NDTMS ADULT SECURE ESTATE INTERVENTIONS AID Dataset R

Clinical interventions — structured

Benzodiazepines detoxification

Withdrawal prescribing should be initiated on the day of admission where there is a history of benzodiazepine dependence (either prescribed or regular illicit use) and the presence of objective symptoms and signs of withdrawal already present. Benzodiazepine dependence requiring treatment is not common in polydrug users and does not normally need pharmacological treatment in those using benzodiazepines in the context of heroin or crack dependence.

Where clinical assessment does, however, indicate a previous history of regular benzodiazepine use that suggests substantial dependence that could require treatment of withdrawals (for example, use of sufficiently high doses over a long duration, and/or with previous withdrawals requiring treatment such as fits), a benzodiazepine assisted withdrawal regimen should be prescribed. The intervention start is the date of dispensing the first dose of medication.

Lofexidine

Lofexidine is a non-opioid alpha-adrenergic agonist authorised for the management of opioid withdrawal. It is most likely to be successful for patients with uncertain dependence, young people and shorter drug and treatment histories. NICE's guidance (NICE 2007b) states that lofexidine may be considered for those who have decided not to use methadone or buprenorphine for detoxification, have decided to detoxify within a short time period or have mild or uncertain dependence.

The intervention start is the date of dispensing the first dose of medication.

Naltrexone

Naltrexone provided during custodial stay or prior to release for users abstinent from opiates and committed to abstinence may be a useful adjunct to psychosocial treatment. However, it is not generally recommended where psychosocial support cannot be secured as dropout from such treatment is associated with a heightened risk of drug-related death. See Drug misuse and dependence: UK guidelines on clinical management.

The intervention start is the date of dispensing the first dose of medication.

Opioid re-induction

Prior to release some patients request re-induction onto opiate substitution treatment. Re-induction should be considered for patients who are about to leave prison and for whom there is a clearly identifiable risk of overdose. Re-induction may be offered after the patient has been offered and has declined relapse prevention interventions, and once the implications of restarting opiate misuse have been explained. See Drug misuse and dependence: UK guidelines on clinical management.

The intervention start is the date of dispensing the first dose of medication.

Opioid reduction – methadone or buprenorphine

The intervention recorded should reflect the medication prescribed – the 3 options are:

- opioid reduction – methadone
- opioid reduction – buprenorphine
- opioid reduction – buprenorphine depot injection (eg Buvidal)

The 'opioid reduction' intervention should be used where the client is receiving substitute opioid prescribing (methadone or buprenorphine) and the client's care plan objective is reduction with a commitment to becoming drug free. Every review of the client's care plan should indicate that the substitute dosage is being reduced. Where it has not been possible to reduce the dosage over successive reviews (2 or more) the client is effectively being maintained and, therefore, this intervention should be ended and a subsequent 'opioid maintenance' intervention opened.

Opioid detoxification may also be recorded under this intervention. Following a stabilisation, detoxification should routinely be for a minimum of 14 days if withdrawing from a short-acting opiate but longer if withdrawing from methadone. See Drug misuse and dependence: UK guidelines on clinical management, Department of Health. . For a planned detoxification. the reduction is normally completed within 12 weeks or less, but this time period can be extended depending on response. If there is use of opioid drugs in addition to the prescribed medication, or other significant loss of stability, the reduction must be reviewed with consideration of the need for dose increase, treatment review and optimisation

It is important that the right balance be achieved in determining whether a detoxification, gradual reduction or maintenance regime is the appropriate approach when prescribing for those who are opiate dependent. DH guidance sets out parameters for the use of substitute prescribing. See Drug misuse and dependence: UK guidelines on clinical management, Department of Health.

There is a requirement that all periods of extended prescribing, whether maintenance or gradual reduction regimes, are reviewed every 3 months as a minimum. The review will have input from the multi-disciplinary team including the patient, prescriber, other members of the substance misuse team and where their involvement is incorporated within an agreed clinical governance framework, a senior officer and/or offender supervisor.

