PRISONS INTEGRATED DRUG TREATMENT SYSTEM

CONTINUITY OF CARE GUIDANCE

September 2009

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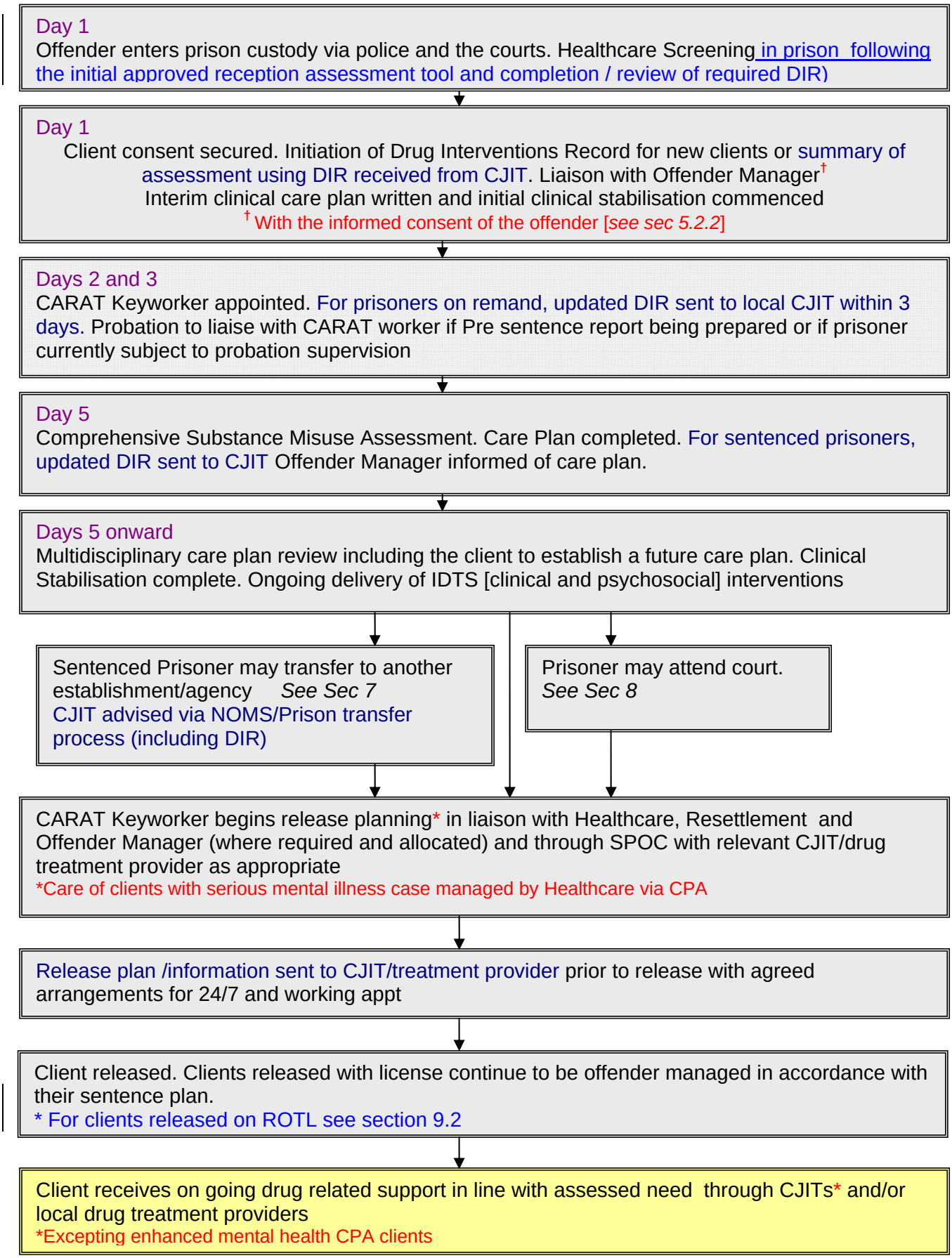
[Dept Health Gateway Ref 7236]

GLOSSARY

Client Management Pathway within the Integrated Drug Treatment System and the Drug Interventions Programme



GLOSSARY

ACCT [*Assessment, Care in Custody and Treatment*] The prisons universal suicide and self-harm support system.
Benzodiazepines Tranquillisers that include Temazepam and Diazepam ('Valium')
Buprenorphine An opiate substitute
CARAT [*Counselling, Assessment Referral Advice and Throughcare*] The prison psychosocial a low threshold, low/medium intensity, non-clinical drug treatment service to prisoners
Clinical An activity or organisation that has a predominantly healthcare function
Clinical Record A medical record in prison
CPA [*Care Programme Approach*] The prisons and community mental health services care planning system. Standard CPAs are used to organise care for mild to moderate mental health. Enhanced CPAs are required for individuals with severe mental health problems
Care Co-ordinator A named worker who has lead responsibility for delivery of a CPA
CJITs [*Criminal Justice Integrated Teams*]Established by DAT partnerships, the CJIT is the key local delivery mechanism of the Drug Interventions Programme in the community. Following an assessment, CJIT workers will use a case management approach and provide/ broker access to drug treatment and wraparound services as appropriate.
D Category A lower security prison for sentenced prisoners
DAAT Drug and Alcohol Action Team. Teams that commission and performance manage community drug treatment services and local implementation of DIP through CJITs. DAATs are usually configured as part of wider crime and disorder reduction partnerships as part of a larger local strategic partnership
Detoxification The treatment of dependence by the gradual reduction of a drug that suppresses withdrawal
DIP *[Drug Interventions Programm*e) DIP involves criminal justice and drug treatment providers working together. It aims to break the cycle of drug misuse and offending behaviour by intervening at every stage of the criminal justice system (through custody court, sentencing and beyond into resettlement. The principal focus is to reduce drug related crime by engaging with problematic drug users moving them into appropriate drug treatment and support.), to engage offenders in drug treatment and broker access into ongoing support from wraparound services.
DIR *[Drug Interventions Record*) The DIR establishes a common tool for use by CJITs and CARATS for monitoring and continuity of care in relation to the Drug Interventions Programme. The DIR is also the form on which the Substance Misuse Triage Assessment is recorded in Prison. (Re-launched April 2009)
Dose Induction The gradual introduction of doses of methadone or buprenorphine
IDTS [*Integrated Drug Treatment System*]
IND [*Immigration and Nationality Directorate*]
ISMG [*Interventions Substance Misuse Group*] The policy unit for all non-clinical drug interventions in prisons
Keyworking A process undertaken by a keyworker to ensure the delivery and ongoing review of the care plan. Within prisons this role is occupied by a CARAT worker
Methadone Maintenance A prolonged prescription of an opiate substitute
Metabolite A substance produced by metabolism of a drug
Methadone An opiate substitute
NOMS [*National Offender Management Service*] A single service that brings together the work of correctional services with a focus on the end-to-end management of the offender.

