



South Wales DIP Work Shop Notes

| Work Shop Title | Venue | Date |
|-------------------------------------|-------------------------------|----------------------------|
| Arrest Referral & DIP Care Pathways | City Hall, Cardiff | 1 st June 2007 |
| CARATS & DIP Care Pathways | The Heronston Hotel, Bridgend | 12 th June 2007 |
| Probation & DIP Care Pathways | The Heronston Hotel, Bridgend | 29 th June 2007 |

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Facilitated by South Wales DIP Regional Management Team

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Introduction

The purpose of DIP is to ensure that the community benefits from a reduction in drug related crime, such as burglaries, theft and prostitution. Through will be less drug driven crime, and inturn the individual health gains will be made, meaning everyone wins. By accessing treatment and sharing information on those being able to access treatment quicker the community will be safer as there motivated to address their lifestyle all elements of the criminal justice system can work together to divert offenders out of the cycle of drugs, crime and prison. Therefore the closer all professions within the criminal justice system work together the greater the potential for success of the individual. A classic example of this is through information sharing between drug services and the police mean those doing well in treatment will not be targeted as it is in everyone's best interest for the service user to succeed in treatment.

The DIP process is however overcomplicated due to the number of treatment and criminal justice elements within it; previously elements of today's DIP have had conflicting agendas. Today however the Police and Prison services work with the same intentions as that of drug treatment services in attempting to support those with drug dependencies into lasting and successful treatment.

Therefore the operational team linking previous criminal justice treatment services such as arrest referral, CARATS and DTTO's now acts as the linkage between all these services – the Criminal Justice Interventions Team (CJIT). The CJIT is a specialist service working within the Criminal Justice System (CJS) that joins up services to ensure drug using offenders do not fall out of treatment and return to criminal activity. The CJIT is based around a performance management framework evidenced through meeting KPI's that can demonstrate it is delivering what it is meant to "Out of crime and into treatment". Therefore it is important that all elements of DIP provision are clear as to who does what and when, and that all elements (DToC, arrest referral, CJIT, CARATS, DRR and mainstream services) promote one another consistently and effectively.

If you have any queries about DIP you can either phone the regional Management Team or check out the South Wales DIP website (www.dipsouthwales.org.uk) or the Home Office website that has lots of DIP frequently asked questions (www.drugs.gov.uk).

Care Pathways (Please see Appendix 3)

In order to assist a service user within DIP maximise their potential each element of DIP must work together as one. This means through understanding the different elements and who does what and when, a service users "Journey" is smooth, consistent and maintained. Therefore when a service user is referred from one part of DIP to another, they should not have to be reassessed, provisions should already be in place for them (especially medications), and everything done to ensure they continue engaging in treatment and do not drop out of services and back to drug use and offending.

Through the introduction of Palbase you will be able to build upon existing pathways and monitor the progress of a service user increasing their likelihood of success.

Care coordination

The overarching principle of care planning and care co-ordination is that those who enter into structured drug and alcohol treatment services receive a written care plan, which is agreed with the client and subject to regular review with the key worker or care co-ordinator. Drug and alcohol misusers who meet the criteria for care co-ordination should have access to a named person who acts as the care co-ordinator, to ensure that the care provided by different services is co-ordinated by one person to provide a comprehensive and integrated approach. Treatment may be provided by a range of professionals and from more than one service at the same time or consecutively.

The aims of care planning and care co-ordination are to:

- Develop, manage and review documented care plans
- Ensure that drug and alcohol misusers have access to a comprehensive range of services across the four tiers of local drug treatment systems
- Ensure the co-ordination of care across all agencies involved with the service user
- Ensure continuity of care and that clients are followed throughout their contact with the treatment system
- Maximise the retention of clients within the treatment system and minimise the risk of clients losing contact with the treatment and care services
- Re-engage clients who have dropped out of the treatment system
- Avoid duplication of assessment and interventions
- Prevent clients falling between services.

The care co-ordinator's role involves encouraging the drug and alcohol misuser to utilise appropriate help and assisting their access to and engagement in treatment, while accepting the individual drug and alcohol misusers' choice as to whether they accept treatment or not (MOC, 2002).

Palbase will assist in coordinating the treatment process; however this must not replace verbal and written communications between services, everything relating to a service user's case must be recorded; this ensures the service user's treatment package is protected and that everyone in the process is accountable for delivering on behalf of the service user.

