Developing the Guernsey treatment system for substance misusers: Phase 3 – best practice factsheets
This report details a series of factsheets commissioned by the Bailiwick Drug and Alcohol Strategy Group (BDASG) to inform the development of a new Guernsey Drug and Alcohol Strategy for 2015.

Factsheet 1 - Prescribing and dispensing of pharmaceutical opiates, hypnotics and anxiolytics
Factsheet 2 - Provision of supervised consumption in community pharmacies
Factsheet 3 - Rapid open access and entry into appropriate treatment
Factsheet 4 - Delivery and evaluation of Identification and Brief Advice (IBA) for alcohol misuse
Factsheet 5 - Inter-agency working
Factsheet 6 - Strategies for reducing substance misuse among young people
Factsheet 7 - Treatment interventions for offenders in the community and in prison
Factsheet 8 - Delivery of recovery-oriented treatment

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The members of the Project Steering Group; Andrea Nightingale, Stephen Bridgman, Gregory Lydall, Jenny Cataroche and Linda Prickett.

The employees of the following services; the Health and Social Services Department (HSSD) including the Community Drug and Alcohol Team (CDAT) and the Child and Adolescent Mental Health Service (CAMHS); Drug Concern; the Guernsey Alcohol and Drug Abuse Council (GADAC); and Action for Children.

The staff at the Centre for Public Health, Liverpool John Moores University; Jodie Freeman, Lisa Jones, Jim McVeigh and Geoff Bates.

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A range of opiate dependence treatments are effective in reducing harm to individual drug misusers, their children, families and local communities (1). The effectiveness of pharmacological and psychosocial treatment for drug dependence is well established (2). The international evidence base consistently shows that drug treatment has a positive impact on drug dependence and can reduce offending and overdose risk (3).

The process of withdrawal from opiates can differ depending on the individual and their drug use history. Some people can withdraw without the aid of prescription medication, however in some serious cases or in more complicated circumstances the need for substitute medication may be necessary. Due to the nature of drug dependence, the process of prescribing a substitute medication is complex (1). Qualified health professionals should carry out a full assessment and initiate a comprehensive care plan. Drug dependence is considered a multi-factorial health disorder and Public Health England (formerly The National Treatment Agency for Substance Misuse) highlights the importance of adopting a multidisciplinary approach to the management of people with drug dependence (2).

In the UK, the current treatment of drug misuse is largely focused on the treatment of opioid dependence, which is associated with much greater rates of harm than the misuse of other drugs such as cannabis or cocaine (4). The National Institute for Health and Care Excellence (NICE) recommends Opioid Substitution Therapy (OST) as the most effective treatment in the management of opioid dependence, alongside psychosocial interventions (5). Methadone and buprenorphine are recommended as treatment options however the decision about the best treatment package is dependent on the individual’s needs (6, 7).

Both national guidelines and the international evidence base provide information relating to prescribing pharmaceutical opiates, including service availability, access into drug treatment and the different types of drug treatment packages available (1), including provision for psychosocial interventions (5).
**UK Guidelines around prescribing pharmaceutical opiates**

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<tr>
<th>Service availability</th>
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<tr>
<td>A community based programme should be routinely offered to all service users considering opioid detoxification and maintenance (4, 8). There should be access to national and local structured drug treatment services (9).</td>
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<tr>
<td>- In the UK, GPs are encouraged to provide specialist drug treatment services (7). Each local primary care trust should have at least one practitioner trained in substance misuse (7). GPs should work closely with structured treatment services for patients requiring support for their substance use (7).</td>
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<tr>
<td>- Supervised consumption is available in most UK retail pharmacies and serves to reduce diversion or misuse and improve safety and compliance with treatment (7).</td>
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<td>- The average wait for treatment is five days (2010-11) and 96% of individuals access treatment within three weeks (10).</td>
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<tr>
<td>- A full assessment is required to establish the presence of drug use and severity of use (4, 7). The care treatment plan should be specifically related to the individual needs of the client and/or patient (7).</td>
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<tr>
<th>Current Guernsey situation relating to pharmaceutical opiates</th>
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<tr>
<td>Service availability</td>
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<tr>
<td>- The misuse of pharmaceutical opioids including suboxone, subutex, fentanyl and dihydrocodeine (DHC) is prevalent and they are often used in combination.</td>
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<tr>
<td>- CDAT is the only treatment service on the island which offers OST prescribing, although GPs in private practices can also prescribe.</td>
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<tr>
<td>- Commencement of substitute prescribing may be delayed by four to six weeks due to limited appointments being available for supervised consumption of suboxone. DHC is not supervised and may be started more quickly.</td>
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<th>Gap analysis</th>
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<td>Service availability</td>
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<tr>
<td>- There is little GP shared care on the island; however several GPs are interested in developing shared care protocols with CDAT.</td>
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<tr>
<td>- OST is only prescribed at CDAT.</td>
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<tr>
<td>- The average wait time for treatment is four to six weeks. Stakeholders perceived the waiting times to access substitute prescribing as a barrier to accessing treatment.</td>
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<tr>
<td>- There is no provision for substance misuse workers or GPs with special substance use interest.</td>
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<td>- The cost of primary care may not be able to afford to attend their appointments and may have outstanding debts to health providers.</td>
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<tr>
<th>Drug treatment</th>
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<tr>
<td>- Methadone and buprenorphine are both effective in the detoxification of prescription or street opioids and should be prescribed as part of a supportive care package (7). There is less risk of opioid overdose associated with buprenorphine than with methadone (4, 11).</td>
</tr>
<tr>
<td>- DHC is sometimes used but is not licensed for treatment purposes (7).</td>
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<tr>
<td>- Patients must be made fully aware of the risks of their medication (12).</td>
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<tr>
<td>- Suboxone is considered for patients who are unsuitable for maintenance treatment with methadone (7, 14). The focus is more recovery orientated (10, 13).</td>
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<tr>
<td>- Naltrexone is provided for people who prefer an abstinence programme, and who are highly motivated to remain on treatment until recovery (14).</td>
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<tr>
<td>- Patient and/or client data are recorded on a central core database creating a core data set and data may be recorded differently from provider to provider.</td>
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<tr>
<td>- Communication between GP and CDAT should prevent individuals being prescribed by both services; however patients can register with more than one GP.</td>
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<tr>
<td>- There are three substitute opioids permitted for use; suboxone, buprenorphine and DHC.</td>
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<td>- Suboxone is the preferred treatment as it includes the opioid antagonist naloxone in a combined sublingual tablet.</td>
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<td>- Reports suggest DHC is prescribed at higher doses than are stated by the British National Formulary.</td>
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<tr>
<td>- Methadone is not prescribed due to a methadone related death (1995) when last permitted.</td>
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<tr>
<td>- Systems currently used by providers do not capture a core data set and data may be recorded differently from provider to provider.</td>
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<tr>
<td>- Communication between GP and CDAT should prevent individuals being prescribed by both services; however patients can register with more than one GP.</td>
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<tr>
<td>- There are no reports of naltrexone being prescribed. It is not offered to individuals wanting a complete abstinence programme.</td>
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<tr>
<td>- Supervised consumption is not available in pharmacies.</td>
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<tr>
<td>- Methadone is not prescribed.</td>
</tr>
<tr>
<td>- DHC is prescribed at higher doses than are stated by the British National Formulary and is not licensed for treatment purposes.</td>
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<tr>
<td>- If a client was accessing more than one treatment service it is probable that it would not be known; making it possible to receive multiple prescriptions.</td>
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<tr>
<td>- Guernsey is currently in the process of creating a core data recording system for drug treatment services.</td>
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Hypnotics and anxiolytics are a class of drugs used to induce sleep and provide sedation (16). Benzodiazepines are the most commonly used anxiolytics and hypnotics and they may be prescribed to manage the symptoms of General Anxiety Disorders (GAD) and insomnia (1). In the UK, benzodiazepines are not licensed for the management of benzodiazepine dependence, however they are licensed for short-term use (two to four weeks only) for the management of severe insomnia and anxiety and withdrawal from alcohol (1).

