National Treatment Agency
for Substance Misuse

Criminal Justice Integrated Drug Teams and treatment interventions

Clinical guidance to maximise access to drug treatment

November 2003

1. Introduction

1.1 Purpose of this document

The purpose of this document is to provide additional guidance to inform the work undertaken by CJIP teams in relation to their role in providing and facilitating access to drug treatment.

1.2 The role of Criminal Justice Integrated Drug Teams in drug treatment interventions

The scope and function of community based integrated drug teams has expanded and evolved in response to the experience of implementing the first phase of the Criminal Justice Intervention Programme (CJIP) in 2003. Initial guidance issued to Drug Action Teams outlined the range of activities to be undertaken or commissioned for the new CJIP teams including:

- assessment
- case management and co-ordination
- immediate access to structured motivational engagement
- initial interventions with crack users
- facilitating immediate treatment requirements including prescribing services.

1.3 Drug Treatment in context

All drug treatment – in any local areas should be set in the context of the local drug treatment system. All new service developments or enhancements should be agreed with local joint commissioners and be in line with local Drug Action Team Treatment Plans and planning mechanisms. Similarly all developments should be in line with Models of Care (NTA 2002) – the national framework for drug treatment, and Drug Misuse and Dependence-Guidelines on Clinical Management (Department of Health et al 1999). The new national occupational standards for drug and alcohol (DANOS) provides standards for individuals providing, managing and commissioning drug treatment. All job descriptions and professional training should be consistent with DANOS, including CJIP teams.

2 Drug treatment as a key part of the CJIP team's remit

2.1 Enhancing CJIP role in drug treatment

The traditional role of criminal justice based drug interventions like Arrest/Court Referral Schemes, prison link workers etc has been to offer screening, assessment and referral services with a view to brokering appropriate mainstream drug treatment services for offenders. Whilst these initiatives proved to be effective in terms of identifying and assessing offenders. A high proportion of offenders do not engage. This may be due to delays between referral and accessing treatment or other factors such as clients having limited motivation and understanding about how they could be helped. A high proportion of offenders have not engaged with treatment. A recent arrest referral evaluation (July 2002) offered clear evidence of the high attrition rates between referral and engagement in treatment.

Even in areas where the waiting times for structured drug treatment provision are within NTA targets, there will be a wait of 2-3 weeks for treatment. Unless offenders can be successfully supported and retained in the intervening period, many of them will fail to engage.

Thus, enhancing the CJIP team's treatment role will offer the following benefits:

- maximise retention and engagement
- provide the opportunity to prepare drug users for more structured drug treatment and therefore improve outcomes
- reduce risk of return to drug using and offending
- reduce the risk of drug related death/harm particularly for those released from custody.

2.2 Assessment and care co-ordination and management by CJIP

To work effectively with drug users, CJIP teams will be expected to adopt the assessment, care co-ordination and care planning framework described in Models of Care (NTA 2002).

a) Assessment

The assessment system is described in detail in Chapter 1.3 of Models of Care. Some of the key features are as follows:

- effective assessment must be undertaken in a way that does not present a barrier to entry and engagement in appropriate treatment
- assessment systems should facilitate rapid access to emergency treatment when drug users present in crisis or with complex needs
- present as an opportunity to provide harm reduction advice/services
- assessment should be needs led and be an ongoing process rather than a one off event
- issues of cultural diversity and the development of culturally competent services are essential ingredients of effective treatment systems

Models of Care sets out three levels of assessment:

- Level 1: Screening and referral assessment (Tiers 1 and 4b)
- Level 2: Drug and alcohol misuse triage assessment (Tiers 2, 3 and 4)
- Level 3: Comprehensive drug and alcohol misuse assessment (Tiers 3 and 4a and some Tier 2)

The levels of assessment reflect the different levels of complexity and expertise required to carry out the assessment at each stage. CJIP teams should be in a position to undertake triage assessment in the first instance but also conduct comprehensive assessments for individuals with more complex needs in order to initiate a care plan.

b) Care planning to enable case management, including

- short term goal setting
- developing risk management strategies
- engagement plan
- relapse prevention
- solutions to presenting problems e.g. housing