NTA [*National Treatment Agency for Substance Misuse*] a special health authority, created by the Government in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

OASys [*Offender assessment and sentence management*] The standardised process for the assessment of offenders

OCA [*Office of Categorisation and Allocation*] Units that place prisoners in conditions of security commensurate with the security risks they pose

Offender Manager An individual responsible for the overall end-to-end case management of offenders (need feedback from Claire)

Offender Supervisor A prison officer that takes the responsibility for offender management in custody

Open Conditions See Category D

PCT Primary Care Trusts are responsible for the commissioning of healthcare services and are accountable to their respective SHA.

Prisoner Escort Record A paper from that accompanies all escorted prisoners

PSI/PSO [*Prison Service Instruction/Prison Service Order*] A mandatory requirement of prisons

Psychosocial A range of psychological and social factors

ROTL [*Released on Temporary Licence*] The mechanism that enables prisoners to participate in necessary activities outside the prison that directly contributes to their resettlement into the community on their release

Sentence Plan The plan for interventions under the offender management system

SHA Strategic Health Authorities manage the NHS within their respective areas and are accountable to (DH) Department of Health

Stabilisation The moderating and control of withdrawal symptoms through a process of dose induction

Supervised Conditions The observed consumption of a prescribed drug

SPoC [*Single point of contact*) Unique contact point established currently in the community (delivered through the CJIT) and each prison to receive information by phone or fax from those working in different parts of the Criminal Justice System as well as drug treatment services. Details of the SPoC are updated monthly and circulated by DIP to DATs/CJITs, and by NOMS ISMG to establishments.

24/7 Client Phone Line DAT/Criminal Justice Integrated Teams (CJITs) are required to have arrangements in place for 24/7 phone line for new and existing clients particularly targeting those drug misusing offenders leaving prison, and/or treatment. Service provision includes advice, information about local services and access to a next day working appointment. Details of those areas that have passed quality checks are promoted on the drugs.gov website and circulated by DIP/NOMS ISMG to DATs/CJITs and CARAT teams through promotion of SPOC arrangements.

1. INTRODUCTION

Please note: this guidance applies only to prisons that have received funding under the Integrated Drug Treatment System

1.1 The Integrated Drug Treatment System [IDTS] aims to increase the volume and quality of treatment available to prisoners, with particular emphasis on early custody, and will start to address better integration between clinical and CARAT Services.

1.2 Many of the benefits of treatments tend only to materialise after several weeks of ongoing intervention[1],[2]

1.3 The management of continuity of treatment is therefore vital, and the Integrated Drug Treatment System for prisons is designed to facilitate continuity at both points of a period of custody: reception of individuals who are in current receipt of treatment, and release of IDTS clients with continuity of treatment needs. This is central to the role of CARAT workers and is outlined in NOMS Drug Strategy Unit DIP Prisons Guidance[3].

1.4 Substance misuse is often one of a number of problems experienced by offenders and services in prisons need to take account of the continued interventions to address these complex needs.

1.5 In view of the potential seriousness of these problems, it is important that drug treatment links to other care planning processes, including the ACCT (assessment, care in custody and treatment) suicide and self-harm support system.

1.6 As keyworkers, CARAT staff will co-ordinate the substance misuse treatment of each client during their time in custody, and both on entry into and exit from custody.

1.7 Keyworking is defined by the National Treatment Agency as a process undertaken by a keyworker to ensure the delivery and ongoing review of the care plan. The keyworker is the dedicated and named practitioner who is responsible for ensuring the client's care plan is delivered and reviewed. This would normally be the practitioner who is in most regular contact with the client. However, given the range of settings in which structured treatment is provided, the keyworker may be a drugs worker, nurse, case manager or other health professional[4].

(ref NTA, *Models of care for the treatment of adult drug misusers*)

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[1] Simpson, D. D., Joe, G. W., & Brown, B. S. (1997). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, *11*(4), 294-307.

[2] Gossop M, Marsden J and Stewart D (2001) NTORS after five years (National Treatment Outcome Research Study): Changes in substance use, health and criminal behaviour in the five years after intake **http://www.dh.gov.uk/assetRoot/04/01/97/29/04019729.pdf**

[3] National Offender Management Service (2006) Drug Strategy Unit DIP Prisons Guidance *Delivery of the Drug Intervention Programme in Prisons – Guidance for Prisons*

[4] National Treatment Agency (at press), *Models of care for the treatment of adult drug misusers*

1.8 End to end offender management (which includes the role of an offender supervisor in custody) will have a phased roll out process. From November 2006, all Prolific and other Priority Offenders and prisoners presenting high and very high risk of harm to others serving determinate sentences of 12 months and over will have an offender supervisor in custody. All prisoners sentenced under the Criminal Justice Act 2003 will have an offender supervisor in custody. For those prisoners subject to post custodial supervision, the Offender Manager is responsible for the overall case management and for preparing the release plan. It is important that release and sentence planning is undertaken in conjunction with the Offender Manager and supervisor. Further guidance on this is currently in development (see para. 5.2.2).

1.9 A fundamental concern for healthcare and CARAT professionals alike will be the respect of a client's consent, and the protection of a client's confidentiality within the framework of an Integrated Drug Treatment System. For this reason, confidentiality within IDTS is the initial subject addressed in this guidance.

2. CONSENT & CONFIDENTIALITY

2.1 The Sharing of Confidential information

2.1.1 The general principle for the sharing of information within the Integrated Drug Treatment System is that:

'Any information required to provide adequate continuity of drug treatment should, with the client's informed consent, be shared between CARAT and healthcare teams and with partner services such as Criminal Justice Integrated Teams, community drug treatment providers and Probation offender managers'.

