of two groupwork sessions a week – as per identified client need
- Continued dialogue with clinical staff
- Referral to Drug Treatment Programmes to enable commencement post 28-days
- Referral to other support services e.g. VDT, AA, NA, BME community groups, VSC
- Commencement of contact with family if required
- Liaison with mental health teams, housing support etc
- Referral to CJIT/treatment programmes in the community

16.3.3 Regular key working sessions and weekly case reviews will be essential to ensure care package remains relevant and progress is being made.

16.3.4 During this phase full use of other support systems such as VDT, AA, and NA available at the establishment should also be made use of.

16.4 Phase Three:
Completion (of 28 days)

16.4.1 Timing of this phase will be dependent on time spent in custody, as some will complete the full 28 days whilst others may be released or transferred. This last phase will be used to review care received to date and plan the next level of care as they move within the prison community or into the wider community. If the client is being released/transferred at this stage then release planning will already have been initiated and this phase will be used to consolidate work already carried out and consider the exit strategy. If transferred – pick up with the IDTS in the receiving prison. This stage could happen at any time after the first week (day 8 onwards) and will need to be built in to the client's care package.

16.4.2 At this stage (if it has not been appropriate earlier) referrals will also be made to other intensive treatment programmes, VTU, AA, and NA etc

17. Rewarding Completion

At the completion of the 28-days the final case review should provide the client with a completion certificate[16] which provides a list of groupwork sessions (or 1:1 if relevant) that have been attended. This can be tied to local incentive schemes/rewards if appropriate.

18. Areas of Responsibility

The areas of responsibility for both Clinical and CARAT teams are identified below.

	Phase 1 (1 - 7 days)	**Phase 2 (8 –28 days)**	**Phase 3 (post 28 – days)**
CLINICAL	1. Reception screening 2. Initiate SMTA 3. Undertake Clinical stabilisation 4. Undertake Clinical Observations x twice daily 5. Observe stimulant users 6. Commence other health interventions	1. Provide ongoing Detoxification, from one or more substances. 2. Provide ongoing slow opiate reduction regimes 3. Provide stabilisation of opiate regime whilst withdrawal is undertaken from alcohol. 4. Provide commencement of Opiate substitute maintenance regimes	1. Provide ongoing Clinical regimes 2. Review and revise prescribing regimes as necessary 3. Initiate Naltrexone programmes 4. Continue integrated working with CARATs to ensure transfer of information and continuity of care

[16] Which will be devised as part of the CARAT casework documents

	7. Undertake 5th day clinical review and care plan jointly with CARATs 8. Deliver groupwork sessions with CARATs ***9. Release /Transfer Planning – can occur at any time and requires transfer of information to CARATs/Healthcare and community prescribers***	5. Provide assessment of efficacy of other health related interventions. 6. Provide continuation of Benzodiazepine reduction regimes 7. Continued observation (of mood and behaviour) of stimulant users 8. Deliver groupwork sessions with CARATs ***9. Release /Transfer Planning – can occur at any time and requires transfer of information to CARATs/Healthcare and community prescribers***	***5 Release /Transfer Planning – can occur at any time and requires transfer of information to CARATs/Healthcare and community prescribers***
CARATs	1. Key worker named within first 24-hours (or first working day) 2. Undertake initial key working/SMTA review 3. Gather information from community and previous contact 4. Refer to CJIT 5. Deliver groupwork with clinical staff 6. Conduct 1:1 Interventions if required 7. Undertake CSMA 8. Develop Care plan jointly with Clinical staff 9. Attend or Contribute to clinical review	1. Weekly key worker sessions – ongoing case reviews 2. Discuss with clinical staff on client need 3. Discuss/refer to healthcare staff 4. Refer to Drug Treatment programmes, VDT[17] AA[18] NA[19] etc 5. Conduct 1:1 Interventions if required 6. Refer to/Liaison with other services 7. Deliver groupwork with clinical staff 8. Follow established CPA for clients with dual diagnosis.	1.Undertake case review and revise Care Pan if required 2. Provide ongoing CARAT intervention 3 Involvement of CJITs in release planning and inform of transfer where appropriate 4. Refer to intensive programmes 5. Follow established CPA for clients with dual diagnosis.

[17] Voluntary Drug Testing
[18] Alcoholics Anonymous
[19] Narcotics Anonymous

	10. Follow established Care Planned Approach (CPA) for clients with dual diagnosis. ***11. Release /Transfer Planning – can occur at any time and requires transfer of information between and to the relevant partners as outlined in the relevant CARAT documents***	***9. Release /Transfer Planning – can occur at any time and requires transfer of information between and to the relevant partners as outlined in the relevant CARAT documents***	***6. Release /Transfer Planning – can occur at any time and requires transfer of information between and to the relevant partners as outlined in the relevant CARAT documents***

19. Level of provision in individual establishments

Each establishment will need to determine the level of delivery relevant to the needs of their PDUs. The throughput of prisoners and length of stay will be key to determining the levels of treatment provision for each establishment. The model described above is just one part of IDTS. Implementation of the full system will be overseen by national, area and local steering groups, details of which will be provide shortly; these will need to take into account the impact on community treatment systems which will need to manage continuity of treatment when clients are released.