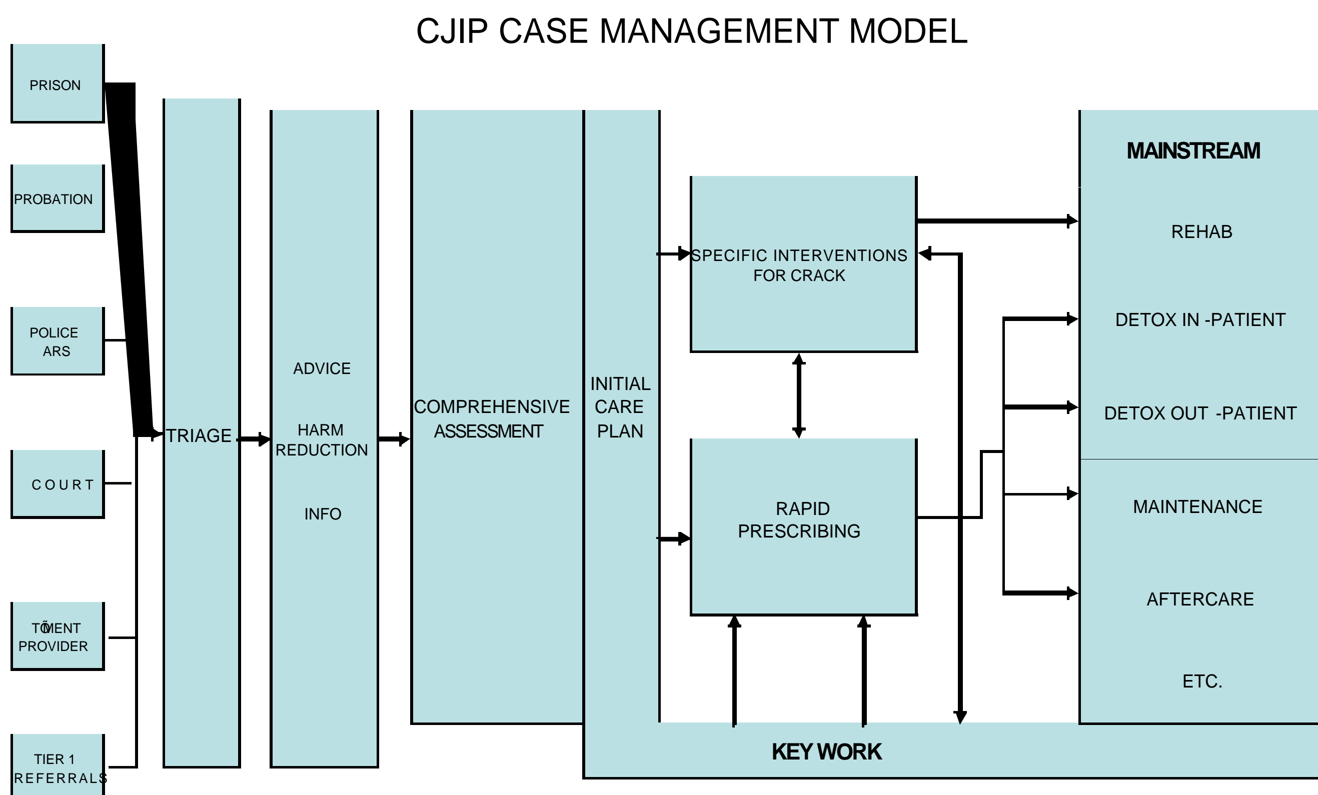
To achieve this, CJIP teams need to ensure that their screening, assessment and referral arrangements are fully integrated and aligned with those agreed as part of local Models of Care implementation. Additionally, they will need to recruit staff with the relevant skills and competencies to undertake the range of activities described i.e. triage and comprehensive assessment, key working, care planning and standard care co-ordination (please see Models of Care chapters 1.3 and 1.4 for details).

c) Care co-ordination or case management.

Following a comprehensive assessment the CJIP team to provide access to and engagement with a range of treatment interventions (Models of Care)

Clear protocols with local treatment providers need to be established to allow for the effective transfer of care co-ordination responsibilities when a drug user is successfully engaged in structured drug services. There also needs to be a clear understanding of how the CJIP team will re-engage with the drug user should they drop out of treatment or need to be referred for aftercare purposes.

Fig. A



The concept of case managing and providing Tier 2 support has already been established by the development of Enhanced Arrest Referral Schemes on a national basis from 2003/04. The implementation of CJIP offers an opportunity to take this one step further and provide

initial structured treatment responses to those drug users with more complex needs who are unlikely to be retained and successfully engaged in structured drug treatment without immediate access to treatment and support from CJIP.

In order to support this enhanced role and maximise retention pending regular structured drug treatment engagement, CJIP teams will need to be in a position to provide immediate access to support, structured motivational/brief interventions and dedicated prescribing provision as part of a care planned approach.

CJIP team taking a proactive approach

In addition to the more accessible, out of hours provision required from CJIP teams a more pro-active approach to engaging and re-engaging drug users will need to be adopted. Teams should employ relevant means of communicating with clients to follow up missed appointments or re-establishing contact with those who are out of contact i.e. text and mobile phones.

If the client is an identified offender, care co-ordination is likely to remain with probation or the CJIP team. It is advisable that CJIP teams should retain a residual role even where some care co-ordination responsibility has been transferred to structured drug treatment services. Joint working arrangements should be made for the CJIP team member to monitor progress and be in a position to act as care co-ordinator to respond quickly if the client drops out of treatment so the client can be contacted and re-engaged a quickly as possible.

2.3 Immediate access drug treatment provided by CJIP

CJIP teams will be expected to provide the following immediate access drug treatment for all drug users.

- advice and information about drug and alcohol misuse
- interventions to address immediate presenting needs e.g. access to housing
- activities to reduce risks identified during risk assessment in the triage assessment e.g. overdose prevention
- access to harm reduction services including interventions to prevent risk of drug related overdose e.g. overdose training, brief alcohol interventions
- harm reduction to prevent the spread of Blood Borne disease e.g. access to needle exchange services, Hepatitis B vaccination etc
- all clients with less complex needs require key working consisting of individual goal centred support.

All drug users should receive basic advice and information about drug use and its health and social consequences, interventions to address immediate needs and risks and key working. Others will require interventions specific to their drug misuse e.g. injectors will require access to needle exchange services and opiate related overdose prevention.