Continuity of care

Therefore continuity of care is ensuring that a service user has a smooth transition from one element of treatment provision to another. This means the care coordinator must regularly communicate with everyone involved in the service users treatment package (especially the service user) until the individual case has been fully handed over and the case closed. Through accessing Palbase you will be able to ensure that the service user has engaged with the next phase of treatment and if they have not, you can assist in reengaging them due to your previous relationship with them. This also ensures that risk is better managed for everyone involved because of better communications.

Through the care pathways process a service user must be engaged in all relevant elements to them and this will partly involve you appropriately marketing the next stages of DIP to them. If a service user is motivated by you to engage in the next stage of DIP/treatment then there is a much greater chance of them succeeding in the goal of breaking the link between drugs and crime and all the other benefits that come with it.

Promotion of DIP in police custody

Whilst in custody many service users will be ambivalent about what is going to happen to them as a result of their situation, this is often a window of opportunity to sell “treatment” to them and engage them in the DIP process. This is particularly evidenced through approximately 47% of DIP clients never accessing treatment before (and therefore DIP is their initial introduction to addressing drug use through a structured approach).

Drug Testing on Charge (DToC)

If a service user is arrested for a “trigger offence” (a list specifically identified as potentially being related to drug driven offending, such as shop lifting, burglary, theft) then they will be tested for opiates and cocaine. The saliva tests currently do not have any purpose except to identify drug users who can then be targeted for the promotion of accessing treatment. There is however no compulsion on the service user to engage and that is why all parties within the custody setting must try and motivate the service user to at least have a chat with an arrest referral worker. Civilian Detention Officers (CDO's) undertake the drug testing, they are however independent from the Police and a crucial part of the DIP process. Therefore an important role for the CDO will be to promote Arrest Referral to the service user.

Arrest Referral

Arrest Referral services are drugs workers based within Police and court settings. Arrest Referral staff have a difficult role to undertake with engaging Police staff in understanding the value of drug treatment and also in engaging service users at a time when they are experiencing a range of emotions and uncertainties. Arrest Referral workers are key to the DIP initiative and must present the service user with a range of options that will entice them into engaging in the treatment process. From the point of assessment a service user will be awaiting a court sentence for either custody (where CARATS could take over their care) or a community sentence (where a DRR could take over their care). If the service user does not get remanded in prison and is bailed, the CJIT could take over their care. All three options, CARATS, DRR and CJIT must be promoted to the service user.

DIP is not about testing motivation it is about enhancing motivation to access and engage in treatment.

At assessment could you ask the service user to enter DAN 24/7 phone number into their mobile phone in case of an emergency or to get appointment details: 08006335588

Promotion of DIP in Prison

If a service user gets remanded in custody (sent to prison before being sentenced due to either risk factors or the severity of the alleged offence) or is actually sentenced to Prison then their access to treatment must be continued. Therefore as a DIP worker, you are obliged to ensure the service users case is handed over to CARATS and/or other prison drug related staff before you close the case. If you are unsure as to which prison the service user has gone, you can try contacting the custody suite they were held in, the solicitor involved, your local CARATS team or Court staff. The sooner you make contact with the Prison the service user is being held in, the sooner they will receive ongoing support and the more likely the service user is to acknowledge you made the effort and re-engage.

Drug Detoxification Units (DDU)

The treatment option for prisoners is through two main options, firstly through the Drug Detoxification Unit (DDU) where medical interventions can take place. Therefore it is essential that communication takes place between DIP workers in the community and prison based staff (arrest referral, DRR or wider CJIT staff must get in touch as soon as possible to confirm levels of medication and who is responsible for continuing the prescribing on release).

This is important as you can also make dates for when medications will potentially need picking back up in the community and allow you to put cautionary dates in your diaries to remind all parties closer to the end of a sentence, and even prepare for eventualities such as early release.

CARATS (Counselling, Assessment, Referral, Advice and Through care Service)

The second treatment option is that of CARATS (Counselling, Assessment, Referral, Advice and Through care Service). This is a team based in the prison to assess need and refer into appropriate treatment services within the prison establishment, such as group work, CBT programmes and education facilities. The CARATS worker is very similar to that of an arrest referral worker but in a prison setting.

The CARATS service has its own unique KPT's (Key Performance Targets) that differ to the wider DIP KPI's (Key Performance Indicators), although both CARATS and CJIT's must work closely together in order to meet each others KPT's and KPI's.