2.1.2 It is essential that at each point of contact where information is to be shared between agencies/service providers, client confidentiality is observed. When consent is sought from a client, s/he must be informed about the uses to which the information will be put. Informed consent can be seen as having been gained when the client has been given sufficient and suitable information and is able to understand and assess the risks of participation. Substance dependence or the experience of withdrawal symptoms are not necessarily impediments to consent to share information, but the timing of a request for consent should be considered for newly arrived prisoners who display cognitive impairment that may be related to acute intoxication or withdrawal

2.1.3 Through the assessment process and use/completion of the Drug Interventions Record (DIR) as appropriate, CJIT workers will gain written informed consent from clients prior to entry into custody to share information from their assessment (to facilitate continuity of care) with the CARAT/Healthcare Team in prison. Healthcare and CARAT teams will need to ensure that they, too, gain informed consent at the appropriate stages in their clients' period of treatment.

2.1.4 The legal contexts for both consent and confidentiality in relation to drug treatment in prison are set out below

2.2 Legal context: Consent to Treatment

2.2.1 The law presumes that an adult (person aged 18 and over) has the capacity to take their own healthcare decisions unless the opposite is proved. It is important not to underestimate the capacity of a client with a learning disability to understand. Many people with learning disabilities have the capacity to consent if time is spent explaining to the individual the issue in simple language, using visual aids and signing if necessary. Further guidance on this is set out in the Department of Health's booklet *Seeking Consent : Working with People with Learning Disabilities* (DH, 2001).

'Seeking consent should usually be seen as a *process*, not a one-off event. People who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point if they still have the capacity (are 'competent') to do so. Similarly, they can change their minds and consent to an intervention that they have earlier refused. It is important to let each person know this, so that they feel able to tell you if they change their mind'.

Seeking Consent: Working with People in Prison (DH, 2002)

2.3 Legal Context: Disclosure of information

2.3.1 There is a range of statutory provisions that influence the way in which client information is used or disclosed. Details of these can be found on the Department of Health web-site at http://www.dh.gov.uk.

2.3.2 ***The key principle of the common law of confidentiality is that information confided should not be used or disclosed further, except as originally understood by the confider, or with their subsequent permission***

2.3.3 Whilst judgements have established that confidentiality can be breached, 'in the public interest', these have centred on case-by-case consideration of exceptional circumstances

2.3.4 Under common law, staff are permitted to disclose personal information (to, for instance, a probation officer) in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual client concerned and the broader public interest in the provision of a confidential service

2.3.5 The position with regard to Prolific and other Priority Offenders (PPOs) is that, although they fall under the same legal requirements, due to the serious nature of some of their offences it is more likely that the exceptions covered in the paragraph above will apply. (see *Guidance to Support the Sharing of Information about Drug Misusing Prolific and Other Priority Offenders (PPOs)*, 2006)

2.3.6 The Data Protection Act 1998 imposes constraints on the processing of personal information in relation to living individuals. It identifies eight data protection principles that set out standards for information handling.
In the context of confidentiality, the most significant principles are:

- The 1st, which requires processing to be fair and lawful and imposes other restrictions;
- The 2nd, which requires personal data to be processed for one or more specified and lawful purposes;
- The 7th, which requires personal data to be protected against unauthorised or unlawful processing and against accidental loss, destruction or damage It also provides for an individual's right of access to personal data.

2.3.7 Within the Human Rights Act 1998 there is a requirement that actions that interfere with the right to respect for private and family life (e.g. disclosing confidential information) must also be justified as being necessary to support legitimate aims and be proportionate to the need.

2.3.8 Current understanding is that compliance with the Data Protection Act 1998 and the common law of confidentiality should satisfy Human Rights requirements.

2.3.9 Where a client has been identified as at risk of self-harm/suicide, information that is relevant to ensure appropriate care and support must be shared with the ACCT Case Manager. Information on the client's needs and proposed/in-place drugs interventions should be provided at ACCT case reviews.

2.3.10 **As both healthcare and CARAT teams operate within the same legislative consent and confidentiality framework [i.e. Data Protection Act 1998, the Human Rights Act 1998 and the common law of confidentiality], any information required to provide adequate drug treatment should, with the client's informed consent, be shared between CARAT and healthcare teams**

3. CONTINUITY OF MENTAL HEALTH CARE

3.1 A substantial proportion of prisoners with substance misuse problems also have mental health problems, some of which may be severe [Singleton et al 1998[5]].

3.2 In cases where there is a potential or identified mental health problem, CARAT and clinical teams should work closely with primary and mental healthcare teams at all points of a client's custody, incorporating assessment, care planning including ACCT Plans, transfer and release (see 2009 prisons dual diagnosis guidance [6])..

3.3 Continuity of care from prison into the community for clients who are managed under the mental health services in prisons should be progressed via the Care Programme Approach (CPA). Release planning should inform the level of drug related support needed and the potential role of the local Criminal Justice Integrated Team and local drug treatment providers in providing ongoing support.

3.4 Where there is an ongoing drug treatment need on release, continuity of care and release planning for clients who do not require specialist mental health interventions ,should be managed in line with existing arrangements between the CARAT team, CJIT and local treatment providers where appropriate.

3.5 Where there is an ongoing drug treatment need on release, continuity of care and release planning for clients who whose mental health needs are managed under a standard CPA, should be managed in line with existing arrangements between the CARAT team, CJIT and local treatment providers where appropriate.

3.6 IDTS clients whose mental health needs are managed via an enhanced CPA should not be referred to a CJIT for continuity of drug treatment. Instead, this should be managed by the CPA Care Co-ordinator in consultation with community services identified within the enhanced CPA.
3.7 For guidance on the transfer of prisoners under mental health act see PROCEDURE FOR THE TRANSFER OF PRISONERS TO AND FROM HOSPITAL UNDER SECTIONS 47 AND 48 OF THE MENTAL HEALTH ACT (1983) http://www.dh.gov.uk/assetRoot/04/12/36/31/04123631.pdf

[5] Singleton, N., et al. (1998) Psychiatric morbidity among prisoners in England and Wales: a survey carried out in 1997 by the Social Survey Division of ONS London: The Stationery Office http://www.statistics.gov.uk/downloads/theme_health/Prisoners_PsycMorb.pdf

[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097695

4. DIVERSITY and EQUALITY

4.1 Prisons should plan and deliver IDTS services in accordance with local and HMPS diversity policies. NOMS has issued a comprehensive *Diversity Toolkit for drug treatment in prisons*.

4.2 Particular thought will be required for planning the release of clients with diverse needs. The early involvement of community organisations should be facilitated to help make transition from custody more likely to succeed. Some clients with disabilities may need to have a community care assessment by the Social Services Department of the area in which they will be living on release. Anyone working with a prisoner might identify such a need, which *must* be brought to the attention of the healthcare centre. If the individual is on post-licence supervision, the Offender Manager should also be informed. It is good practice for the healthcare team and the NPS to work together to ensure that such referrals to Social Services Departments are made.