Benzodiazepines are prescribed for short term use due to concerns about the adverse psychological effects and risk of overdose when used for longer periods of time and when used alongside alcohol (16). Tolerance and dependence can occur in individuals who take benzodiazepines, and their discontinuation can lead to a withdrawal syndrome (16).

Within the literature it is widely recognised that benzodiazepines are over prescribed and are used more frequently than recommended (17). This causes many health and social problems for individuals and can result in significant costs for health services (18). The so-called Z-drugs, zaleplon, zolpidem and zopiclone (non-benzodiazepine hypnotics) were developed with the aim of overcoming some of the adverse effects associated with benzodiazepines (19, 20). However, findings reveal that they have similar issues linked to tolerance, dependency and withdrawal symptoms (20).

Discontinuation of benzodiazepines or a significant reduction in the dose should be undertaken gradually. Abrupt cessation can lead to recognised withdrawal symptoms (confusion, toxic psychosis, convulsions, or a condition resembling delirium tremens) and the process needs to be clinically managed and appropriately supervised (1). Prescribing of benzodiazepines to assist withdrawal should only be considered when there is clear evidence of dependency. A long term care plan should be implemented with the aim of reducing the dose over a planned period of time (1). Longer-term prescribing of benzodiazepines should adhere to the general principles of management as set out in the Department of Health clinical management guidelines (1).

Prescribing for benzodiazepine withdrawal is often combined with adjunctive therapies (structured psychosocial interventions, support groups and relaxation techniques) (1). Due to the long term effects, the care plan for individuals prescribed benzodiazepines should be monitored and if possible, follow a similar schedule to that for other drugs of dependence, including daily dispensing and supervised consumption (1).
### UK Guidelines around prescribing hypnotics/anxiolytics

- Currently in the UK, use of benzodiazepines is indicated only for severe or extreme cases of anxiety or insomnia and their use is not recommended for the general treatment of anxiety or insomnia disorders (21).
- Benzodiazepines are recommended for short term use (two to four weeks) only, due to the potential for tolerance and dependence to occur (18).
- Careful consideration of the need to prescribe benzodiazepines is necessary to reduce the frequency of inappropriate prescribing (1). In some cases Z-drugs may be prescribed instead of benzodiazepines, however there have been similar reports of dependence and withdrawal issues with these drugs (22).
- Long-term substitute prescribing of benzodiazepines is not recommended for the management of benzodiazepine dependence. There is increasing evidence that long-term prescribing (of more than 30 mg diazepam equivalent per day) may cause harm (1). Longer-term prescribing of benzodiazepines should adhere to clinical guidelines (1).
- The prescribing regimen for benzodiazepine withdrawal should depend on initial dose, duration of use and the patient’s clinical response (16).
- Prescribing for benzodiazepine withdrawal requires regular reviews and methods to prevent diversion (1).

### Current situation in Guernsey in relation to hypnotics and anxiolytics

- A recent audit by CDAT revealed prescription-only medication (including benzodiazepines) was being misused by 95% of its clients.
- A comparison of prescription rates reveal; hypnotics and anxiolytics (such as benzodiazepines) are prescribed at around double the rate of that in England.
- Benzodiazepine withdrawal is provided by a GP who provides a tailored reduction process.

### Gap analysis

- Hypnotics and anxiolytics (such as benzodiazepines) are prescribed at around double the rate of that in England.
References

Developing the Guernsey treatment system for substance misusers:  
Factsheet 2: Provision of supervised consumption in community pharmacies

In the UK, pharmacists provide more than 14 million face to face contacts with drug users every year (1, 2), highlighting the important role they play in the treatment and care of these individuals. Pharmacies offer a range of services for drug users including the dispensing of drugs as part of supervised consumption arrangements, needle exchange services and harm reduction advice (1).

Public Health England (formerly the National Treatment Agency for Substance Misuse) has provided specific guidelines on the provision of pharmaceutical services for drug users (1). The report states the importance of working with local community pharmacists in prescribing drugs and encouraging good relationships between health professionals whilst maximising the use of resources (1).

In the UK, pharmacists are a key link with drug users and are available to all individuals in receipt of an NHS prescription with drug related problems (3). Pharmacists play an active role in the shared care of patients by liaising with the prescriber or named keyworker (4). Pharmacists are responsible for the daily care of the patient and ensure that agreed treatment plans are correctly followed (2, 4).

Over the last 7 years the role of pharmacies in the shared care of drug users has increased (5). Provision of supervised consumption in pharmacies has been linked to decreases in diversion rates and increased compliance with treatment (4). Pharmacists can also provide support and build therapeutic relationships with patients to facilitate continuation of treatment (1).