Prior to release could you ask the service user to make a note of the DAN 24/7 phone number in case of an emergency or to get appointment details: 08006335588

Promotion of DIP by Probation

If a service user receives a community sentence and has been identified as a drug user (normally at Pre-Sentence Report or PSR stage), the recommendation would be for a Drug Rehabilitation Report (DRR). This will however not always be the case and therefore in cases where a service user receives a non DRR community sentence you should refer to the "*Probation Joint Working Protocol*", as these sentences are too varied to be discussed in this training, however if you are aware of a service user who is due to be sentenced, you need to discuss the option of a DRR with them and the PSR author.

Promotion of DIP by DRR

This is different to an old Drug Treatment and Testing Order (DTTO) as a DRR has a variety of levels of treatment and therefore can be applied to all drug users, whether they need a lot of support (high intensity DRR) or some basic support around their drug use (low intensity DRR). This court sentence enables drug-using offenders to be treated for their drug use in the community, facilitating a greater chance of success, as they can learn to address their lifestyle in a non-artificial environment as compared to a prison setting.

The DRR is useful for service users as it is made up of some key elements such as:

- Access to Tier 3 structured interventions such as prescribing
- Access to regular drug testing, which is there as a motivational tool
- Court reviews where the sentencing magistrate or Judge will want to know how the service user is progressing and support them to make positive changes.

These sentences are supported through accessing a range of interventions from one-to-one key working, group interventions, prescribing services, and complementary therapies; however you should speak with your local DRR providers to ensure you can sell their service effectively and even distribute leaflets as you are discussing the option.

At assessment could you ask the service user to enter DAN 24/7 phone number into their mobile phone in case of an emergency or to get appointment details: 08006335588

Completing a court sentence and DIP

At the end of a court sentence a service user may still need some ongoing support (aftercare) to help them reintegrate back into the community

It is therefore essential that if you have a service user being sentenced to a court order, you find out when they are likely to finish it (all potential dates) and arrange to check prior to that date.

If you are working with a service user who is serving a court sentence you must communicate with the CJIT or mainstream services as early on in the sentence as possible to allow for provisions to be made for the service user.

If the service user is suitable to access the CJIT then aftercare can be provided, however the service will not receive any credit in relation to KPI's, unless a new DIR has been started (prisoners will already have a DIR running and this means the Home Office are aware they are in the system – they are **NOT** a new client to DIP).

The time length for service users needing aftercare with the CJIT will still remain at 13 weeks, as with any other DIP service user. This means DIP service users must be motivated to succeed in treatment and be moved into longer-term mainstream services to enable more individuals to enter treatment and in turn continue the focus of DIP in reducing drug related crime, this in turn demonstrates to the community that they benefit from investing in drug treatment services.

PPO and DIP alignment

The main focus of DIP is to reduce drug related crime and through intelligence within the CJS it is known that a disproportionate amount of crime is committed by a small minority of people known as Prolific and Priority Offenders (PPO's). It is for this reason that extra resources have been allocated to addressing the needs of those PPO's whose offending behaviour is compounded by their dependency or use of illicit substances.

This affects all elements of DIP provision for the following reasons:

- **DToC** as all PPO's will get drug tested (if they are arrested for a non trigger offence, the Inspectors authority will be used)
- **Arrest Referral** as all PPO's need to be targeted to try and motivate engagement
- **CARATS** as at any one point in time 90% of PPO's are in prison custody
- **DRR and Probation** staff as the greater length of time a PPO is maintained in community treatment, the greater the potential for being diverted out of the CJS
- **CJIT's** role will be to maintain PPO's in treatment with a more intensive approach from the team

Due to the high levels of crime a PPO has previously generated (PPO status is not gained through a few petty criminal acts); they will receive a high level of treatment provision compared to other service users.

Also they will be monitored for their criminal behaviour, unless they remain in treatment. PPO's know the criminal Justice System well and DIP is an opportunity for them to move out of crime, therefore if they are doing well in treatment the Police will leave them alone and be glad to support them, even give them wake up calls if requested!

The DIP Processes (Please see Appendix 1)

The DIP process is about moving service users through and out of the criminal justice system and into core services (if ongoing treatment is still needed). This means assessing service users to ensure they access the most appropriate treatment to them, hence treatment services are ranked in "Tiers", (1>4) with specialist treatment such as DIP being ranked at level 2, and for those needing more structured interventions they would be referred into higher Tiers (either 3 or 4). This is why your assessment is critical and must be accurate to ensure that everyone gets the right treatment for them. For example if you hurt your eye, you would want to be referred to an ophthalmologist and not a psychiatric nurse for treatment and if you had a mental illness you would want to be referred to the psychiatric nurse as opposed to someone who could treat your eyesight.