2.4 Intermediate term structured interventions provided by CJIP teams for all drug users

All drug users known to CJIP who require drug treatment should receive intermediate term support within the context of a care plan agree with the client. This should include as a minimum:

- key working

- motivational work to aid retention (for all users)
- for those with heroin or opiate dependency: facilitated access to immediate prescribing and related support
- specific interventions for crack or stimulant users
- specific interventions to address other drug and alcohol misuse that may or may not require prescribing e.g. brief interventions for alcohol misuse, access to clinical interventions for benzodiazepine misuse
- preparation for longer term structured drug treatment
- other as required in the care plan e.g. peer support (via NA/AA), group work support

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3. Rapid prescribing services for opiate users

3.1 Commissioning rapid prescribing services for CJIP clients

Local programmes of rapid assessment and care should be commissioned in CJIP areas so drug misusing offenders access substitute prescribing in days (or in less than a week) and be on an adequate (optimal maintenance) methadone dose within one to three weeks. However, the faster the system chosen the higher the additional resource costs required. This section describes key requirements for rapid prescribing services, and outlines a number of possible models.

Adequate assessment of patients is essential in all cases to confirm opiate dependence and to assess risks. In some cases this may require review over a number of days or longer.

Rapid access will require substantial additional amounts of dedicated medical and drugs worker time and resources to be made available. Some clinical settings will already have good infrastructure in place, such as day service provision, that could help minimise such increased costs.

Some patients may not be considered suitable for such rapid induction and stabilisation. Additional factors (such as co-morbid mental health problems) may require a more prolonged assessment phase before initiating treatment.

Optimal doses of substitute methadone for heroin users can only be safely achieved with a period of assessment, tolerance testing and dose titration **up** to optimal doses. There may be opportunities to reduce the time this takes to below NTA waiting time standards in CJIP areas with extra resources. If this can be achieved and the drug user is also using crack and/or cocaine, this will need to be addressed separately.

Urine or oral fluid testing is needed. Laboratory testing of samples is the most reliable method but can involve 1-2 weeks delay in obtaining results. Immediate on-site testing to confirm recent drug use, can be valuable for assessment for rapid induction but is open to challenge.

Whilst adequately high doses of opiate substitute treatment need to be achieved as rapidly as possible – the immediate provision of full therapeutic doses of substitute methadone for heroin users (e.g. 60 to 120mg) is not clinically advised and could result in death through overdose.

3.2 Requirements for rapid prescribing in all CJIP areas

a. Essential clinical assessment procedures entail:

- Assessing recent substance use history including recent prescriptions
- Establish of drug dependence by history taking, clinical examination and immediate drug testing
- Assessment of major medical and psychiatric factors and social issues
- Adequate risk assessment
- Consent to treatment and information for client (e.g. about methadone).

b. Staffing and resources required

- Doctor with adequate training to carry out medical aspects of assessments, physical and mental states assessments, clinical decision making.
- Competent drugs worker or nurse
- Testing facilities and trained staff to undertake: urine or oral fluid testing; breathalyser tests to assess breath alcohol levels; access to pregnancy testing.
- Adequate follow up arrangements to continue with dose induction i.e. increase doses as indicated, to continue assessment and define a care plan i.e. for identified mental or physical health issues.

c. Organisational requirements to facilitate rapid access to substitute prescribing services:

- The medical staff need to be available and have time available to see a client. This means they have to have no other booked appointments. The process of initially assessing and inducting drug user onto a prescription takes at least 1 to 2 hours of a drug worker and doctor working together.
- There needs to be a supervised consumption facility on-site or in a nearby pharmacy.
- Contact every other day and possibly daily to allow doses to be increased safely to one that is adequate to reduce opiate use.
- Continuing access to a keyworker or case manager to complete the assessment develop a care plan and monitor the prescription. (this may be possible using trained, competent CJIP staff)

d. Further considerations

- The needs of crack cocaine misusers are not met by this model
- Establishing details of previous or current treatment may not be possible in a few hours e.g. it is difficult to obtain information from prisons.
- Serious poly-substance abusers (including those with concurrent alcohol and opiate dependence may require more assessment).
- It is unsafe to prescribe for those who are seriously intoxicated.
- Buprenorphine is an effective maintenance drug. However induction onto buprenorphine is a more complex process and clients may need more time to be prepared for it.

3.3 Possible models of enhanced rapid prescribing of opiates in CJIP areas.

Model 1 : Status quo model: rapid prescribing provided by local specialist service)

Referral for assessment and treatment to local specialist or primary care prescribing service. CJIP provides active psychosocial support in the interim. In this model, access to prescribing services should be provided within the NTA two week waiting time. Channelling CJIP resources into the community team may enhance overall capacity and bring down waiting times in some cases. Other general improvements in access will also benefit CJIP patients.

Model 2: Specific slots for rapid assessment and induction with stabilisation over weeks

In this model "fast track treatment slots" are available 3 days a week with a doctor and other clinical staff and resources available at those times. The maximum wait to see a clinician is therefore 3 days. At the first appointment, the client has a comprehensive clinical assessment. Initial prescriptions could be given at a first appointment for non complex cases, dispensed at a community pharmacy and then doses increased incrementally over

the next few days/weeks. Most clients could be on methadone/buprenorphine within 3 days and stable optimised maintenance doses within 3 weeks.

Model 3: Intensive models featuring full time medical cover. for rapid assessment induction and stabilisation.

This model requires a doctor and other clinical staff on site Monday to Friday. At the first appointment, the client has a comprehensive clinical assessment. Initial prescriptions could be given at a first appointment for non complex cases. This model features an enhanced dose assessment service where all new clients are seen on a day 1 then seen again on day 2 and day 3. Incremental does are given on site and titrated to withdrawal symptoms over 3 or 4 hours.

This option requires daily nursing/pharmacy support (and may be more feasible where day services already exist). Most clients could be commenced on methadone/buprenorphine within 1 day and on stable initial doses within 3 days and stable optimised maintenance doses within 3 weeks.
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The continuing case management of clients would be carried out by the CJIP team. The team would require access to medical supervision and time to maintain the prescriptions.