In the UK, pharmacists also offer free harm reduction services such as needle and syringe programmes (NSP) (4). This service aims to reduce the rate of injection equipment sharing between drug users by providing clean and sterile equipment to promote safer injecting and reduce the spread of blood borne viruses (6). NSP services can also support adults who inject performance and image-enhancing drugs (4).
<table>
<thead>
<tr>
<th>UK Guidelines around provision of supervised consumption in community pharmacies</th>
<th><strong>Services and availability</strong></th>
<th><strong>Current Guernsey situation relating to supervised consumption in community pharmacies</strong></th>
<th><strong>Gap analysis</strong></th>
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</table>
| **Services and availability** | -Commissioners should ensure that a broad range of pharmaceutical services are available for drug users and that a full range of interventions can be provided within local systems (1).  
-Supervised consumption allows for the supervision and guarantee that a medicine is being taken as directed, reduces diversion and improves compliance with treatment (4). It can reduce drug related deaths and allows for optimal dosing regimens (2).  
-Supervision is provided by a community pharmacist (4). There should be a good relationship between GPs and pharmacists (3).  
-All pharmacists and pharmacy staff involved in the delivery of pharmaceutical services to drug users must have an appropriate level of competency to undertake these services (1).  
-Dispensing and supervised consumption services should provide a user with a friendly service and should respect their privacy (7).  
-Drug users accessing pharmaceutical services should be provided with advice and information, including referral to primary care or specialist treatment where appropriate (3).  
-Pharmacists should be aware of exceptions when supervised consumption is not considered necessary or appropriate (1).  
- UK guidelines highlight the difficulties in supervising consumption for DHC and suggest prescription and dispensing should be carried out by clinicians with appropriate specialist competences (2). | -Supervised consumption of suboxone can only take place in nurse led clinics by appointment in CDAT premises at Castel Hospital.  
-Substitute prescribing may be delayed by up to four to six weeks due to limited appointments being available for observed consumption of suboxone.  
-There is no supervised consumption of dihydrocodeine (DHC) at all.  
-CDAT audit revealed that 90% of all doses of OST were not supervised. | -Only one service provides supervised consumption.  
-Substitute prescribing may be delayed by up to four to six weeks. Stakeholders believed this to be a barrier to accessing treatment  
-There is no supervised consumption of DHC.  
-Pharmacies do not provide supervised consumption.  
-There is little GP shared care on the island. |
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<td><strong>Harm reduction services</strong>&lt;br&gt;- Needle and syringe programmes consist of a three tier structure involving exchange, signposting and harm reduction advice (6).&lt;br&gt;- Pharmacy NSP and harm reduction initiatives are part of wider approaches to prevent the spread of blood borne viruses (BBV) (HIV and hepatitis B and C) and reduce drug-related harm (6).&lt;br&gt;- Pharmacy-based NSPs should provide needles, syringes and other injecting equipment (legally permitted equipment such as filters, mixing containers and sterile water). Where possible, needles and syringes should be made available in a range of sizes (6).&lt;br&gt;- Pharmacy-based NSPs should provide sharps bins and advice on the safe disposal of used equipment.&lt;br&gt;- Harm reduction services often come into contact with drug users who are not in touch with other specialist treatment services (6).&lt;br&gt;- Pharmacy-based services should encourage people who inject drugs to access services that can support them to stop using drugs or to switch to non-injecting methods, and address their other health needs (6).&lt;br&gt;- Data are collected by local regions for harm reduction services provided by pharmacies (8).</td>
<td><strong>Harm reduction services</strong>&lt;br&gt;- One pharmacy on the island sells needles, syringes and sharps bins but does not offer harm reduction advice to its customers.&lt;br&gt;- Drug Concern delivers a free needle exchange service issuing a variety of injecting equipment.&lt;br&gt;- Although there is no weekend provision, the service operates two mornings and two evenings a week. Due to the size of the island, its population count and the mobility of service users this is considered to meet the needs of service users. There is also provision to arrange collection outside of these times dependent upon staff availability. This is a harm reduction initiative which provides all of the relevant safer injecting advice and referrals to BBV services for screening and care.</td>
<td><strong>Harm reduction services</strong>&lt;br&gt;- One pharmacy on the island sells needles, syringes and sharps bins.&lt;br&gt;- There is no free needle and syringe provision in community pharmacies.&lt;br&gt;- Pharmacies do not provide advice and information or harm reduction services, e.g. BBV and needle and syringe exchange services.&lt;br&gt;- Data are not collected for pharmacies.</td>
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References

Developing the Guernsey treatment system for substance misusers:
Factsheet 3: Rapid open access and entry into appropriate treatment

Treatment provides an opportunity for management and recovery from drug and alcohol dependence (1). Treatment for a successful recovery requires effective management through early identification of needs, timely support (2) and rapid access to evidence based interventions (3). Everyone with a need has the right to access treatment (4) and it is important that people needing support for their alcohol or drug use are identified and encouraged to seek treatment at the earliest opportunity (5).

Healthcare organisations should provide accessible and responsive care (6). Individuals should receive services as promptly as possible, be given choices and access to services and treatment, and not experience unnecessary delay (6). Individual’s views should be taken into account to maximize patient choice (6). Reducing waiting times (7), providing flexible services and opening times (8) and increasing the availability range of treatment options (7) provides individuals with the best opportunity to access the right treatment at the right time for them, and to enable and support their recovery (2). Treatment services in England currently work towards a performance measure to ensure that all patients have access to treatment within three weeks of a referral (9).

Models of care for alcohol misusers (4) and models of care for adult drug misusers (8) provide best practice guidance to health organisations and partnerships in England. They aim to assist an integrated local treatment system to benefit alcohol and drug users, their families and local communities through improving delivery and effectiveness of treatment (4). Models of care (4, 8) outline a four-tiered framework for provision of treatment. Commissioners need to ensure that all tiers are commissioned and provided (4). It is important that clear standardised screening and assessment procedures are followed to establish what interventions are required and are most appropriate and to determine urgency of treatment (4). Models of care recommends adequate sharing of appropriate information between services with protocols for joint working and a clear pathway for referral (4).
**UK Guidelines around rapid open access and entry into appropriate treatment**

- Increased identification and assessment of alcohol-use disorders is required to ensure rapid and appropriate treatment can be provided to prevent further harm (10). This requires trained and competent staff in services provided for services users who may have alcohol-use disorders (10).
- There are a wide range of treatment opportunities both in the community and/or inpatient settings including; brief Interventions, service user organisations such as Alcoholics Anonymous, psychosocial interventions and talking therapies, medically assisted alcohol misuse programmes and residential rehabilitation.

**Current Guernsey situation relating to rapid open access and entry into appropriate treatment**

- **Alcohol-use and treatment options**
  - GADAC provides a service for individuals whose primary substance of misuse is alcohol, or for family and friends of problematic drinkers. It provides advice and information, psychosocial interventions and referral to residential rehabilitation.
  - Drug Concern and Action for Children provide alcohol awareness in secondary schools, outreach work in partnership with community organisations and make referrals to specialist services.

**Gap analysis**

- Structured treatment providers have the ability to refer yet have little relationship with providers of off-island residential rehabilitation.
- Treatment providers may refer their clients to other treatment providers where appropriate but do not consistently check with the receiving agencies that clients have engaged with them.
- There is usually a waiting list for inpatient detoxification at Castel Hospital.
- Stakeholders believed incapacity within treatment services was a barrier to accessing and engaging clients in treatment.