DIP services are Tier 2 and therefore will not always be appropriate for everyone, core treatment services are still available for those with more complex needs and although it can be difficult, a judgement needs to be made as to who can access the service otherwise CJIT's will become clogged up and those appropriate DIP service users will not be able to access the service. DIP services are specialist and are not intended to duplicate existing core treatment services.

DIP Paperwork, recording and Processes

The introduction of criminal justice drug treatment services funded through the Home office and the Welsh Assembly Government has resulted in providers having to adopt a performance management approach to delivering services to evidence value for monies. This has meant that in order for service providers to secure the credit they deserve for the work that is undertaken, paperwork must be accurately completed.

Getting the right Information

It is essential that the correct information is to be gained during the assessment process, therefore if you are uncertain simply ask.

A classic example of this is around personalised issues such as age and ethnicity. It is essential that no assumptions be made during the assessment process. Due to assumptions being made we have had a number of errors also being made and these could have been avoided simply by asking a question. This is especially important when undertaking risk assessments.

The introduction of Palbase has been created in a particular way that now limits the number of terms you can use, for example the term "Arrest Referral Worker" in South Wales had been entered on DIR's in 23 different ways, making it difficult to accurately analyse such data. Now there is only one category on Palbase for the term "Arrest Referral Worker".

Using “Professional Judgement”

We would ask that during the assessment process you make a judgement call around the recording of primary and secondary drugs. This issue relates to what a service user perceives to be their problem drug and what you as a worker interprets to be the case, for example a service user will often state heroin is their most problematic drug as they need a prescription, however they may be using other substances that are more or just as serious, and although it is essential to listen to what the service user states, it is your experience that will ensure they get the right treatment in the most appropriate way. For example all substance dependence can be treated (or part treated) through psychosocial interventions. It is essential that the service user is aware of the *treatment package* and is not just aware of substitute medications, if full engagement is to be successful.

Record as soon as you can, simply because everyone’s interpretation changes following an event. Clarifying with service users what they mean is also useful to ensure accurate information is being gathered. For example, checking the name of a service user’s primary care GP and the name (address) of the surgery can really help in checking levels of substitute medication and the likelihood of the prescription being continued following their time spent in custody.

Also to help meet KPI 3 you need to use your professional judgement around the interpretation of *meaningful contact* for further clarification and a greater understanding around this definition, please refer to the DIR guidance.

Communication

In order to help your colleagues in other DIP provisions (CJIT's, arrest referral, Probation, DRR, CARATS) we must ensure that communication happens as regularly as possible. If someone presents to you and states that they are on a prescription or are in treatment and they have signed a DIR, then they have given permission for you to speak with your colleagues in other parts of DIP and it is in their interest that you discuss their case with your other colleagues.

All DIP services have now signed up to the "DIP Information Sharing Protocol", meaning we are all working with the same aims and can now discuss cases appropriately, so long as the service user has signed the DIR and given their consent.

Regular communication among DIP services will help with the following:

- Ensure continuation of medication e.g. discussing whether they have consumed their medication on that day or whether the originating clinician who was prescribing will continue following custody?
- If they have been arrested this may be a sign that they need further help, or are not on an adequate dosage yet?
- If they have engaged in treatment, the Police and Courts need to give them a chance to succeed.
- If appropriate service users access DIP, then they will be taken off core services waiting lists, freeing up more spaces for others to access treatment.
- Regular communication between professionals can save the service user repeating the same information, time and time again.
- DIP is about everyone working together for both the service user and the community.

DIP and helping to reduce Drug Related Deaths (DRD's)

DIP services are in an ideal position to help reduce the potential for Drug Related Deaths (DRD's) as we can now track and support a service user throughout all risky areas of the treatment process.

Police custody: At the point of arrest, staff in the custody suites can provide harm reduction information (including overdose awareness information); there is the opportunity to check whether a service user has consumed their substitute medication that day. The fact the service user is in custody (may) indicate that they are still offending to fund their drug use, which would therefore indicate they are using on top of their prescription. If they are in custody then, it is the ideal opportunity to re-engage them back into treatment.