This model will only be possible within an existing specialist drug service where facilities exist for supervised dispensing.

3.4 Appropriate responses for crack users

In order to respond effectively to drug misusers who use crack the following techniques and skills will be required within CJIP teams.
Knowledge of effects of crack on client
Dealing with immediate crisis and concerns
Auricular acupuncture to aid retention
Key working involving structured goal setting using crack specific assessment and monitoring tools
Relapse prevention
Managing craving and triggers to crack use
Cognitive Behavioural Therapy approaches (requires specific training)
Peer support groups

In August 2002 the NTA published research into practice guidance into treating cocaine/crack dependence. The briefing reviewed the current evidence base and concluded that the same skills and techniques which characterize effective drug treatment in general are equally applicable to crack and cocaine treatment. However it did highlight that factors like attracting, motivating and engaging this client group were crucial if they are to be retained in treatment for long enough achieve positive outcomes.

Some of the key characteristics were identifies as:

- trained, knowledgeable and competent staff
- responsive, empathic key workers
- rapid intake, pro-active reminders
- Informal, flexible and accessible services (drop-in, peer networks, 24 hour help lines

The NTA is currently developing a training programme for drug workers that will be made available to staff in CJIP teams in early 2004. Given the increasing prevalence of crack use, particularly amongst the offending population, a staff group who are trained and competent in working with crack users will be essential.

4. Professional competencies requires for CJIP teams

4.1 DANOS

The Drugs and Alcohol National Occupational Standards (DANOS), specify the standards of performance to which people in the drugs and alcohol field should be working. They also describe the knowledge and skills workers need in order to perform to the required standard.

Used in a very straight forward way, DANOS standards allow individual workers to be perfectly clear about what is expected of them in their work. Workers can check that they are doing a good job. They can also identify any knowledge they need to acquire or skills they need to develop.

Appendix 2 outlines DANOS standards required by most CJIP workers. CJIP teams should ensure workers have skills and knowledge in line with DANOS standards and plan training and development to meet identified gaps.

Appendices

Appendix 1: Three Case Studies

Case 1 – John

John is a 29 year old with a long history of substance use problems. Eight years ago he began to inject heroin and 3 years ago his venous access became so poor he began to inject in his groin. He has hepatitis C. He has been offending since he was a young teenager and as a result has experienced frequent short periods in custody mainly on remand. He mainly shoplifts and at times has been involved in professional shoplifting gangs.

About 18 months ago he did engage in treatment following a hospital admission for an abscess in his groin. He was stabilised on 70mg of oral methadone. During that time his offending reduced substantially and he was able to stop injecting in his groin although did continue to use crack cocaine when his benefits income allowed. Unfortunately an old friend moved back into his flat and they started shoplifting again to fund their crack use.

Two months ago he was remanded in custody for yet another shoplifting offence. Whilst in custody he was continued on his methadone prescription although at the reduced amount of 40mg daily.

He pleaded guilty to the shoplifting offence and was given bail so he could be assessed in the community for a DTTO. The CARAT worker in prison contacted his local CJIP team when they knew he was likely to be released. She was able to notify them by fax the day before they John was taken to court. A member of the CARAT team was able to met John on the day he was released from court and give him an appointment for the next day with the prescribing team. The local prescribing service where John had been receiving his prescription had a 3 week waiting list.

The next day John was seen by the prescribing team with his CJIP worker. His urine was tested and the nurse spoke to the prison who were able to fax confirmation of John's dose. His prescription was then continued at 40mg daily using a local pharmacy supervision scheme.

At a full assessment several days later John was found to be experiencing mild opiate withdrawals. He was therefore given an appointment with the doctor to consider an increase in his dose. A full treatment plan was later developed which included methadone maintenance and attendance at group sessions to help deal with his concurrent crack cocaine problem. His CJIP worker continued to carry out motivational work with him. After an assessment he was transferred to the DTTO programme where his treatment continued and he was reviewed regularly by the court.

Case 2 – Darren

Darren is 22 years old. He has been using crack cocaine for 2 years although did regularly use cannabis before then. He was able to continue his college course until 6 months ago. In the last 6 months he had been using almost every day, has lost contact with his family and has moved in with a friend who also uses crack. He has no criminal record.

He was eventually arrested as part of a police operation targeted at a local dealing network. He was found in possession of a small amount of crack and was taken to the police station

where he was interviewed and charged with possession. He was kept in custody overnight but released on police bail the next morning.

Whilst in the police cell the local arrest referral worker saw him and assessed him. He was offered a follow appointment with the CJIP worker the next day. His friend met him from custody however and he failed to attend the appointment. Knowing he was due in court 2 days later the CJIP worker met him there and spent some time with him. He did then attend the next appointment and was able to begin to do some motivational work. It became clear that Darren was desperate to reduce his crack use and resume normal life.

The CJIP worker was able to support Darren to reduce his crack use and after a full assessment he was referred to a crack day programme. He continued to receive support from the CJIP service after he received a community punishment order for the possession offence. After a few months he was able to go back to college despite the occasional lapse into crack use.

Case 3 – Karen

Karen is 27 years old. She has been a polydrug user for many years although has never injected any drugs. In the past she has abused dihydrocodeine tablets and diazepam and mainly obtained her supplies fraudulently from GPs. She has been smoking heroin for the past 18 months and has frequent binges on diazepam.