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<tr>
<th>Access into appropriate treatment services</th>
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<tr>
<td>- Referrals can be made by GPs, drug services, A&amp;E wards, probation and non-specialist sections of community alcohol teams and self-referrals are accepted. The referral services should monitor and support any person waiting to go into alcohol treatment (10).</td>
<td>- Individuals may self-refer to Drug Concern or GADAC, or be referred by their GP, HSSD services or criminal justice agencies.</td>
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<td>- The aim is to ensure that individuals can access their appropriate treatment method as quickly as possible and figures show that in 2012, 85% of people’s wait time into treatment was less than three weeks (11).</td>
<td>- IBA is used to identify and move individuals quickly into treatment.</td>
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<tr>
<td>- Failure to identify alcohol-use disorders means that many people do not get access to alcohol interventions until the problems are more chronic and difficult to treat (11).</td>
<td>- If an individual is experiencing alcohol withdrawal (for example delirium tremens) this would be classed as a medical emergency and they would be treated at hospital.</td>
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<tr>
<td>- Rapid open access to appropriate treatment can ensure individuals are treated at the right stage. If a service user is not ready to engage in treatment, work on enhancing the service users’ motivation towards making changes is particularly important (11).</td>
<td>- There is a waiting list for an inpatient detoxification at Castel Hospital because there in only one acute admission ward with 21 beds.</td>
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<td>- Individuals may require a range of treatments such as medically assisted alcohol withdrawal and membership into service user support groups (10).</td>
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<td>Drug treatment options</td>
<td>Drug use and treatment options</td>
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<td>- Drug treatment should be available quickly to anyone who needs it (1). Every drug user in treatment has a personal care plan to assess their needs to ensure that individuals get tailored and the right treatment for their needs (1). - A wide range of treatment options should be offered including; advice and information, substitute prescribing, detoxification, needle and syringe exchange, residential rehabilitation, psychosocial interventions and alternative therapies. These should be delivered by NHS and voluntary organisations including drug workers, doctors, nurses, counsellors (1).</td>
<td>- CDAT provides substitute prescribing, psychosocial interventions, community detoxification, acupuncture and referral to inpatient detoxification and off island residential rehabilitation. Drug Concern provides advice and information, psychosocial interventions, alternative therapy, family support, needle and syringe exchange. - CAHMS provides structured psychosocial interventions for young people. Action for Children provides advice and information and referrals to structured treatment for young people. Drug Concern and Action for Children provide drug awareness in secondary schools, outreach work and make referrals to specialist services. - Supervised consumption only takes place in nurse led clinics by appointment In CDAT premises at Castel hospital.</td>
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<tr>
<td>- Referral to community drug treatment can be made by anyone including; GP, primary care staff and other health services, criminal justice services, other drug and alcohol services, family, friends and self-referral. Referrals to residential rehabilitation are usually made by drug workers and GPs via social services (12). - England has a quick access to treatment as part of the recovery ambition (13). The average wait is currently five days (14) and 96% of individuals start treatment within three weeks (1). Waiting times are monitored (15). - Increased investment in the UK has expanded the availability of drug treatment and cut the time people waited for it (1). - Drop in services and appointment cues (2) can reduce missed appointments and reduce waiting times (7).</td>
<td>- CDAT receives referrals from GPs, HSSD services and treatment providers. - GADAC operates an open referral system. The maximum waiting time for an appointment is usually no more than 48 hours. - CAMHS receives referrals from GPs, HSSD services for young people, the Youth Justice Service, the Education Welfare Service and Action for Children. CDAT and CAMHS do not accept self-referrals. - GP referrals to CDAT and CAHMS can take up to a fortnight. - Substitute prescribing may be delayed by four to six weeks due to limited appointments being available for observed consumption. - CDAT monitor when an individual is put on a waiting list and this is discussed at weekly multidisciplinary team meetings.</td>
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<tr>
<td>Access into appropriate treatment services (continued)</td>
<td>Current Guernsey situation relating to rapid open access and entry into appropriate treatment</td>
<td>Gap analysis</td>
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<td>- Positive and responsive services can reduce treatment drop outs (2).</td>
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<td>- Stakeholders believed the necessity to obtain referral from a GP to access the prescribing services was a barrier to accessing treatment. Waiting times to access substitute prescribing were also seen as a barrier.</td>
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<tr>
<td>- Rapid access to substitute prescribing can engage drug users more effectively and enhance early harm reduction (2).</td>
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<td>- Providing early follow-up appointments can improve early engagement with treatment (16).</td>
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<td>- Pharmacies providing supervised consumption work alongside GPs and drug services and aim to retain people in drug treatment (17).</td>
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<td>- Treatment needs to be made more accessible (3) this includes; support with transport (18), flexible access through extended opening hours (2) and childcare facilities (19).</td>
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<tr>
<td>- There needs to be a seamless referral service for individuals moving between providers to ensure continuity of treatment and care (8).</td>
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References

Developing the Guernsey treatment system for substance misusers: Factsheet 4: Delivery and evaluation of Identification and Brief Advice (IBA) for alcohol misuse

In UK, the Government previously advised that adults should drink less than 21 units per week for men and 14 units per week for women (1). These recommendations were updated to daily limits, advising against the regular consumption of more than 3-4 units per day for men, and 2-3 units per day for women (2). The UK Chief Medical Officers are currently reviewing all drinking guidelines.

Identification and Brief Advice (IBA) is a tier 1 intervention (3) and consists of simple structured advice (4). It is a short intervention aimed at individuals drinking above lower risk levels and drink at increasing risk and higher risk levels (4) and aims to motivate people to reduce their alcohol consumption (5). IBA can be used opportunistically in a variety of settings (6), initiated by front line health staff (5) and typically involves identification using a validated screening tool to assess alcohol consumption (5). Extended brief interventions utilise motivational interviewing approaches (7).

IBA is a simple cost effective approach (5) and is effective in reducing high risk levels of consumption to lower risk levels (4). IBA and the Alcohol Use Disorder Identification Test (AUDIT) screening tool have been rolled out across a number of countries (8). IBA has an international evidence base (9) with many trials proving the benefits of brief interventions (10). IBA can reduce weekly drinking by between 13% and 34% (11), and one in eight people who receive simple alcohol advice will reduce their drinking to lower risk levels (10). The SIPS alcohol screening and brief intervention (ASBI) research programme tested different levels of brief intervention with trials in primary health care, emergency departments and probation settings (12). The ‘eSBIRTes’ project has recently been piloted across European countries to test an early intervention tool in Emergency Departments (EDs) using a SBIRT (Screening, Brief Intervention and Referral to Treatment) for poly-drug users (13). The evidence is mixed on the additional benefit of providing extended brief interventions in healthcare settings and therefore IBA is recommended as a first step (6). There is limited evidence on the effectiveness of brief interventions for young people under the age of 16 (6).
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<thead>
<tr>
<th>UK guidelines around delivery and evaluation of Identification and Brief Advice (IBA) for alcohol misuse</th>
<th>Current Guernsey situation relating to delivery and evaluation of Identification and Brief Advice (IBA) for alcohol misuse</th>
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</table>
| **Identification**  
- IBA is aimed at risky drinkers with a typical AUDIT score of 8+ (5) and aims to provide individuals with an informed choice about their alcohol consumption (5) and motivate people to reduce their drinking (5).  
- Alcohol consumption is identified using a validated screening tool e.g. AUDIT (5) or Fast Alcohol Screening Test (FAST) (3). | **Identification**  
- IBA is aimed at individuals who require support around their alcohol use and aims to reduce drinking.  
- Screening tools are used to identify alcohol consumption in tier one and two services. Tools used include; AUDIT, FAST, Five shot, Cage, MAST and PAT where appropriate. | - Information and advice is provided substance misuse services, however it is not used in other settings, for example in primary care, hospitals and probation.  
- GPs do request information leaflets and signpost patients who require alcohol support but not detoxification to GADAC. However GPs do not provide IBA.  
- Healthcare professionals have received BDASG funded IBA training; however the training is not monitored and has not been evaluated.  
- Data are not currently collected and monitored for IBA.  
- Current IBA provision and delivery has not been evaluated. |
| **Delivery**  
- IBA is opportunistic (5) and provided in a variety of settings including; hospitals, occupational health, sexual health, needle exchange, pharmacies, dental surgeries, antenatal clinics, voluntary and community services, criminal justice services, social services, higher education and other public services (6). Research supports the use of IBA in numerous settings (14).  
- Professionals working in primary healthcare, emergency departments, drug and alcohol services and other healthcare services deliver IBA (3).  
- Staff who have had adequate training and have skills to deliver screening, brief advice and referral to specialist services (4). They should have access to recognised, evidence based packs (IBA guide, screening tool and self-help leaflets) (6). Staff may be required to meet competencies on Drugs and Alcohol National Occupational Standards (DANOS) (15).  
- IBA normally lasts around 5-10 minutes (4) and is usually delivered over one session (4).  
- IBA is delivered through the use of recognised evidence based resources e.g. FRAMES (feedback, responsibility, advice, menu, empathy and self-efficacy) (6). Potential harm, reasons for changing behaviour, health and wellbeing benefits and barriers to change are all discussed, with practical strategies to alcohol reduction and a set of goals are established (6). | **Delivery**  
- Drug Concern and GADAC provide IBA. CDAT is a specialist service.  
- Healthcare staff from Drug Concern and GADAC deliver IBA.  
- The BDASG funded and arranged training in IBA for GPs, substance misuse workers and other healthcare professionals.  
- Drug Concern provide 45 minute sessions. The number of sessions depends on the need of the individual.  
- Drug Concern provides advice and information, psychosocial interventions and alternative therapy. Advice is also provided over the phone. GADAC provides advice and information and psychosocial interventions. GADAC has over 120 different advice/information sheets and packs covering a whole range of subjects pertinent to issues with alcohol. It also has developed a workbook. |  
| **Monitoring**  
- The UK collects data on IBA. Read codes (primary care monitoring codes) are collected in primary care and from 2009 the National Alcohol Treatment Monitoring System (NATMS) started to collect IBA as an intervention delivered by alcohol services (4). | **Monitoring**  
- Data are not collected for IBA if a person only received one session or for phone interventions at GADAC. |  