CJIT: If the service user is with the CJIT it is the ideal opportunity to provide harm reduction advice and overdose awareness information, there is the opportunity to communicate with other elements (including outreach services) if the service user disengages from treatment. Also through meeting a service user at the gates when they are released from custody, the potential of a DRD can be minimised

DRR is an ideal opportunity to ensure service users are aware of their role with accessing support and communicating with the CJIT if they are going to be transferred over to the CJIT. The DRR can also be an ideal opportunity to promote harm reduction and overdose awareness information. Also through the provision of relapse prevention groups DRD's can be avoided.

CARATS can ensure that all DIP service users are informed on overdose risks prior to release. CARATS can also ensure on admission that there is a continuation of prescribing on release, and if there is not, an opportunity to arrange further medication or implement a detoxification programme.

All DIP services across the region and further a field can learn from one another as to what strategies have been adopted to assist in reducing drug related deaths and share best practice.

Drug Related Deaths is an issue that will affect all services and it is essential that service users be regularly reminded of the potential risks and how to minimise the potential for overdose. Even if a service user states they have heard this information before, you can check it is accurate advice and that they practice it or make an informed decision. It is better to bore a client by hearing the same information again as opposed to dealing with their death.

Key Performance Indicators (KPI) and DIP

The success of DIP is measured by the Home Office around providers meeting specified KPI's, these demonstrate the level of treatment being accessed and delivered in order to justify the financial investment they have made to drug treatment. Alongside this the Welsh Assembly Government measures the same information that demonstrates compliance with Health Solutions Wales data. Made simple if we all do not meet the KPI's then the Home Office will question whether it is worth investing money in South Wales drug treatment and therefore everyone loses out. Essentially this means less treatment for those people we are working to help. This is a serious point as this year drug services in England had a 3% reduction in funding and therefore we have to ensure this does not happen in Wales.

Because the KPI's are structured in a similar way to domino's (as one knocks onto another), and measured as percentages, this mean if we do not engage many service users, missing one or two can dramatically effect the KPI.

As the KPI's are started from drug tests undertaken in police custody and end once someone has engaged in treatment, we do not get credit for those service users accessing the CJIT from CARATS. Therefore the more service users taken onto caseload from CARATS the less staff time available to help meet the KPI's. CARATS have their own separate KPT's to meet.

The 13 week benchmark for treatment

This is partly the reason why the 13 week time period has been adopted, as it provides a bench mark to move service users through the CJIT and into mainstream treatment, freeing up more spaces for new service users to access the CJIT. Effectively DIP is a conveyor belt for getting service users in the CJS into treatment and out of offending.

The reason the 13-week rule exists is as a result of the National Drug Treatment Monitoring System (NDTMS), the English equivalent of Health Solution Wales, which evidenced that if a service user is retained in treatment for 13 weeks or longer their chance of successfully completing treatment is greatly enhanced (Gossop, 2006). We do however recognise this is not the case for everyone, and therefore some people will need much more support (such as those who lapse), but without this benchmark we would have nothing to work towards and the CJIT would simply silt up and waiting lists would eventually materialise.

KPI's explained

The only difference in Intensive and non-intensive areas is that in non-intensive areas KPI's 1 and 2 do not apply and those assessed are not drug tested.

The KPI's made simple are as follows:

1. Proportion of adults charged with a trigger offence who get tested (we need to get 95%).

Therefore if 10 people in a month are charged for a trigger offence (say shoplifting) and one fails to get tested then we only get 90% which means we do not hit the target set by the Home Office.

2. Proportion of those tested positive and have contact made with them (we are aiming for 90% of those who are tested)

So if the 10 people get tested and all 10 are positive for cocaine we must have 10 DIR forms or 10 ICF's (or a combination totalling 10) to demonstrate that we have made contact with them. Even if you speak to them on a phone, record this and we get an outcome.

3. Proportion of those NOT tested that have a DIR completed to 8.2 (We are aiming for 60%)

Therefore if arrest referral assesses a service user up to 8.2 or complete an ICF anyone where there is any *meaningful contact* such as a known drug user (this is a mop up of all service users who do not get tested).

4. Proportion assessed as needing a further intervention and gets taken onto the caseload (85% of those having a DIR done, must be taken onto caseload for further treatment)

If someone has a DIR done, then either they will be assessed as not suitable or if they are suitable for CJIT then they need some form of treatment and the care plan started which evidences this (this MUST be recorded).