The client will also be expected to participate in the psychosocial, educational and rehabilitation opportunities available to them whilst in custody to assist them with achieving abstinence.

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Clinical interventions — structured (continued)

Opioid maintenance – methadone or buprenorphine

The intervention recorded should reflect the medication prescribed – the 3 options are:

- opioid maintenance – methadone
- opioid maintenance – buprenorphine
- opioid maintenance – buprenorphine depot injection (eg Buvidal)

The option of methadone (first line) or buprenorphine maintenance after stabilisation should be considered where a chronic opiate user is received into custody on remand to enable them to engage in treatment upon release.

It should also be considered where an opiate-dependent client is received into custody for a period of less than 26 weeks to enable them to engage in treatment upon releasewhere, based on a full clinical assessment, it is considered necessaryto protect the client on release from the risks of opiate overdose upon release.

There is a requirement that all periods of extended prescribing whether maintenance or gradual reduction regimes are reviewed every 3 months as a minimum. The review will have input from the multi-disciplinary team including the patient, prescriber, other members of the substance misuse team and where their involvement is incorporated within an agreed clinical governance framework, a senior officer and/or offender supervisor.

Where longer term prescribing is offered to those whose sentence exceeds 26 weeks, it should be explained that at an appropriate time, there will be an expectation that the client works towards reducing their dose of opiate substitute medication, and that abstinence remains the ultimate goal.

When a client moves from a maintenance to a reduction regime, the maintenance intervention should be ended and a new intervention of 'opioid reduction' be opened to indicate the change in treatment goal.

The client will also be expected to participate in the psychosocial, educational and rehabilitation opportunities available to them whilst in custody to assist them with achieving abstinence.

The intervention start is the date of dispensing the first dose of medication on a maintenance script.

Alcohol – prescribing

Prescribing involves the provision of care planned specialised alcohol treatment, which includes the prescribing of drugs to treat alcohol misuse. This intervention should be used to capture the 3 classes of pharmacotherapy that are effective in the treatment of alcohol misusers:

- medications to promote abstinence or prevent relapse, includingsensitising agents
- medications for treating withdrawal symptoms during medically assistedalcohol withdrawal
- nutritional supplements as a harm reduction measure for heavy drinkersand high-dose parenteral thiamin for the treatment of Wernicke's encephalopathy and its prevention

There is significant research evidence and consensus on the most appropriate medications to use in managing the side effects of withdrawal from alcohol and these conventions should be followed. Typically, the medications of choice will be benzodiazepines, such as chlordiazepoxide or diazepam. Medications for reducing craving for alcohol should only be prescribed alongside psychosocial treatment and not as a stand-alone intervention. Use of sensitising medications requires continuing support from professionals and from families or social networks.

Pharmacological therapies should be delivered in the context of structured care planned treatment and are not a stand-alone treatment option (there is some evidence that multiple episodes of assisted withdrawal can be associated with increased harmful outcomes).

Pharmacological therapies are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care.

The intervention start is the date of dispensing the first dose of medication.

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Psychosocial Interventions — structured

Psychosocial intervention mental disorder

Many users of drugs and/or alcohol also have considerable co-morbid problems, particularly common mental health problems such as anxiety and depression. There is evidence that a range of evidence - based psychosocial interventions can be beneficial for a wide range of mental disorders. Such disorders may include:

- depression (NICE, 2007b)
- anxiety (NICE, 2007c)
- post-traumatic stress disorder (NICE, 2005a)
- eating disorders (NICE, 2004)
- obsessive compulsive disorder (NICE, 2005b)
- antenatal and postnatal mental health (NICE, 2007d)

Psychosocial interventions to address these disorders range from, for example, guided self-help and brief interventions for mild forms of problems to cognitive behavioural therapy and social support for more moderate forms. All psychosocial interventions to address common mental disorders should be recorded using this code regardless of their intensity.