She had a disrupted childhood and was subject to physical and sexual abuse. Her mother used alcohol. She was taken into care when she was 14 and eventually was placed in secure care because she kept running away. She had a period of cutting her wrists when she was a teenager. Her offending started when she was in care and she has since served several long sentences for burglary and attempted burglary. She had worked as a prostitute at times.

She was referred to the CJIP team by the CARAT service in the local women' prison where she was coming to the end of a 14 month prison sentence. She had cut her wrist a few times in prison but had been reasonably stable and was able to take part in the prisons drug treatment programme. She had been detoxified from heroin using buprenorphine at the beginning of her sentence. She had been put on a slow reducing course of diazepam and although she had complied with this she freely admitted to using illicit diazepam in the prison. Unfortunately on leaving prison she was homeless.

The CJIP worker saw her before she left prison and advised her about women's hostels in the area. He also agreed to meet her on the day she left prison.

There were many other drug using women in the hostel. Karen relapsed and smoked heroin on the first night. When she saw the CJIP worker however she was clear she did not want a prescription as she was keen to stay drug free. The prescribing team were aware of the case and one of the nurses arranged to see her with the CJIP worker, at the hostel, to discuss the possible advantages of a prescription. The assessment was that she was not yet dependant on heroin – she was not using every day and was trying hard to stay drug free – but they took a urine test anyway. A week later she was beginning to experience some withdrawal symptoms in the mornings and had smoked £10 of heroin daily for the last 3 days. In view of that she was given a time to see the doctor the next day. All her urine test had been positive for opiates and benzodiazepines (diazepam).

The day the doctor saw her Karen was experiencing mild withdrawal symptoms so she was started on a buprenorphine induction regimen. She was seen every day that week and her dose increased gradually.

Over the next few weeks a full care plan was developed. The plan was to maintain her on a stable dose of buprenorphine and help her find stable housing. Her diazepam use was monitored and prescribing would be considered if she became addicted again. The team were also going to refer her to a local psychiatrist for an assessment of her mood.

Over the next few months she dropped out several times. Each time her CJIP worker maintained a relationship with her and was able to persuade her to come back into treatment and have her medication regime restarted. After a few months she was stable enough to be transferred to the local Tier 3 service.

Appendix 2: DANOS competencies required for CJIP teams

National Occupational Standards for DANOS A - Service Delivery A - Help individuals access substance misuse services (DA_AA Units)	
DA_AA1	Recognise indications of substance misuse and refer individuals to specialists
DA_AA2	Establish, sustain and disengage from relationships with individuals
DA_AA3	Enable individuals to find out about and use services and facilities
DA_AA4	Promote people's equality, diversity and rights
DA_AA5	Interact with individuals using telecommunications

National Occupational Standards for DANOS A - Service Delivery B - Support individuals in difficult situations (DA_AB Units)

DA_AB1
Support individuals when they are distressed

DA_AB2
Support individuals who are substance users

DA_AB3
Contribute to the prevention and management of abusive and aggressive behaviour

DA_AB4
Contribute to the protection of individuals from abuse

DA_AB5
Assess and act upon immediate risk of danger to substance users

DA_AB6
Support individuals with difficult or potentially difficult relationships

DA_AB7
Provide services to those affected by someone else's substance use

National Occupational Standards for DANOS A - Service Delivery C - Develop practice in the delivery of services (DA_AC Units)	
DA_AC1	Develop your own knowledge and practice
DA_AC2	Make use of supervision
DA_AC3	Contribute to the development of the knowledge and practice of others
DA_AC4	Support and challenge workers on specific aspects of their practice

National Occupational Standards for DANOS A - Service Delivery D - Educate people about substance use, health and social well-being (DA_AD Units)	
DA_AD1	Raise awareness about substances, their use and effects
DA_AD3	Facilitate group learning
DA_AD4	Develop and disseminate information and advice about substance use, health and social well-being

National Occupational Standards for DANOS A - Service Delivery F - Assess substance misusers' needs for care (DA_AF Units)	
DA_AF1	Carry out screening and referral assessment
DA_AF2	Carry out assessment to identify and prioritise needs
DA_AF3	Carry out comprehensive substance misuse assessment

National Occupational Standards for DANOS A - Service Delivery G - Plan and review integrated programmes of care for substance misusers (DA_AG Units)	
DA_AG1	Plan and agree service responses which meet individuals' identified needs and circumstances
DA_AG2	Contribute to the development, provision and review of care programmes
DA_AG3	Assist in the transfer of individuals between agencies and services

National Occupational Standards for DANOS A - Service Delivery H - Deliver healthcare services (DA_AH Units)	
DA_AH2	Prepare and administer drugs as directed or prescribed by the clinician *
DA_AH3	Supply and exchange injecting equipment for individuals *
DA_AH4	Support individuals in undertaking health care
DA_AH5	Undertake agreed clinical activities with individuals whose health is stable in non-acute care settings *
DA_AH6	Prepare and undertake agreed clinical activities with individuals in acute care settings *
DA_AH7	Support individuals through detoxification programmes
DA_AH8	Dispense medicines and products *
DA_AH9	Supervise methadone consumption *

* Desirable, as opposed to essential, competencies for CJIP Teams

National Occupational Standards for DANOS A - Service Delivery I - Deliver services to help individuals address their substance use (DA_AI Units)

DA_AI1
Counsel individuals about their substance use using recognised theoretical models

DA_AI2
Help individuals address their substance use through an action plan

DA_AI3
Counsel groups of individuals about their substance use using recognised theoretical models