5. Proportion on caseload that engage (we are aiming for 85%)

All service users with CJIT must have a care plan (evidence this on the DIR) section 9 on the DIR MUST be completed then this KPI is evidenced.

Explaining the Treatment Tiers System

In Models of Care, the NTA groups' treatment into four "tiers" or levels. These reflect increasing intensities of intervention.

Tier 1

This level mainly involves interventions from general healthcare and other services that are not specialist drugs services, for example hospital A&E departments, pharmacies, GPs, antenatal wards and social care agencies. Tier 1 services offer facilities such as information and advice, screening for drug misuse and referral to specialist drugs services.

Tier 1 services may include:

- Access to full range of health, social care, housing and other services.
- Substance misuse screening, assessment and referral mechanisms to substance misuse services from generic, health, social care, housing and criminal justice services.
- Management of substance misusers in generic health, social care and criminal justice settings.
- Health promotion advice and information.
- Hepatitis B vaccination programmes for substance misusers and their families. Alternatively, if investments in vaccinations are made within tier 2, 3 or 4 services, they can be recorded in the relevant grid.

Tier 2

This is open-access drug treatment (such as drop-in services) that does not always need a care plan. Tier 2 covers things like triage assessment, advice, information and harm reduction given by specialist drug treatment services.

- The aim of the treatment in this tier is to help substance misusers to engage in treatment without necessarily requiring a high level of commitment to more structured programmes or a complex or lengthy assessment process.
- Services in this tier include needle exchange programmes and other harm reduction measures, substance misuse advice and information services and ad hoc support not delivered in a structured programme of care.

Advice and Information

Advice and information services provide accurate, appropriate and factual information which is accessible and meaningful (in terms of context, language and comprehensibility) to the recipient.

Access to advice and information should be provided by services in Tier 1, and may be a core component of services in Tier 2. Specific services offering advice and information are characteristic of open access services.

However, staff in all treatment tiers should provide the provision of advice and information on substance-related issues.

Harm reduction services (including needle exchange)

Needle and syringe exchange schemes were developed within the wider context of harm minimisation or risk reduction, which refers to the reduction of the various forms of drug-related harm, including social, medical, legal, and financial problems, until the substance misuser is ready and able to come off.

They are important for preventing blood-borne diseases, most particularly HIV and hepatitis as well as being important public health measures. The majority of needle exchange schemes are those where sterile needles and syringes are given out and their safe disposal is offered.

Assessment and care management

- Assessment and care management should encourage the substance misuser to seek appropriate help and to assist their access to and engagement in treatment, whilst accepting the individual substance misuser's choice as to whether they accept treatment or not.
- Care management should facilitate access to a programme of integrated and co-coordinated health and social care and to minimise disengagement ('drop out') from the treatment system. All substance misusers should have access to appropriate and effective assessment and Care Co-ordination. As a distinct service, this has been offered by Community Care teams operated in social service departments. But this should not be the exclusive territory of social workers or local authority care managers. A wide range of professionals need to be able to undertake Care Co-ordination.

Other Tier 2 services may include:

- Other services that minimise the spread of blood-borne disease.
- Services that minimise risk of overdose.
- Outreach services targeting high risk and local priority groups.
- Motivational and brief interventions for drug and alcohol service users.

Tier 3

This is drug treatment in the community with regular sessions to attend, undertaken as part of a care plan. Prescribing, structured day programmes and structured psychosocial interventions (counselling, therapy etc) are always Tier 3. Advice, information and harm reduction can be Tier 3 if they are part of a care plan.

This Tier can be defined as providing services solely for substance misusers in a structured programme of care.

- Services within this Tier include structured cognitive behaviour therapy programmes, structured methadone maintenance programmes, community detoxification, or structured day care (either provided as a drug-free programme or as an adjunct to methadone treatment).
- Structured community-based aftercare programmes for individuals leaving prisons are also included in Tier 3.
- The principal expectation is that the substance misuser attending these services will have agreed to a structured programme of care which places certain requirements on attendance and behaviour (e.g. a certain number of days or hours attendance per week, review of programme is triggered if attendance is irregular).

Community prescribing – Specialist

Community prescribing programmes involve the provision of a medically supervised drug substitute to an illicit drug misuser. The substitute can be used to maintain the individual's tolerance to the drug of misuse or to facilitate withdrawal through a reduction programme.

- The prescribing programme is the basis for providing medical and psychosocial counselling and support. Community Drug Teams (CDT's) usually deliver specialist services or Drug Dependency Units (Duds) operated by NHS Trusts.