The difference between psychosocial interventions for problem substance misuse and formal psychological therapies targeting a client's co-morbid mental health problems is that the latter interventions are specialist psychological treatments (such as cognitive-behaviour therapy for depression or anxiety, cognitive-analytic therapy, dialectical behaviour therapy, or schema-focused therapy for personality disorders) aimed primarily at the non-substance psychological problem. Such interventions should only be delivered by specialist practitioners such as clinical and counselling psychologists, suitably trained psychiatric staff or other specialist therapists with relevant training, qualifications and supervision in the therapy model being offered.

The intervention start is the date of the first formal and time-limited appointment.

Other structured psychosocial intervention

This intervention category includes other psychosocial therapies that are used in drug and alcohol treatment and that are beneficial for some clients as they are practical and broad-based techniques. Psychosocial therapies recorded under this category will include the Community Reinforcement Approach and Social Behaviour Network Therapy. Structured psychosocial interventions are clearly defined, evidence-based psychosocial interventions, delivered as part of a client's care plan, which assist the client to make changes in their drug and /or alcohol misuse. These interventions are normally time limited and should be delivered by competent practitioners. Competent practitioners will have adequate training, regular clinical supervision to ensure adherence to the treatment model and be able to demonstrate positive client outcomes.

The intervention start is the date of the first formal and time-limited appointment.

Structured day programme

The structured day programmes category should be used to record a range of programmes where a client must attend for a fixed period. Interventions tend to be either via a fixed rolling programme or a fixed individual timetable, according to client need. In either case, the programme includes the development of a care plan and regular key working sessions. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

Clients will usually attend the programme according to specified attendance criteria, and follow a set timetable that will include group work, psychosocial interventions, educational and life skills activities.

In secure settings, the majority of drug and alcohol treatment programmes would fall into this category, including 12-Step programmes and therapeutic communities.

The category of 'other structured intervention' should be used for less extensive or less structured 'day care' provided in the context of a structured care plan.

The intervention start is the date of the start of the programme.

Psychosocial Interventions — structured (continued)

Other structured intervention

'Other structured intervention' describes a package of interventions set out in a client's care plan which includes as a minimum, regular planned therapeutic sessions with a keyworker or other substance misuse worker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

This intervention category reflects the evidence base that drug treatment consisting of individually tailored packages of care, in the context of a therapeutic relationship, is beneficial.

This intervention may be particularly relevant for non-opiate drug misusers and clients who are receiving criminal justice treatment interventions. Most clients receiving 'other structured intervention' will receive a range of interventions to meet needs identified in their care plan. These will involve a range of interventions to address their substance misuse and support to address needs in other domains.

Examples of these may include:

- a crack user who is receiving regular sessions with a keyworker and attending 'day care' sessions to address a range of social and health-related needs
- an opiate user who has been through detoxification and is receiving ongoing support to maintain abstinence as part of the care plan (prior to referral on or provision of aftercare arrangements), and is also receiving harm reduction interventions and help to deal with health needs
- an uncomplicated problem cannabis user who is receiving a short period of care-planned regular brief interventions to deal with problem cannabis use
- clients who are not receiving a structured psychosocial intervention for their problem drug or alcohol use – but who receive regular sessions with keyworkers to address their social and/or health-related needs and offending behaviour
- an alcohol client who is receiving ongoing support following alcohol withdrawal to maintain abstinence as part of the care plan
- a short period of care-planned regular brief interventions to address problem alcohol misuse

'Other structured intervention' can describe regular sessions with a keyworker, delivered in order to keep a client engaged in the treatment system while they are waiting to start receiving another care-planned intervention, if the structured interventions are outlined in an initial care plan following a triage assessment.