- Current IBA provision and delivery has not been evaluated.
References


5. Alcohol Academy. [http://alcoholibacom/about/][Internet blog] [cited 4th November].


Drug use is associated with a range of health and social problems and treatment populations can change rapidly (1, 2). In response, health care services need to work closely together to ensure that the right treatment packages are available (1, 3). In the UK, health services including NHS drug treatment services and voluntary drug treatment providers work together with patients to provide an individual care and treatment plan (1).

There needs to be effective joint working between health care services to ensure that treatment is managed appropriately and successfully (4). The delivery of treatment is normally managed by one key individual, often referred to as a key worker, who is responsible for the overall care of the patient and plays an important role in co-ordinating the treatment process (5). They manage the treatment and care plan, liaise with a number of other individuals and services to provide a complete package of care (5) and are responsible for the sharing of appropriate client information between services (5). Every person in treatment should have a care plan that provides a tailored care package for their individual needs which is reviewed regularly (6).

Inter-agency working is important at all stages of the drug and alcohol treatment process (5, 6). This is particularly important for vulnerable groups and more complex cases such as; homeless people, poly drug users, pregnant women, adolescents and individuals with mental health issues (4, 7). Individuals may require different treatment options from different treatment providers including, residential rehabilitation, mental health trusts, community support groups and a community pharmacist (5). They may also require support for other issues including accommodation and employment, therefore it is important for services to work together to ensure that individuals move between services and get access to all the care that they require (8).

Good relationships ensure that information and data sharing policies are adhered to in accordance with confidentiality policies (5). In the UK, all drug and alcohol treatment data is collected through the National Drug Treatment Monitoring System (NDTMS) (9). This allows providers to record and evidence treatment and care being provided to the client (6). It also provides the ability to track an individual through the treatment system to ensure that they do not fall between any gaps (10).
<table>
<thead>
<tr>
<th>UK Guidelines around inter-agency working</th>
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<tr>
<td><strong>Structured treatment services</strong>&lt;br&gt;-Joint working across health and social care with access to psychosocial interventions is a key feature of effective treatment (3).&lt;br&gt;-In the UK there is valuable partnership working between statutory NHS drug treatment services and non-statutory and voluntary sector drug treatment providers (11).&lt;br&gt;-Individuals with severe mental health problems will have a named mental healthcare co-ordinator. Drug treatment providers usually contribute to elements of the mental health plan of care (12).&lt;br&gt;-In the UK, structured treatment facilities are available (such as residential rehabilitation) for those who find this approach more suitable. For example, where community intervention has previously failed, for people with poly-drug use issues and in cases of co-morbidity with significant physical, mental health or social issues (13).&lt;br&gt;-To ensure a continuation of effective service, providers work closely alongside acute care to ensure the right treatment is available on an individual basis (4).&lt;br&gt;-The more support an individual receives, the more consistent the care plan and the more informed the client is (5). Clients should be involved in their own treatment plan (14).</td>
<td><strong>Structured treatment services</strong>&lt;br&gt;-CDAT work closely with probation, social services, sexual health services and mental health services.&lt;br&gt;-Drug concern has a good working relationship with probation, children’s services and sexual health services.&lt;br&gt;-Structured treatment providers have no communication with off island residential rehabilitation.&lt;br&gt;-Drug Concern and GADAC have no communication with off island residential treatment.</td>
<td><strong>Structured treatment services</strong>&lt;br&gt;- There is some evidence of effective joint working between Guernsey’s substance misuse treatment providers and other support services.&lt;br&gt;-However there is minimal communication with other structured treatment services with no opportunities for discussions relating to individual clients i.e. care plans belong to the agencies.&lt;br&gt;-There is no communication with off island rehabilitation services. Clients are not provided with information or opportunities to access alternative off island treatment services or aftercare approaches.&lt;br&gt;-There is unclear effectiveness of residential treatment and provision of aftercare for clients exiting rehabilitation.</td>
</tr>
<tr>
<td><strong>Community pharmacist</strong>&lt;br&gt;-In the UK, pharmacists provide a significant point of first contact with patients and they make an important contribution to shared care arrangements with substance misuse (15).&lt;br&gt;-Pharmacists work closely with GPs and drug services to provide a consistent effective range of services throughout the treatment process (16). Incorporating pharmacists in shared care arrangements may increase availability of primary and structured drug services and decrease waiting time for drug treatment (16).&lt;br&gt;-Pharmacists supervise consumption and offer harm reduction advice and services alongside providing a therapeutic relationship (16).</td>
<td><strong>Community pharmacist</strong>&lt;br&gt;-Supervised consumption is not provided.&lt;br&gt;-One pharmacy on the island sells needles, syringes and sharps bins; however there is no free needle and syringe provision in the community pharmacies.&lt;br&gt;-The pharmacy does not offer harm reduction advice.</td>
<td><strong>Community pharmacist</strong>&lt;br&gt;-There is some effective inter-agency working practices carried out on the island however there is no evidence that pharmacists have an active role in the shared care of drug misusers in terms of supervised consumption.&lt;br&gt;-There are limited shared care arrangements and therefore there may be delays in availability and services.&lt;br&gt;-There is no free needle and syringe provision in the community pharmacies.</td>
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<td><strong>General Practitioners</strong></td>
<td>-GPs communicate with structured treatment providers by post. -CDAT will inform a GP if a patient is no longer accessing substitute prescribing, however they can register with more than one GP without informing CDAT. -There is no formal shared care arrangements linking GPs with treatment services and no substance misuse workers or GPs with special interest in primary care. -GPs liaise with treatment providers to varying extents. There is no guidance for GPs for managing patients who do not wish to engage with CDAT.</td>
<td>-If a client was accessing more than one treatment service it is probable that it would not be known. -There is no provision for substance misuse workers or GPs with special interest in substance use. -There are no structured shared care arrangements. However several GPs are interested in developing shared care protocols with CDAT.</td>
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<td>-GPs are responsible for providing general medical services for drug misusers (1). -Each local authority should have at least one practitioner trained in substance misuse (1). GPs should work closely with structured treatment services for patients requiring support for their substance use (5). -Individuals can contact their GP for support with substance misuse, particularly if they do not want to engage with drug treatment services (1).</td>
<td><strong>General Practitioners</strong></td>
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<td><strong>Data recording and monitoring</strong></td>
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<td>-An effective treatment system does not require providers, GPs and primary care staff to have direct access to each other’s electronic systems. It requires good communication between all services involved in the care of a client. Relationships are developed through robust information governance and data sharing policies and protocols (17). -All drug and alcohol treatment services must have a clear confidentiality/data handling policy, which is understood by all members of staff (17). -In England, all alcohol and drug treatment data are collected through the National Drug Treatment Monitoring System (NDTMS). This allows providers to record the full package of treatment and care being provided to the client (9).</td>
<td>-Systems currently used by providers do not capture a core data set that could be used for international comparison. It is understood that TrakCare and Daisy have the potential to be modified. Excel spread sheets and paper-based systems are currently used to record client information. -There is no common CDS with consistent definitions, therefore data may be recorded differently from provider-to-provider and may even be inconsistent within treatment services. -Tools used to measures treatment outcomes vary from provider-to-provider (e.g. Treatment Outcomes Profile (TOP), Outcomes Star) or they are not used at all. -Data sharing protocols are not consistently applied across services. Providers are reluctant to share client information with other agencies, even if clients have given consent, due to concerns about confidentiality and particularly due to the small population size.</td>
<td>-GPs and other primary care staff have expressed a wish for better information sharing. -Current data systems are not considered to be robust data capture tools. -Data may be recorded differently from provider to provider and/or within service. -Guernsey is currently in the process of creating core data recording system for drug treatment services. This should positively impact the way different services work together.</td>
</tr>
</tbody>
</table>
References