Community prescribing – GPs

Community prescribing programmes involve the provision of a medically supervised drug substitute to an illicit substance misuser. The substitute can be used to maintain the individual's tolerance to the drug of misuse or to facilitate withdrawal through a reduction programme.

- The prescribing programme is the basis for providing medical and psychosocial counselling and support. These services are delivered in general practice but often in liaison with specialist services using shared care protocols.

Structured care-planned counselling

Care-planned counselling is defined as formal structured one-to-one counselling approaches with assessment, clearly defined treatment plans, treatment goals and regular reviews, as opposed to advice and information, drop-in support and informal key-working.

Structured day programmes

Structured day programmes provide intensive community-based support, treatment and rehabilitation. They should offer clear programmes of defined activities for a fixed period of time with specified attendance criteria – usually four to five days a week.

Other Tier 3 services may include:

- Liaison substance misuse services for acute medical and psychiatric sectors.
- Liaison substance misuse services for local social services and social care sectors.
- Specialist structured community based detoxification services.

Tier 4

This is residential drug treatment – inpatient treatment and residential rehabilitation. Treatment should include arrangements for further treatment or aftercare for clients finishing treatment and returning to the community.

Services in this tier are aimed at those individuals with a high level of presenting need. Services in this tier include inpatient drug treatment, including detoxification and residential rehabilitation. Tier 4a services usually require a higher level of motivation and commitment from the substance misuser than for services in lower tiers.

Inpatient detoxification

Inpatient substance misuse treatment programmes are specialised units for people with substance misuse disorders or inpatient services delivered in general medical or general psychiatric facilities. Inpatient services also include episodes of detoxification purchased from independent sector units. They provide medically supervised assessment, stabilisation and withdrawal with 24-hour medical cover and a multidisciplinary team.

Residential rehabilitation

Residential rehabilitation services are specialist services offering intensive and structured programmes delivered in controlled residential or hospital environments. These services are mainly available in the independent sector and including therapeutic communities, concept houses, 12 step Minnesota model programmes and general houses including those with a faith-based philosophy.

www.nta.nhs.uk/about_treatment/the_tier_system.aspx

DIP Work Shop Agenda

DATE
VENUE

09:00 Coffee

09:30 Introductions

09:45 Aim of the session (Enhancing the understanding of DIP and the elements within it)

10:00 Elements that make up DIP and your role within it

Question: List the number of different professionals (from DIP) you have communicated with in the past week and the purpose of the communication?

Question: What can you do within your day to day role to help the other elements of DIP provision?

Question: Can you think of one *good* way of working that happens within your element of DIP that the other elements could think about adopting?

10:30 Break

11:00 Care Pathways (what is it, care coordination, SPOC, continuity of care, Palbase, tracking, minimising disengagement, enhancing motivation, communication)

Question: What steps must you and your team take to ensure a service user does not drop out of treatment?

Question: How can communications be improved between the different elements of DIP?

Question: What are the benefits of good care coordination and clear care pathways?

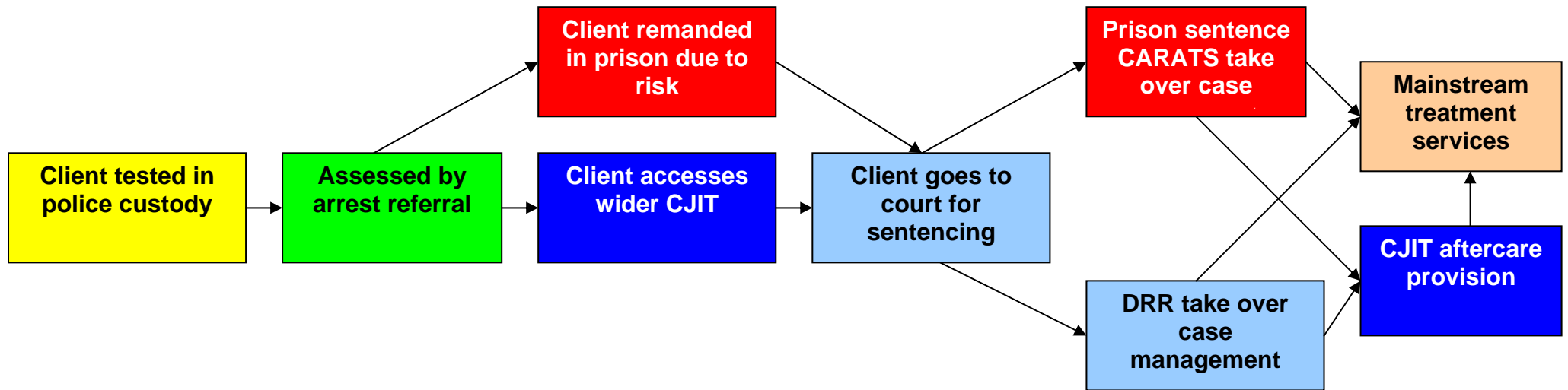
11:45 Evidencing DIP works KPI's, Palbase, effectiveness strategy, communications)