Clients receiving 'day care' rather than a 'structured day programme', as part of a care plan, may be recorded as receiving 'other structured intervention'. Day care is distinct from structured day programmes, because it has a lower requirement to attend than structured day programmes (usually 1 to 2 days). Some clients may have a care plan that specifies regular attendance at day care with regular sessions with a keyworker. As part of the care-planned day care they may receive a range of interventions and support including emotional and psychological support, educational and life-skills work and related activities, advice and information, harm reduction support, further assessment and subsequent referral to alternative structured treatment. This may be particularly relevant for clients who have co-existing mental health problems.

The intervention start is the date of the first formal and time-limited key worked appointment.

Alcohol brief intervention — non-structured

Alcohol brief intervention

This intervention should be used for recording brief interventions for alcohol. Brief interventions for hazardous and harmful drinkers include:

- a session of structured brief advice on alcohol for adults who have been identified via screening as drinking a hazardous or harmful amount or who would benefit from a brief intervention prior to release (including ROTL).
- an extended brief intervention for adults who have not responded to structured brief advice or who may benefit from an extended brief intervention for other reasons, including prior to release. See 2011 NICE alcohol commissioning guidance

Further definitions are provided in the 2011 NICE alcohol commissioning guidance.

A brief intervention can comprise either a short session of structured brief advice or a longer, more motivationally based session (that is, an extended brief intervention) – both aim to help someone reduce their alcohol consumption or abstain and can be carried out by non-alcohol specialists.

An extended brief intervention is motivationally based and can take the form of motivational-enhancement therapy or motivational interviewing – the aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change; in this guidance, all motivationally based interventions are referred to as 'extended brief interventions'.

Further definitions are provided in the 2011 NICE alcohol commissioning guidance.

Brief interventions for alcohol that are delivered in isolation (without other structured treatment) do not need to be reported to NDTMS.

The intervention start is the date of the first face-to-face (or equivalent) contact where a simple or extended brief intervention has been provided.

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Facilitated access to mutual aid — non-structured

Facilitated access to mutual aid

Facilitating access to mutual aid (FAMA) is a short, simple and effective method for increasing mutual aid participation (see Facilitating Access to Mutual Aid).

Mutual aid groups may be based on 12-step principles (such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous) or another approach (such as SMART Recovery). FAMA is a technique that can be used by treatment professionals. It involves using 1 or more one-to-one keyworking sessions to help people to engage with any mutual aid group (12-step and non-12-step).

The FAMA guidance is based on 1-3 sessions. The number of sessions will vary between individuals, depending on each person's experience of engaging with mutual aid. As part of this process, staff introduce mutual aid including discussing any past experience, providing information about mutual aid groups and agreeing goals. This is followed by encouraging the individual to attend a mutual aid group including exploring barriers and solutions and reviewing goals. Where a person wants to try mutual aid, staff should facilitate the initial contact by, for example, arranging for them to meet a mutual aid group member, arranging transport or someone to accompany the person to the first session and dealing with any subsequent concerns. In follow-up sessions, staff take an active interest in the individual's attendance of and engagement with mutual aid. It is not enough to simply provide someone with a leaflet.

FAMA sessions that are delivered in isolation (without other structured treatment) do not need to be reported to NDTMS.

Drug Recovery Wing (DRW) and Incentivised Substance Free Living (ISFL)

Drug Recovery Wing

Dedicated locations within prisons where a culture of abstinence is promoted and closely supervised, largely by the prisoners themselves. Inmates on recovery wings commit to higher scrutiny and security, with treatment and peer support services provided to those who need them.

Incentivised Substance Free Living

Specialised wings to treat drug addiction, including through abstinence, and then keep prisoners substance-free.

Up to 100 'incentivised substance-free living units' (ISFL units) will be rolled out in prisons by 2025.

Prisoners willing to turn their lives around are supported to get off illicit drugs and will receive regular drug testing, peer support, and incentives such as extra gym time for good progress.