4.3 Other initiatives that should be available are:

- Compilation of a directory of community services including all voluntary sector groups
- Links with interpreter and signing services
- Cultural, language and ability-relevant information
- Particular regard to confidentiality issues

4.4 The principal legislation that regulates the equality of services comprises:

Race Relations Act 1976
Race Relations (Amendment) Act 2000
Disability Discrimination Act 1995
Disability Discrimination Act 2005
The Sex Discrimination Act 1975
Gender Recognition Act 2004
Civil Partnerships Act 2004
Human Rights Act 1998

The prison regulations that govern equality of practice are:
PSO 2800 and PSI 11/2000, Race Relations
http://www.hmprisonservice.gov.uk/resourcecentre/psispsos/listpsis/index.asp?startrow=301

PSO 8005 Establishing an Appropriate Staff Gender Mix in Establishments.
http://pso.hmprisonservice.gov.uk/PSO_8005_staff_gender_mix.doc

PSO 2855 Managing Prisoners with Physical, Sensory or Mental Disabilities
http://www.hmprisonservice.gov.uk/resourcecentre/psispsos/listpsos/

See also the single equality schemes of NOMS and the Dept Health
http://www.justice.gov.uk/publications/noms-single-equality-scheme.htm

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075463

5. UPON ENTERING CUSTODY

5.1 Any individual entering a prison with IDTS funding, an identified clinical substance misuse need will become, with his or her consent, a client of the Integrated Drug Treatment System, with access to a range of services provided by both clinical and CARAT teams. The care of that client will be co-ordinated by a CARATs keyworker. This includes primary stimulant users, irrespective of whether they require prescribed management.

> When a prisoner enters reception a new clinical record is created….Efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with[7]. The prisoner's explicit consent should be obtained before doing this, although in exceptional circumstances information may be requested and disclosed without consent.
>
> *PSO 3050* (HMPS, 2006)

5.2 Information from Criminal Justice Integrated Teams

5.2.1 In view of the urgency of the need for clinical treatment information, and where the client agrees to assessment/information being shared by the CJIT worker, the DIR as a minimum should be faxed to the single point of contact in prison. For those clients who did not have previous CJIT involvement, but were in contact with a local drug treatment provider, protocols should be set up with the local treatment providers to enable the transfer of information to occur, providing client consent has been given.

5.2.2 Liaison between probation/OMs, CJITs and CARATs should be in line with the processes described in this document and "Delivery of the Drug Interventions Programme in prisons: A Guide for Prisons" [NOMS 2006]. Further detailed guidance on the interface between probation/OMs, CJITs and CARATS in custody and in the community is to be issued shortly.

5.2.3 Detailed instructions on the co-working between CARAT teams and CJITs can be found in *'Delivery of the Drug Intervention Programme in Prisons – Guidance for Prisons'* (NOMS, 2006), '*The First 28 Days; Psychosocial Support'* (NOMS 2006) and *'Clinical management of drug dependence in the adult prison setting'* (DH 2006).

5.3 OASys assessments/sentence planning

5.3.1 OASys assessments contain some substance misuse information and, where these are available, they should be used as part of an information gathering process

> 'With the consent of the offender, CARAT workers will feed into the OASys assessment and sentence planning process'[8].
>
> *PSO 2205 – Offender assessment and sentence management – OASys*

[7] Eg, Probation; this service may have significant information on an offender's drug use and recent treatment history, particularly if he or she has recently been part of a DTTO/DRR programme

[8] This use of information must be within the legal framework described in section 2.3 above.

5.3.2 The CARAT team will liaise, following client consent, with the CJIT/drug treatment provider in the offender's area of residence as appropriate when preparing release plans as well as liaising with sentence planning and resettlement teams in prison.

5.3.3 The Offender Manager should be informed, with the consent of the client, of all drug interventions undertaken in prison and any treatment planned on release so they can produce a sentence plan that takes into account all offending related needs.

5.4 Handover from CJITs and/or community drug treatment providers to CARATs

5.4.1 If an offender has either been assessed by a CJIT worker or is on the CJIT caseload and has given informed consent for information to be shared, the CJIT will be responsible for referring that offender into prison drug treatment services. CARATs then become the lead agency for linkage and will ensure that:

- the offender is referred using the Drug Interventions Record (DIR) via the single point of contact in prison; and

- the DIR is sent as soon as possible depending on urgency but always within twenty-four hours of reception into prison.

5.5 Individuals currently receiving prescribed community drug treatment

5.5.1 In view of the evidence of the growing effectiveness of treatment programmes over the course of time, members of the Integrated Drug Treatment System [clinical and CARAT colleagues] should consider continuation of all existent prescribed treatment regimes for prisoners entering custody. The following factors may be taken into account in determining whether or not continuation should be provided:

1. The informed wishes of the client
2. The view of the community prescriber
3. The anticipated duration of custody
4. The physical health of the client [is s/he suffering from a serious condition that may be exacerbated by practices such as injecting drug use?]
5. The mental health of the client

5.5.2 Should a collective decision be to continue a prescribed community treatment, the procedure outlined under section **6.1** below should be followed

6. CONTINUING COMMUNITY-PRESCRIBED TREATMENTS

6.1 Continuation of community-prescribed methadone regimes

6.1.1 Continuation of methadone programmes ***at the existent community dose*** may only be provided in circumstances that meet all of the following criteria:

(i) The client gives informed consent to continue the programme
(ii) The client is receiving methadone under supervised consumption conditions
(iii) The client has been receiving methadone regularly for the previous seven days, and in particular the last three days
(iv) The client last had his or her full supervised dose of methadone within the past 48 hours
(v) The client's treatment details and identification, including a description, have been verified with the prescribing doctor **and** the supervising pharmacist by the end of the second day of prison custody

6.1.2 In cases that meet all of the criteria in 6.1.1 above, the following supports local practice pathways:

First night:
Assuming the client has had their methadone on the day of arriving in prison, no further doses will be given. The client must be clinically drug tested and must be positive to methadone metabolites. Should the patient not have had that day's dose, 10mgs (ten milligrammes) of methadone should be prescribed, and this dose can be repeated every six hours.

Next day (day two)
Confirmation needs to be obtained from the prescribing doctor/drug service of the dose and duration of methadone treatment. Where the location of the community pharmacist is unknown, the chief pharmacist within a primary care trust may be able to identity the correct practitioner.