National Occupational Standards for DANOS A - Service Delivery J - Help substance users address their offending behaviour (DA_AJ Units)	
DA_AJ1	Help individuals address their offending behaviour
DA_AJ2	Enable individuals to change their offending behaviour

National Occupational Standards for DANOS A - Service Delivery K - Support individuals' rehabilitation (DA_AK Units)

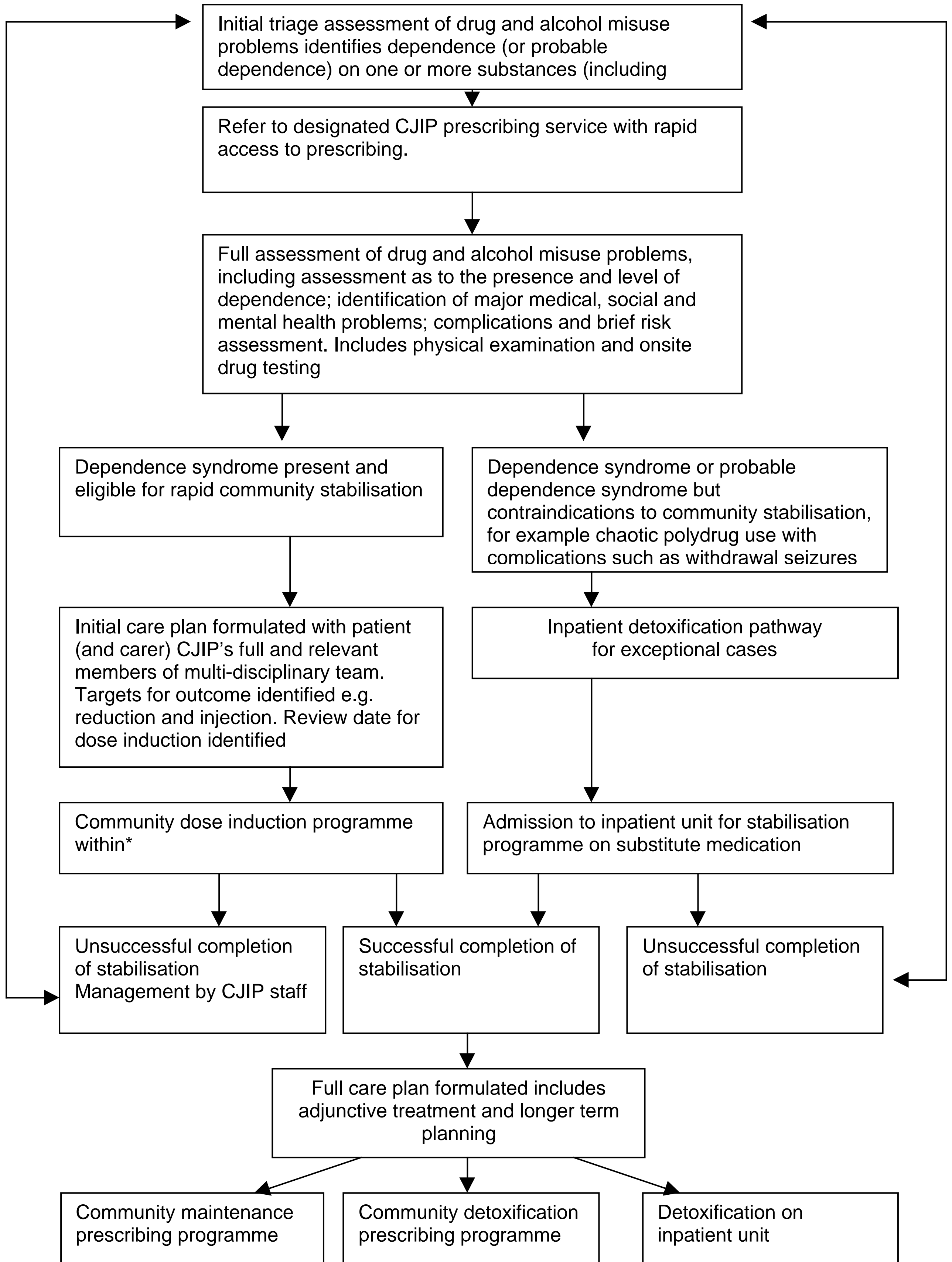
DA_AK1
Assist individuals to explore future employment, training and education opportunities