Drug and alcohol misuse can burden young people through its impact on their education, health and their families (1). It can affect their opportunities and ‘long term chances in life’ (1). Young people’s drug and alcohol use requires a different approach to target and support them, distinct from adult services (2). Strategies and services targeted at young people need to be provided as part of a broad range of support (2) and offered as early as possible (1). In the UK, there are a number of strategies for reducing substance misuse among young people including; community based approaches, prevention and early intervention schemes, and specialist support services (2, 3).

The UK drug strategy outlines prevention and education as a key approach embedded in a much wider framework of social action to address the needs of young people. It focuses on the need to provide extra support in a child’s early life, through programmes designed to support families to give children ‘the best possible start in life’ (1). All young people should have access to ‘good quality’ education around drugs and alcohol. Schools play an important role in this by providing young people with the knowledge, skills and confidence to reduce the risk of them engaging in risky behaviours including alcohol and drug use (1). Community based interventions take place in the community, schools and youth services and also aim to reduce risk (4).

Vulnerable and disadvantaged young people are more at risk of misusing drugs and alcohol; particular groups at risk include young people who are: looked after children, excluded from school or play truant, homeless, sex exploited, involved in crime, have behavioural, mental health or social problems or if they come from families who misuse substances (4). Vulnerable young people require more targeted prevention and early intervention (1). Young people who are experiencing harm through their alcohol and drug use and are at risk of becoming dependent should have rapid access to structured treatment (1). Specialist young person’s treatment services work to reduce harm caused by drug and alcohol use and prevent it continuing into adulthood (2). Treatment services work in partnership with youth offending, mental health and children’s services to provide a multi-agency package of care to prevent further harm (1).
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>- In England, guidelines recommend that local strategic partnerships, practitioners, educational services, parents and carers should liaise and work closely together to provide support to young people (5).</td>
<td><strong>Prevention programmes</strong> - The Drug Education and Training Worker (Drug Concern) and the Youth Alcohol Worker (Action for Children) deliver drug and alcohol awareness and education in all secondary schools. The programme is monitored and evaluated. - STAART is a health promotion programme aimed at preventing alcohol misuse amongst 11-15 year olds. The aim of the programme is to encourage all young people to postpone alcohol use until adulthood. It also aims to increase parent and child communication. - The Solomon Theatre Company performs the ‘Last Orders’ play and workshop to all year nine students. The performance tackles the subjects of underage drinking and alcohol and the links with anti-social behaviour, teenage pregnancy, STIs and illegal purchase of age restricted products. - MPACT is a preventative programme for young people. It seeks to reduce the risk factors associated with the uptake of substance misuse. - GPP is an early intervention home visiting programme for families at risk of poor health and social outcomes. The programme commences early in the antenatal period and continues until the child is two. The work is multi-disciplinary and involves liaison and co-working with a range of professionals and services.</td>
<td>- There are a number of prevention schemes running in schools. - Treatment providers carry out community based activities to raise drug and alcohol awareness. - Health care professionals highlight that there is still a need for more education around the harmful effects of alcohol on the adolescent brain and the dangers of pre-loading. - Specialist services work closely with children and young people that require specialist support. - Treatment providers work in partnership with other services. - Support is provided to families of young people who misuse drugs and alcohol.</td>
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<td>- Prevention programmes are carried out in schools with specific guidelines for schools on how to provide education to reduce and prevent alcohol and drug use (6).</td>
<td><strong>Community and structured programmes</strong> - The Drug Education and Training Worker (Drug Concern) and Youth Alcohol Worker (Action for Children) provide outreach services in partnership with community organisations to engage young people in their own setting. - CAMHS provide structured treatment for young people under the age of 25 years. Psychosocial interventions are delivered by a Young Person’s Substance Misuse Treatment Nurse and substitute prescribing is available through CDAT. - Drug Concern provides tier two advice and information for young people and takes referrals from HSSD young people’s services. - Action for Children provides a service for disadvantaged young people aged 16 to 21 years. Trained staff provide tier two advice and information and make referrals to structured treatment providers where appropriate. The service also runs activities and programmes and works together with other agencies to address young people’s needs in relation to housing, education, training and employment, criminal justice and health and wellbeing.</td>
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<td>- The Early Intervention Grant was created in the UK to reach and support vulnerable groups who misuse substances (7). Schemes include ‘Troubled Families’ and the school based prevention programme ‘Family check-up’ (8).</td>
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<td>- Specialist support services are available to all young people who already have a substance misuse problem or are at risk of becoming dependent (5). Services and interventions are integrated with community activities to involve families and provide wider education (6).</td>
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<td>- The main interventions offered in the UK include: <strong>Drug and alcohol education services</strong> provide accurate information on drugs and alcohol through drug education as well as targeted information from the TALK to FRANK service (6).</td>
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<td><strong>Family Intervention</strong> offers a family based programme of structured support over two or more years, drawn up with parents or carers and trained staff (3).</td>
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<td><strong>Behavioural Intervention</strong> offers group based behavioural therapy to children who are persistently disruptive and deemed high risk. Group based training for parental skills is also provided (3).</td>
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<td><strong>Motivational Interviews Intervention</strong> is aimed at vulnerable and disadvantaged young people who are problematic substance misusers. It is carried out by trained practitioners (9).</td>
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References

Developing the Guernsey treatment system for substance misusers: Factsheet 7: Treatment interventions for offenders in the community and in prison

There is a complex relationship between drug use and crime, and drug users are likely to be involved with the criminal justice system at some point in their lives (1). A high proportion of prison admissions are from people who have recently taken drugs (2) and individuals who are alcohol dependent are more likely to be involved with the criminal justice system (3). Poly-drug use is common among offenders entering custody (4). Although there is less injecting drug use in prisons, where it does occur, sharing of equipment is more likely (5) and imprisonment is associated with blood borne viruses (BBV) (hepatitis B and C, and HIV) (6).