6.1.3 Where possible further information should be sought from the supplying pharmacy/dispensary to verify correct client identity and confirm the client's recent prescribing and supply (i.e. administration) history. To protect client confidentiality, mechanisms should be put in place to ensure pharmacists can confirm the identity of the healthcare team they are talking to before giving out this information.

6.1.4 As a further safeguard, it is recommended that the first two days' doses of methadone are evenly divided in two, with at least six hours' gap between the supervised administrations of each dose. Any methadone given the preceding night (see section 6.1.2 'First Night') will need to be deducted from the day two morning dose.

6.1.5 Local protocols should determine roles and responsibilities to be assumed within the healthcare team to gather and communicate prescription information.

6.1.2 To ensure safety, unless the criteria set out in section 6.1.2 are met, clients received into a local prison who are currently receiving a community methadone prescription should be treated in accordance with the standard dose induction regime, which involves:

Gradual dose induction of methadone (methadone mixture, 1mg in 1 ml) according to national clinical guidelines (DH 2006, 2007)
The healthcare team should monitor the client regularly and, in the event of any sign of drowsiness, withhold the due dose of methadone and any other sedating medication, pending reassessment
All prescribed doses of methadone should be consumed under supervision and followed by the administration of at least 200mls of water to reduce the potential for diversion

6.2 Continuation of benzodiazepine prescriptions

6.2.1 As described in **6.1** (above), confirmation of community benzodiazepine prescriptions must be sought as soon as is practical after the client's reception into prison. Whilst awaiting the confirmation some benzodiazepine replacement prescribing should be undertaken, commencing on the night of arrival and accompanied by withdrawal monitoring to ensure that the dose is adequate, but not excessive. A prescription of 10mg of Diazepam twice daily will usually be sufficient as a "holding dose" and can then be adjusted according to the level and duration of the community prescription, and objective withdrawal monitoring. Should the prescription not exist, then discontinuation of treatment will then be indicated, unless it is evident that there is recent illicit use, which has resulted in dependency, in which case continued prescribing should be based on the evidence from the withdrawal monitoring.

6.2.2 There will be times when the community prescription is for the management of a mental health or physiological problem, and in these cases continued prescribing is indicated, with adjustments to dose being made in consultation with the relevant mental health or primary healthcare services. A joint plan of care involving these teams will be necessary.

6.2.3 Rarely will community benzodiazepine prescriptions have been given under "supervised conditions" and therefore it is essential that the withdrawal monitoring also takes account of sedation and drowsiness, which are indications for a reduction in dose. Particular care is needed when benzodiazepines are being prescribed concurrently with an opiate substitute.

6.3 Continuation of buprenorphine regimes

6.3.1 As with methadone, clients received on a community prescription of buprenorphine, should be re-stabilised with gradually increasing doses, until withdrawal symptoms are under control. When prescribed as a single agent, buprenorphine can be used in doses equivalent to the community prescription if this is required, although very often a lesser dose will prove adequate once stabilisation in prison has been achieved. Again, it should be remembered that confirmation of a prescription does not guarantee that the client has actually been taking all or indeed

any of the prescription, (unless there is confirmation that the client has been receiving the treatment under supervised consumption), and therefore close observation and monitoring is required during the stabilisation period of any opiate substitute medication.

6.3.2 When concurrent prescribing is required of both buprenorphine and benzodiazepines, then the precautions of dose induction and withdrawal/intoxication monitoring must be adhered to as for methadone.

7. TRANSFERS BETWEEN PRISONS

7.1 Clinical criteria for transfer

Whilst taking full account of other safety and security factors, a prisoner who is receiving clinical management of their drug dependence may only be transferred from a Local prison to another prison that offers clinical substance misuse care in accordance with the Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006).

Where a prison receives a prisoner transferred from another prison with incomplete clinical records and/or prescription charts etc, that prisoner **MUST NOT** be transferred back to the sending prison for this reason. The receiving prison has an obligation to ensure that they arrange for the treatment regimes to be continued.. Prisoners can only be transferred back to the sending prison where they require a level of healthcare that the receiving prison cannot provide. An example of this is where the prisoner is at Relapse level 4 (see section 11 below) or where for any other reason they require 24 hour healthcare which cannot be provided in a Training Prison.

7.1.1 Alcohol:

Where one has been prescribed, a prisoner must have completed an alcohol detoxification, and a further 48 hours needs to have elapsed following the completion of that withdrawal regime. The prisoner must be assessed as being "fit" to transfer by a member of the healthcare team, and evidence of this must be recorded in the clinical record.

7.1.2 Opiate detoxification:

Following a minimum period of 5 days' stabilisation onto an opiate substitute regime, a prisoner may elect to undergo a full detoxification in preference to an ongoing opiate substitute maintenance regime.

Detoxification falls into two main categories:

1) A rapid reduction regime of no less than 14 days but completed within 28 days.
2) A reduction regime which exceeds 28 days and is tailored to an individual's needs.

7.1.2.1 If, following stabilisation, a detoxification regime has been prescribed which is less than 28 days in duration, that reduction must have been completed, and a further 48 hours must have elapsed after its completion before a transfer is undertaken. It is important to remember that withdrawal symptoms often re-occur at the end of a detoxification regime, and until these are adequately treated, usually with symptomatic relief, transfer must not take place. The prisoner must be assessed as being "fit" to transfer by a member of the healthcare team, and evidence of this must be recorded in the clinical record.

7.1.2.2 If a very slow reduction regime is being prescribed (of around 2mg Methadone per week, or 5mgs per fortnight, or at an equivalent rate of Buprenorphine per week/fortnight), then the prisoner **can be transferred to a Training prison** once s/he has been assessed by healthcare as being "fit" to transfer. This is in keeping with an out-patient reduction regime similar to that which would be prescribed to a patient living at home in the community. A minimum of 14 days since the commencement of the reduction is recommended before such a transfer is considered. It is further recommended that a prisoner's dose of Methadone is held at a steady level for a week prior to the transfer, and that upon arrival in the receiving prison, the dose is maintained for at least one further week before any ongoing reduction is considered.

7.1.3 Opiate substitute maintenance prescribing:
For transfer to a Training Prison of a client receiving opiate substitute maintenance, a minimum period of 7 days' opiate stabilisation must have passed for prisoners in receipt of opiate substitute maintenance prescribing.