DA_AK2
Assist individuals to plan for future employment, training and education

DA_AK3
Enable individuals to access housing and accommodation

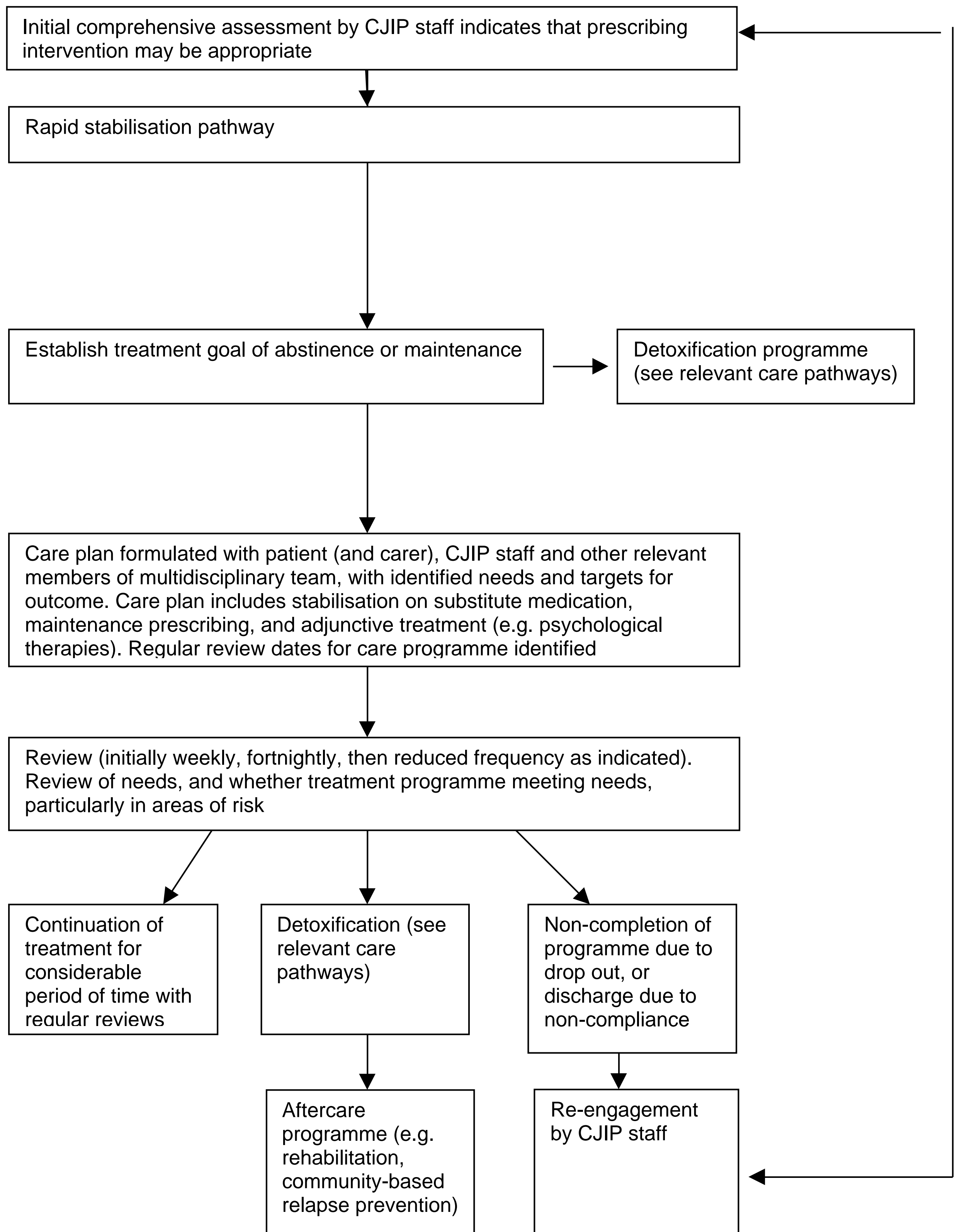
DA_AK4
Enable individuals to administer their financial affairs

Appendix 3
Diagram 1
Integrated care pathway – CJIP
Rapid Community Stabilisation on substitute medication