The Criminal Justice System (CJS) works to help drug users tackle their drug and alcohol related problems. Prisons provide an opportunity to engage drug users in effective treatment at the earliest possible opportunity (7). Benefits to accessing treatment include lower levels of drug and alcohol related crime (7) and successful treatment can lead to significant reductions in offending levels (8). Effective treatment provides the “opportunity for drug using offenders to recover, rebuild their lives and reintegrate back into society upon release” (1). The Integrated Drug Treatment System was introduced to provide a consistent, evidence based, individual focused system across England to ensure that all problem drug users in prisons have “access to the same quality of treatment as those in the community” (1).

In the UK, drug treatment in prisons is considered more effective when pharmacological and psychosocial support are used together (9). Detoxification and maintenance programmes are key treatment modalities (4) and research highlights the benefits of implementing substitute prescribing (10) and harm reduction approaches (11). Vaccinations against hepatitis B are well established in prisons (12). Alcohol treatment in prison is less developed than drug treatment in England (13); however individuals should have access to screening and assessment, detoxification, one to one and group sessions, structured treatment and service user groups such as Alcoholics Anonymous meetings (14).

Prison may not always be the most appropriate place for offenders to tackle their drug and alcohol dependence (15). The Ministry Of Justice aims to integrate criminal justice services with health and community services to address the need of offenders, identify non-custodial options (2) and ensure that offenders are encouraged to seek treatment at every opportunity during their contact with the CJS (15). The availability and quality of drug treatment for offenders serving their sentence in the community has improved with the introduction of criminal justice drug programmes (1). The Drug Interventions Programme (DIP) aims to encourage more people into treatment (7) and brings together local services to provide a tailored and structured treatment for drug using offenders (1). Continuity of care is vital to treatment and support (1), particularly as opiate drug users have an increased risk of overdose during the first week of release from prison (16). A key aim is to ensure that there is consistent and seamless transition for individuals moving between prison and community services (15).
### UK Guidelines around treatment interventions for offenders in the community and in prison

**Prison provision**
- Prisoners should have access to the same treatment options as people in the community (17). Access to and choice of treatment should be the same whether people attend treatment voluntarily or are required to attend as part of a court order (18).
- There should be joint working and case management between clinical teams, Counselling Assessment Referral Advice and Throughcare (CARAT), Community Justice Integrated Teams (CJITs) and prisoners, which is care planned and reviewed (18).
- Special attention should be given during the early stages of custody (19); the UK recommends a minimum of 28 days open intervention of psychosocial support (18).
- Interventions in prison include; advice and information, blood borne virus (BBV) services, prescribing and psychosocial programmes (20).
- Structured programmes in prison include; Cognitive Behavioural Therapy, 12 step programmes and Structured Therapeutic Community (4). Voluntary compact drug testing provides an incentive for people in prisons to stay drug free (4).
- Opiate dependent prisoners should be stabilised on a licensed opiate substitute medication, followed by standard or extended detoxification (18). Community maintenance programmes should be continued in prison (18). Opiate users on longer sentences should be encouraged and supported to achieve abstinence (21).
- Assessment for alcohol withdrawal should begin in prison reception (all prisoners with a history of heavy alcohol consumption) (18). Alcohol detoxification should be managed with chlordiazepoxide (18). For opiate and alcohol dependence, alcohol detoxification should be completed before an opiate substitute is prescribed (18). Individuals should have access to screening and assessment, detoxification, one to one and group sessions, structured treatment and Alcoholics Anonymous meetings (14).

### Current Guernsey situation relating to treatment interventions for offenders in the community and in prison

**Prison provision**
- Drug concern has a prison substance misuse worker (PSMW) (22). The PSMW delivers structured psychosocial interventions and a drop-in service for prisoners and aims to access each prisoner in a week of them entering prison. Group sessions run four times per year (and mini-groups when needed). Programmes are followed up with one to one structured work with the PSMW. The group work is monitored and evaluated.
- Psychosocial interventions are provided and include motivational interviewing and relapse prevention. Interventions use a harm reduction and integrative counselling approach.
- The same interventions are provided for alcohol and drug treatment.
- BBV services are provided through a vaccination clinic available to all prisoners offering hepatitis B (and if applicable hepatitis A) vaccinations. BBV screening is offered to all prisoners and positively promoted. Testing for STIs is offered as appropriate, individuals who test positive for hepatitis C are referred to the Orchard Clinic (STI clinic) for treatment by a virology specialist.
- Healthcare is provided in the prison, the nursing team provides services including regular nurse led clinics and detoxification.
- Sentenced prisoners are routinely detoxified during the first few weeks of their sentence, including those who were engaged in treatment prior to entering prison.
- Prisoners on remand have access to substitute prescribing by visiting HSSD doctors with consumption supervised by a primary care nurse. The prison GP also