7.1.4 Benzodiazepine reduction regimes:
Stabilisation must have been achieved with Diazepam for any benzodiazepine reduction regime for a minimum of 7 days before transfer is considered. The dose of Diazepam must be no more than 20mg daily so that it can be given in a once-daily dose - regimes that do not meet this criteria or are more rapid than the DH guidance suggests cannot be transferred to training prisons within this timescale..

Prisoners who have for any reason undergone a more rapid benzodiazepine withdrawal regime must remain in the Local prison for 14 days beyond the completion of prescribing to ensure that Benzodiazepine withdrawal monitoring is undertaken, and that this demonstrates that there is no ongoing withdrawal symptoms which require further clinical management. The benzodiazepine withdrawal monitoring scale must then be filed in the medical records and transferred with the prisoner to the training prison. If the reduction regime is subsequently brought into line with the recommendations within the DH guidelines, then the prisoner can transfer as described above.

The prisoner must be assessed as being "fit" to transfer by a member of the healthcare team, and evidence of this must be recorded in the clinical record.

7.1.5 All prescribing regimes:

All of the above should be regarded as minimum periods particularly with regard to stabilisation, and will need to be extended where stabilisation has not been attained and unresolved withdrawal symptoms persist. Other complications or exceptions may prevent transfer and these should be discussed on a healthcare-to-healthcare basis between the sending and receiving prisons.

7.1.6 The client's overall physical and mental health must be consistent with the local healthcare system that ensures appropriate and continuing clinical care in any transfer (see PSO 3050 'Continuity of Healthcare for Prisoners' *http://www.phrn.nhs.uk/workstreams/primarycare/Continuity.pdf)*

7.1.7 OCA departments must not be asked to make healthcare decisions, and it is therefore the responsibility of the prison healthcare staff to ensure that all IDTS clinical transfers are carried out in accordance with the guidance in this document.

7.1.8 Care pathway protocols that set out specific roles and responsibilities should be negotiated between local prisons and their key trainer prisons to facilitate the immediate adoption of existent prescriptions.

7.1.9 Prior to a client's transfer, current prescription details must be entered in the Clinical Record, which will accompany the client when s/he leaves the prison. A printed summary of treatment should be sent in the case of electronic clinical records. The CARAT case record may also be transferred by this method.

7.1.10 It is advised that at the earliest opportunity following reception into the new prison, any reduction regimes (opiates or benzodiazepines) are reviewed and may be temporarily halted until the client feels settled, and able to progress with his/her reduction regime.

7.1.11 It is possible that clients may require an extension to either their slow withdrawal or opiate substitute maintenance regimes upon transfer to a less secure prison.

7.1.12 All prisons participating in the IDTS must hold stocks of diazepam, methadone and buprenorphine in order to meet the needs of newly received prisoners. Supplies of these medications should not be transported with the client

7.1.13 The Population Management Service will be advised regularly by the IDTS central project team which prisons have an Integrated Drug Treatment System established to enable transfer of clients who are currently receiving prescribed management.

7.1.14 In view of the universal use of supervised consumption of methadone in prisons, it is anticipated that clients on methadone programmes transferring between prisons will meet all the criteria set out in section **6.1.2** above. In such cases treatment should be continued at the existent dose.

7.1.15 As part of the initial assessment, the healthcare team will either initiate the Drug Intervention Record for clients who have not been referred via the DIR, or

update the DIR . A copy of the key clinical and demographic sections should be entered in the clinical record.

7.1.16 The CARAT team will inform the CJIT of the inter-prison transfer of any of their clients via the NOMS/Prison transfer process (including the DIR).

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7.2 Continuation of 28-day psychosocial support in a receiving prison

7.2.1 Where a transfer is planned and occurs within the first 28 days of custody, the CARAT team in the receiving prison must be notified to enable a keyworker to be nominated prior to transfer.

7.2.2 CARAT teams in receiving establishments must have a system in place to enable identification of those within the first 28 days and allocate a keyworker as required.

7.3 Unplanned transfers

7.3.1 Unplanned transfers may take place due to overcrowding or security issues. As always, the Clinical Record will travel with the client, as they must first be deemed fit to travel. Healthcare staff should ensure that it contains the current prescription record in case of an unplanned transfer. A printed summary of treatment should be sent in the case of electronic clinical records. Healthcare in a receiving prison should then notify CARATs that the client will need to be taken onto the caseload. The CARAT file may need to follow the client, in accordance with the protocol in the CARATs Practice Manual[9], if there is no opportunity to send it with the Clinical Record.

7.3.2 Prisons will need to have contingency arrangements for the management of clients who arrive via an unplanned transfer. Safe management of prescribed care is necessary to avoid the risk of breakthrough withdrawal problems. The clinical governance committee of each prison partnership should agree a means to manage the clinical needs of these prisoners.

7.3.3 The CARAT keyworker in the sending prison should notify the CARAT team in the receiving prison as soon as they are aware of the transfer and inform them of the method of transfer of the files.

8. GOING TO COURT FROM PRISON

8.1 Ensuring Continuity of Care and treatment for prisoners at court

8.1.1 All prisoners going to court must be accompanied by their clinical record, which is referenced in the Prisoner Escort Record and given to the escorting service. This is an important means for communicating clinical information to another prison, should a client be sent by the court to a different establishment. The Clinical Record should be kept up to date and contain the current prescription record. A printed summary of treatment should be sent in the case of electronic clinical records.

[9] NOMS (2005) CARATs Practice Manual, Drug Strategy Unit

Appointment details, contact numbers or generally relevant drug information such as the local 24/7 client phone line, and details of local peer led mutual aid and support organisations e.g. AA/NA, should be given by an IDTS team member to the healthcare team in reception, to go with a client to court in their personal effects.

8.1.2 Important documents should be included with the Prisoner Escort Record[10]. The escorting staff in the courts have a professional relationship with prisoners and should be included in planning and delivery of continuity of care.

8.1.3 Receiving staff (whether prison, contracted escort or other agencies) must be notified when a prisoner with drugs related care planning needs is to be handed over into their care, and any significant information on the PER (Prisoner Escort Record) must be highlighted as part of these procedures. It is important that the healthcare highlights on the PER that a client is receiving regular prescribed medication.
Prisoners receiving regular medication for substance misuse management are not suitable for overnight accommodation in police cells (ref **Operation Safeguard**[11]). To ensure that they are discounted from Operation Safeguard, healthcare managers should clearly indicate on the Prisoner Escort Record that a prisoner is receiving regular medication and whether doses (what and when) will be required during transit or during court detention. . To protect the medical confidentiality of that person, further detail on the type of treatment provided should not be entered on the form unless doses are needed whilst the prisoner is in the care of the escort.