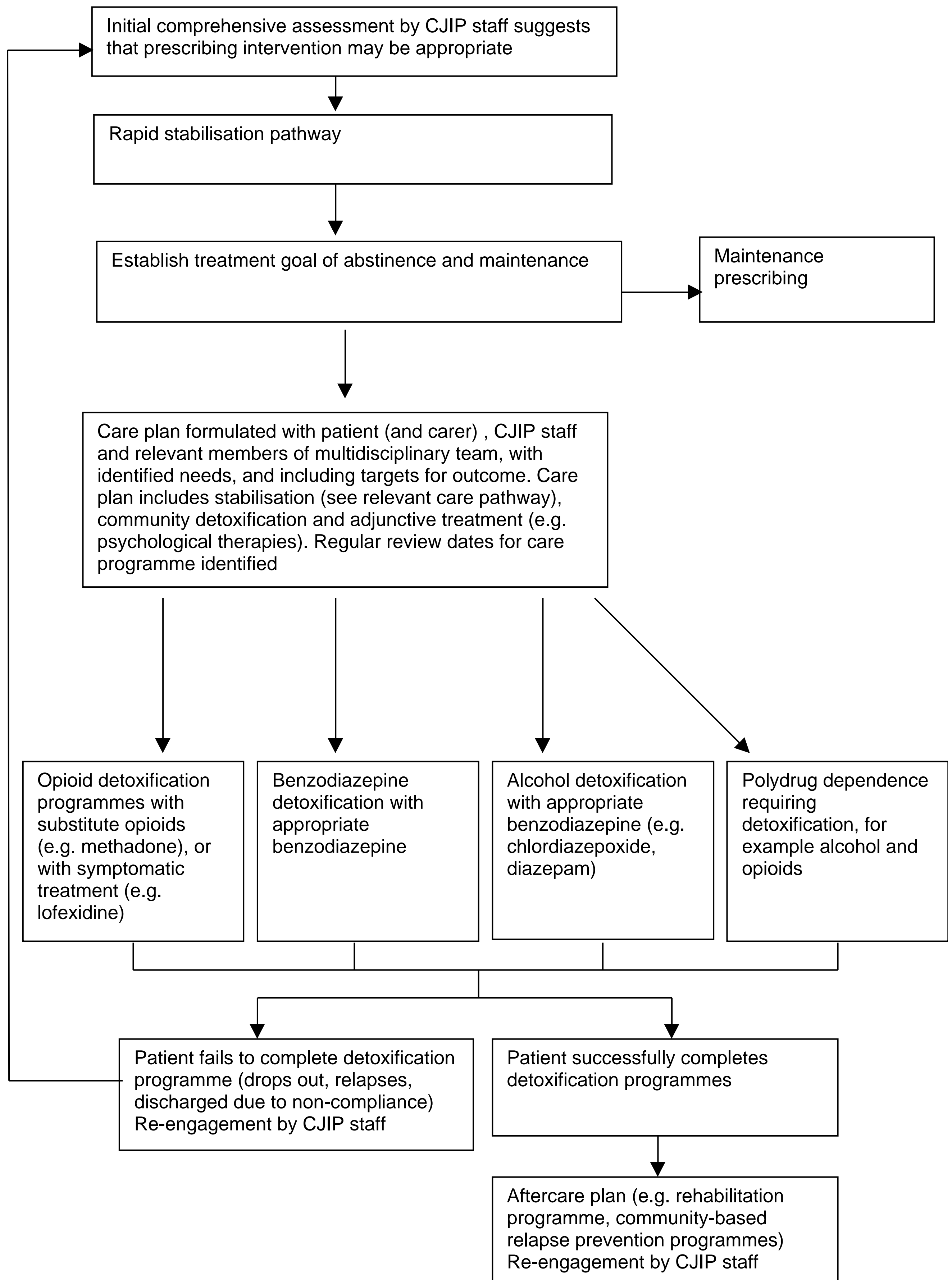


*Number of days to be defined

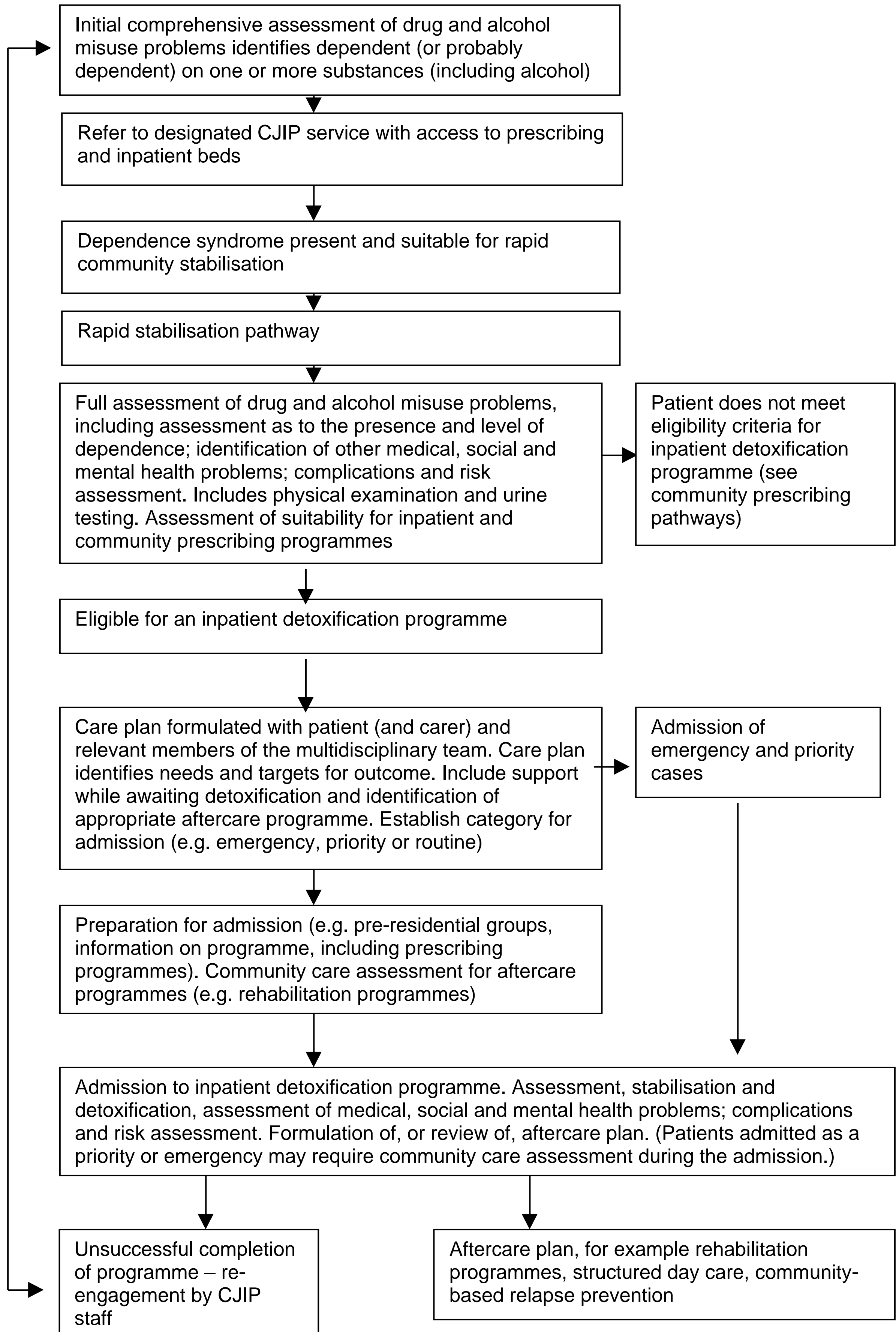
Appendix 3
Diagram 2
Integrated care pathway - CJIP
Community maintenance prescribing for opioid dependence



Appendix 3
Diagram 3
Integrated care pathway – CJIP
Community detoxification



Appendix 3
Diagram 4
Integrated care pathways – CJIP
Inpatient detoxification



Appendix 3
Diagram 5
Integrated care pathway: CJIP
Residential rehabilitation