12:00 Scenarios

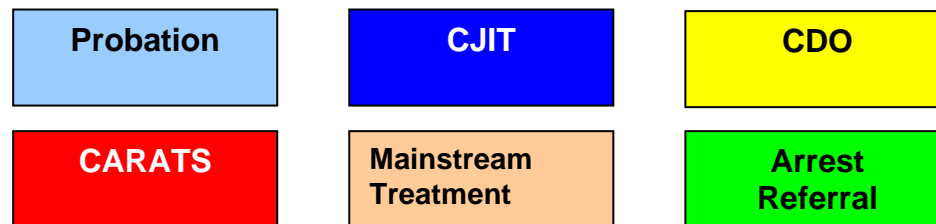
12:15 Q&A

12:30 Finish and opportunity to exchange contact details

The DIP Process in Treatment Phases



Process phase delivered by:



DIP Work Shop Scenarios

The following set of scenarios are structured to raise certain topics, there are however no real right or wrong answers. Discuss with your group what are the potential outcomes for each scenario, and think back to the topics covered, such as:

- The Care Pathways for the service user
- Communications (with DIP colleagues and with service users, also issues such as literacy)
- Meeting the Home Office KPI's
- Preventing overdose (sharing information on prescribing, using DAN 24/7)

Arrest Referral, CDO and DToC Scenario

A heroin user called Gareth is arrested for shoplifting and tests positive for opiates and cocaine at 22:30. Gareth agrees to access treatment as he has had enough of his current lifestyle.

Questions

1. What member of staff does what and how would you help to meet the Home Office KPI's?
2. What would you do next?
3. How would you promote the other elements of DIP?
4. What are Gareth's options?

CARATS Scenario

A heroin user called Lee is serving a 12-month sentence for fraud and is on methadone 100mg/ml he has made contact with you and says he isn't sure what he wants to do when he leaves prison.

Question

1. What information do you need to establish?
2. Who do you need to speak to and by when?
3. What are Lee's options?
4. What do you need to do next?

Probation and DRR Scenario

Naomi has been referred for a DRR assessment after her arrest referral worker suggested she could address her heroin and offending behaviour in the community rather than going back to prison again. Naomi has been using crack and heroin for 5 years and has persistently been trouble with the police.

Questions

1. What information do you need from colleagues in the field?
2. When do you need to contact any DIP staff?
3. What information do you need from Naomi?

CJIT Scenario

You have your first appointment with an amphetamine user Phillip who is from Bridgend, Phillip has been using for 2 years and for the first time got into trouble with the police. This is the first time Phillip has been in contact with treatment and he doesn't know what is going to happen to him.

Questions

What information do you need to get and from whom?

What paperwork do you need to complete in order to hit the Home Office KPI's?

How would you ensure Phillips needs are met?

Glossary

| | |
|----------|---|
| CARATS | Counselling Assessment Referral Advice Through care Service |
| CBT | Cognitive Behavioural Therapy |
| CDO | Civilian Detention Officer |
| CDT | Community Drug Team |
| CJIT | Criminal Justice Interventions Team |
| CJS | Criminal Justice System |
| DAN 24/7 | Day And Night 24/7 |
| DDU | Drug Detoxification Unit |
| DIP | Drugs Intervention Programme |
| DIR | Drugs Intervention Record |
| DRD | Drug Related Death |
| DRR | Drug Rehabilitation Requirement |
| DToC | Drug Testing on Charge |
| DTTO | Drug Treatment and Testing Order |
| ICF | Initial Contact Form |
| KPI | Key Performance Indicator |
| KPT | Key Performance Target |
| NTA | National Treatment Agency |
| PPO | Priority and Prolific Offender |
| PSR | Pre Sentence Report |

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