8.1.4 Any medication * required by a client during a court appearance must be sealed in a package, bearing the offender's name and prisoner number and clearly marked as medicine. The escorting staff will give the sealed pack to the client at an agreed time or at the point of release from the court. Unless there is certainty that the prisoner will return to the previous establishment, adequate medication should be provided by healthcare to ensure continuity of medication[12] if the prisoner then goes to another prison or a police cell or is released unexpectedly i.e. the advice in the table below.

* Controlled drugs must be given as prescribed before the client leaves prison before court. CDs must not accompany the prisoner.

8.1.5 Coverage by CJIT workers in courts is improving particularly with the expansion of Restriction on Bail, and implementation of Testing on Arrest and Required Assessment. Where CJIT workers have been informed by CARAT Teams and or Probation about court appearances, information about case disposal is more likely to be available. In addition relationships are also being developed with court staff and defence solicitors so information about potential clients not known to CJITs is also being brought to their attention. Regional Prison Clinics also provide the opportunity to clarify arrangements and manage expectations between CJITs and CARAT teams regarding court working and information arising from court disposal

[10] PSO 1025, Communicating Information about Risks on Escort or Transfer – The Prisoner Escort Record. ***Please note, the Prisoner Escort Record is currently under review.***

[11] HMPS (2006) PSI 30/2006 Operation Safeguard
[12] Dept Health (2003) A Pharmacy Service for Prisoners

8.2 Avoiding the emergence of withdrawal symptoms

8.2.1 The emergence of withdrawal symptoms are best avoided as these may act as a precursor to relapse. In the case of sedative withdrawal, there is an additional risk of a consequential acute health problem.

8.2.2 A court appearance may be postponed for client undergoing an alcohol detoxification, but where this cannot be arranged, the client's medication should accompany him or her in a sealed labelled package, with court staff given the authority to hand that sealed package to the client at the indicated time.

8.2.3 All IDTS clients due in court to should receive their opiate substitute medication in the morning, administered under observed conditions, prior to leaving the prison, in order to provide protection against the emergence of withdrawal symptoms later in the day. Where release is anticipated, arrangements for ongoing prescribing should be made prior to the court appearance, with take-home medications being supplied for all regimes (including alcohol) if there is likely to be any delay in the prisoner gaining access to a community prescription.

8.3 Non-returns from court

This table summarises information management for a range of circumstances that may occur following a client's attendance in court where the client does not return to the sending prison. As in any situation, the transfer of any information can only take place with the informed consent of the client.

Reason for non-return to prison	Recommended management	Note
(i) From Court to a different Prison	Sending prison should ensure that Clinical Record is kept updated and contains current prescription record, and that it accompanies every client when s/he leaves the prison for court. A printed summary of treatment should be sent in the case of electronic clinical records. Receiving prison will request CARAT file from previous establishment. If CJIT at the court are notified of the court date, and the client is known to the worker, information on the court outcome should be communicated by the CJIT to the CARAT team of the sending prison to enable them to forward the CARAT file on.	Welfare of an offender whilst s/he is located in a court is the responsibility of that court. It is however vital that any doctor called to the court has access to current prison treatment information. Further information on the duty of CARAT teams in this regard may be found in the CARATs Practice Manual, the CARATs Specification and the Guidance for the Delivery of DIP in Prisons.
(ii) Departure from court : - on a community	The CARAT keyworker, where possible and where they suspect that the client might be released	Where this information cannot be given to the client in person, it should

Reason for non-return to prison	Recommended management	Note
sentence - on licence - following case dismissal - on bail - following a finding of not guilty - on receipt of any other non-custodial disposal	from court, should ensure that information on community services, including the 24/7 client phone line of local CJIT and any appointments with treatment services, are given to the client as soon as they are available. When release is confirmed the CARAT file is closed and treatment information sent to the client's local CJIT, or other treatment provider, and Offender Manager where applicable.	be placed in his or her personal effects in reception prior to departure.
(iii) From Court to overnight stay in police cell	Healthcare to indicate clearly on the Prisoner Escort Record if patient is receiving regular prescribed treatment (see *8.13*)[13]. Ensure Clinical Record is updated and contains current prescription record, and that the file accompanies every client when s/he leaves prison for the court. A printed summary of treatment should be sent in the case of electronic clinical records.	Welfare of an offender in police custody is the responsibility of the custody sergeant. It is however vital that any doctor called to the court has access to current prison treatment information.

9. RELEASES FROM PRISON

The following tables summarise a range of circumstances that may occur when a prisoner is released from prison. As in any situation, the transfer of any information can only take place with the informed consent of the client.

9.1 Unplanned Releases

Type of release	Recommended management	Note
Instant release via judge in chambers or follow quashing of conviction or sentence on appeal	As part of the assessment process the CARAT keyworker should ask the client if there are any plans to ask for bail by judge in chambers or if there is an appeal in progress. There should be protocols in place in reception as part of the discharge process to alert Healthcare/CARATs to the consideration of ongoing treatment needs.	

[13] HMPS (2006) PSI 30/2006 Operation Safeguard

Type of release	Recommended management	Note
	The CARAT keyworker, where possible, should ensure that information on community services, including 24/7 client phone line of local CJIT, and of any appointments with treatment services are given to client as soon as they are available. Once release is confirmed CARAT file is closed and treatment information sent to the client's local CJIT, or other treatment provider, and Offender Manager where applicable.	Where this information cannot be given to the client in person, it should be placed in his or her personal effects in reception prior to departure.

9.2 Planned Temporary Releases

Type of temporary release	Recommended management	Note
Released on Temporary Licence (ROTL)	The CARAT keyworker, where possible, should ensure that information on community services, including 24/7 client phone line of local CJIT, and of any appointments with treatment services are given to client as soon as they are available.	The CARAT keyworker should, if possible, be aware of the reason for the ROTL and prepare accordingly, e.g. a ROTL may have been arranged for the client to be assessed at a rehabilitation centre.
Working out while in D Category / Open prison	Medication administration should be timed to facilitate outside working.	Following stabilisation, methadone, buprenorphine and diazepam treatment regimes are not ordinarily an impediment to work. Driving regulations are detailed in the Dept Health Drug Misuse and Dependence, Guidelines on Clinical Management (1999) Annex 16: Drugs and Driving[14]

9.3 Planned releases

9.3.1 Clients will need to have a release plan, which is the CARAT release plan and is separate from but feeds into a prisoner's general release plan, (which is the responsibility of the offender manager). for those who are not released on

[14] http://www.dh.gov.uk/assetRoot/04/07/81/98/04078198.pdf

supervision CARATs will feed into other release planning as appropriate. The CARAT team will liaise with the CJIT/drug treatment provider in the offender's area of residence when preparing the release plan as well as liaising with sentence planning and resettlement teams in prison and the Offender Manager (in the community).

9.3.2 Clients who have been assessed as requiring ongoing access to drug treatment services in the community will be referred to the Single Point of Contact (SPOC) in the relevant CJIT, as long as the individual has given their consent for information to be passed to the CJIT. The CJIT will consider whether the individual is to be taken onto its caseload. This decision is based on the drug-related needs of the individual and the capacity of the CJIT. Where the individual is taken onto the caseload, the CJIT will provide or broker access to drug treatment and wraparound services as appropriate.

9.3.3 When it is not appropriate for the individual to be taken onto the CJIT caseload e.g. where there are more appropriate services for the individual than those which the CJIT would provide, the CJIT might, more appropriately, "signpost" or refer the individual to other services in the community. The release plan should be sent to the relevant CJIT or local drug treatment provider and Offender Manager, subject to client's consent, prior to release. Release planning must commence at least 3 weeks in advance of release for prisoners who are in custody for at least this length of time.

9.3.4 Responsibility for enforcement of the overall release plan for sentenced prisoners (of which the CARATs release plan is separate but should link with) rests with the Offender Manager. The Offender Manager needs to be aware of treatment undertaken/planned so they can produce a comprehensive release plan and ensure that interventions and contact times/dates are consistent.

9.3.5 Standards for the management of the release of sentenced offenders are found in *PSO 2205 – Offender assessment and sentence management – OASys.* Standards for supervision of offenders on licence are included in the *Home Office National Standards for the Supervision of Offenders*.

http://www.hmprisonservice.gov.uk/resourcecentre/psispsos/listpsos/

9.4 Continuation of treatment in the community

9.4.1 The transition from custody to community is a critical phase for clients and part of the release planning should include assessment of the need for immediate as well as ongoing support on release. Issues relating to victims and any licence conditions will need to be factored into any decision making. This should be done in conjunction with the Offender Manager, as they are responsible for proposing licence conditions. It will be the responsibility of the CARAT team to liaise with CJITs and others involved in resettlement, to ascertain the best option for the client, for example:

- do they require in-reach contact;
- do they need meet and greet at prison gate; and/or

- what special consideration will be needed for those being released a great distance from home.

9.5 Continuation of prescriptions

9.5.1 The period immediately following release is a time of considerable vulnerability. For clients leaving prison with existent prescribed management of their substance misuse problem, contact should be established with a community service following the client's entry into the Integrated Drug Treatment System, so that an appointment may be made for the earliest possible opportunity following release. Integrated working between the clinical and CARAT teams, with strong links to the local CJIT or relevant community treatment provider, and Offender Manager if on post custodial supervision, is central to the securing of good continuity of care.

9.5.2 Whilst it is hoped that an appointment can be arranged for ongoing prescribed treatment for the day of, or the day following a planned release, it is envisaged that in cases where a client leaves prison on a Friday, s/he may not be seen until early the next week. In these circumstances, the prison healthcare team should identify a community pharmacist to provide an interim dispensing service. In the event of no pharmacy being available, a consideration of risk factors (particularly covering the capacity to keep the medication securely from any children or vulnerable adults in the home) should be conducted to help determine how much take-home medication should be issued to the individual. Routinely it is recommended that 3 days' take home medication is given. In the case of methadone this should be given in three separate bottles. On a holiday weekend, further days' medication may be required. Harm minimisation advice should be given to the client on the danger of client overdose and the risk of poisoning presented to children and opiate-naïve adults.
Harm reduction and advice must be provided as part of assessment and release planning as outlined in the CARAT service specification[15].

9.6Transfer to the Immigration and Nationality Directorate

Where a client is to be deported from the United Kingdom and is to be transferred to immigration detention before being removed, a summary of ongoing clinical substance misuse treatment needs should be communicated by the prison healthcare team to the medical authorities at the place of detention. When an at-risk client is to be discharged into the community, the procedure outlined in Prison Service Instruction 18/2005 PSI 18/2005 *Introducing ACCT (Assessment, Care in Custody & Teamwork)* must be followed.

10. ACCESS TO TREATMENT WITHIN PRISON

10.1 Prisons will need to consider the safety and practicality aspects of delivering IDTS services to prisoners throughout the establishment. Clinical IDTS practitioners

[15] HMPS (2004), Drug Strategy Unit. Provision of Tier 2/3 drug service. CARATs service specification

will need to engage in the processes by which decisions are made on cellular confinement and segregation[16], including the completion of the initial segregation safety screen (OT014). It should be noted that offenders with substance misuse problems have a markedly higher than risk of suicide than the greater population of prisoners in the first week of custody

11 CLINICAL MANAGEMENT OF RELAPSE/ILLICT DRUG USE IN TRAINER AND OPEN PRISONS.

11,1 There is an expectation that in prison patients will be treated upon presentation – it is not acceptable to operate waiting lists (ref IDTS announcement letter 2009-10 funding, 17th March, 2009).

11.2 The majority of cases of illicit drug use can be clinically managed within a non-24 hour setting. The following sets out the recommended response to varying levels of severity and complexity of drug use. Only Level 4 would require transfer to a Local prison from a Trainer or Open prison.

Level 1	Non-dependent intermittent use ***No clinical intervention required – refer to CARATs***
Level 2	Mild dependent use Symptomatic relief – lofexidine, methadone or buprenorphine ***[+naltrexone if indicated] – refer to CARATs***
Level 3	Marked dependence ***Substitution treatment indicated (methadone or buprenorphine including stabilisation) – refer to CARATs***
Level 4	Severe dependence with physiological and/or psychiatric complications ***Treatment in IDTS Local prison indicated to enable provision of 24 hour healthcare [please note: active withdrawal management must commence upon presentation, and not be delayed until a place in a Local prison has been found]***

Levels 3 & 4 - Consider maintenance if longstanding use/frequent relapse.

[16] PSO 1700 Segregation. http://pso.hmprisonservice.gov.uk/pso1700/default.htm

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