### Gap Analysis

**Prison provision**
- It must be noted that Guernsey has a much smaller drug/alcohol using prison population than the UK. It must also be noted that the Guernsey prison population has offences linked to importation rather than drug use.
- Treatment providers and criminal justice agencies work together, however not all treatment options are accessible to offenders. Prisoners do not have the same access to and choice of treatment as in the community.
- Community maintenance programmes are not continued.
- Prisoners do not have access to service user groups such as Narcotics (they do have access to Alcoholics Anonymous).
| prescribes and manages substitute prescribing for prisoners.  
<p>| -GADAC has a Criminal Justice Alcohol Service worker who conducts assessments of offenders who have committed an alcohol-related offence and face a custodial sentence. This may form part of a Social Enquiry Report which assists Probation Officers in making a recommendation of sentence to the court. |</p>
<table>
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</table>
| **Community provision** | - Community support is provided as an alternative to custody as part of a court order and as a condition of bail and release. Offenders can attend community treatment as part of an order. Offenders have the same access to community clinical treatment as other members of the community including substitute prescribing and psychosocial programmes.  
- CIIT teams are based in the community and work in police custody and courts to provide a gateway into treatment for offenders with drug problems including recently released prisoners (23).  
- DIP requires agencies to work in partnership to provide a tailored treatment for offenders with drug problems (1).  
- Drug Rehabilitation Requirement (DRR) is part of a community sentence for offenders to address drug use and how it affects them and others (1).  
- Test on arrest and required assessment provides police with the option to drug test adults arrested for specific offences. If an adult tests positive for heroin or cocaine police can require them to attend an assessment with a drug worker (1).  
- Restrictions on bail can deny an offender bail if they test positive for heroin, crack or cocaine, unless they agree to attend treatment (1).  
- Offenders can receive an Alcohol Treatment Requirement as part of a community order. They are required to attend probation and alcohol treatment (24). Probation provide alcohol screening, advice and information and referral to specialist treatment (25).  
- The Transforming Rehabilitation strategy for reform (26) proposes that all offenders released from custody should have statutory supervision and access to rehabilitation.  
- CARAT teams case manage and liaise with relevant services to ensure that drug related needs are identified pre-release and appropriately addressed post release to develop a holistic support package (18). Residential treatment is considered for people who have decided to remain abstinent after release (17). | - Community provision  
- An offender may be required to attend treatment as a condition of post release supervision, or as a condition of a suspended or community sentence.  
- Treatment services deliver initiatives to tackle drug and alcohol related offending in partnership with the probation service (CIAS, CJDS).  
- Drug Concern has a Criminal Justice Drug Service (CJDS) worker who delivers treatment at the probation office to offenders sentenced to community orders which include a treatment requirement and operate an arrest-referral service at the police station. They deliver structured psychosocial interventions and a drop-in service for prisoners and provide testing on an individual basis as recommended as additional conditions in licence or supervision orders. They work with the probation service to identify offenders for treatment and report to the probation service on offenders’ compliance with treatment. GADAC has a criminal justice alcohol worker (CIAS) who also works at the probation office undertaking similar integrated risk management plans, including alcohol testing as a condition of a supervision or post custodial licence.  
- Parolees are not expected to access needle and syringe exchange services. A condition of their parole is that they remain drug free. If they access needle and syringe exchange services, their probation officer may be informed leading to a potential breach of conditions.  
- Offenders can access residential rehabilitation upon release however this is rare and limited.  
- Drug Concern’s PSMW shares prisoners’ care plans with | - Community provision  
- There are no specific community programmes to divert people at the earliest opportunity.  
- Offenders do not have the same access to community treatment.  
- Needle exchange services available to parolees are limited by the current practice of notifying the supervising officer if a parolee is accessing needle exchange. Parolees may resort to sharing needles or other injecting equipment.  
- There is limited access to residential rehabilitation for offenders upon release.  
- There is good joint working between
| the Offender Management Unit and agree treatment goals. The PSMW works alongside the CJDS and CJAS workers to facilitate transition to continued structured psychosocial intervention in the community upon release from prison. -CDAT, Drug Concern and GADAC work with Probation. GADAC has a criminal justice worker (CJAW) who liaises with CDAT and probation. | services to provide support for prisoners post release. |
References
Developing the Guernsey treatment system for substance misusers:
Factsheet 8: Delivery of recovery-oriented treatment

The UK Coalition Government’s drug strategy sets out a new approach for tackling drug and alcohol dependence by focusing on a full recovery orientated system. The approach is based on three principles; wellbeing, citizenship and freedom from drug dependence (1). The strategy sits within the broader aims of the Coalition Government to build a social recovery through early intervention, strengthening families, welfare reform and rehabilitation (2).

The strategy outlines the Government’s intentions to not only reduce the harms caused by drug and alcohol dependence (2), but to offer every opportunity for people to choose recovery as their treatment goal (2). The strategy determines that treatment must now enable individuals to achieve a ‘full and sustainable recovery’ (1); but noting that there is not a ‘one size fits all’ treatment journey (3). Within the structures of a recovery orientated approach, individuals need a person centred tailored treatment pathway to address their specific needs and a package of support to maximise their chance of recovery (2); therefore a balanced treatment system is needed to achieve recovery orientated outcomes (3).

The Recovery Orientated Drug Treatment (ROTD) Expert Group was formed to determine how drug treatment in England can be re-orientated towards a clear pathway for recovery and abstinence and meet the aims of the drug strategy (4). The Group acknowledges that well-delivered Opioid Substitution Therapy (OST) has an important role in stabilising drug use and the potential to support early steps to recovery. They suggest that for other people, active support for detoxification, followed by relapse prevention may be more appropriate. Residential rehabilitation has been acknowledged to be an important part of drug and alcohol treatment and available as an option to anyone who may need it (5). Within a recovery orientated model, they emphasise the need for treatment to be seen as a platform that provides opportunities for individuals to safely move towards full recovery from drug dependence (4). The ROTD Expert Group highlight that people entering treatment will have different levels of ‘recovery capital’ (their level of personal and other resources) and caution against arbitrary or premature disengagement from OST (4).

Specialist alcohol treatment in England has also adopted a recovery focus. Recovery can be promoted in high quality alcohol services through integrated treatment that involves family and carers, and includes coordinated care and reintegration support (6). Individuals seeking alcohol treatment should be offered interventions to promote abstinence and prevent relapse as part of a structured community based or inpatient treatment (7). Abstinence is considered the appropriate goal for individuals accessing specialist treatment for alcohol dependence (7). For individuals requiring a withdrawal from alcohol, medications to prevent relapse should be considered in combination with psychosocial interventions (7). Mutual aid support groups provide a community support network (6).

For all individuals entering recovery orientated drug and alcohol treatment it is essential that ongoing recovery support is available and based on individual needs (4). Long term monitoring through regular reviews, and early intervention for those who relapse will reduce time spent in treatment and improve longer term outcomes (8).
### UK Guidelines around recovery orientated treatment

**Recovery options**
- Clinicians, and people in treatment need to be aware of the range of options available for residential and non-residential rehabilitation, their benefits and how they might be used at different phases of the treatment journey (4, 9).
- For recovery orientated treatment, a combination of interventions is most likely required depending on the needs of the individual.

* **Drug dependence**
  - For heroin dependence this should include OST for early stabilisation or active support for detoxification and relapse prevention where appropriate (4).
  - ROTD Expert Group specifies three levels of care: standard; enhanced (those with particular social needs or with a high level of motivation); intensive (for those who fail to derive substantial benefit from enhanced care) (4).
  - Standard packages of care could include community detoxification, keyworking and low intensity psychosocial interventions (4).
  - Intensive packages of care could include in-patient and medically-monitored residential detoxification, residential rehabilitation, structured community rehabilitation programmes, contingency management and peer support and role-models. Support should also be provided for employment, family and social networks and for housing problems (4).
  - Enhanced packages of care could include psychosocial interventions (4).
  - Naltrexone may be prescribed for people who are motivated to remain in an abstinence programme (10). This should be carefully discussed and planned with experienced health professional (10).

* **Alcohol dependence**
  - Packages of care should be delivered based on individual need incorporating psychological interventions; medically assisted withdrawal (community-based, inpatient or residential depending on severity of dependence); relapse prevention medication; mutual aid, peer support and re-integration support; and aftercare (6).
  - Relapse prevention medication should be prescribed where appropriate following a successful alcohol withdrawal (acamprosate, disulfiram or oral naltrexone) (6).

### Current Guernsey situation relating to recovery orientated treatment

**Recovery options**
- Guernsey’s treatment providers adopt both harm reduction and abstinence-based approaches.
- Disulfiram, acamprosate or naltrexone is prescribed for relapse prevention following alcohol withdrawal.
- There is no consistent approach to following-up clients who have exited treatment, whether successful or unplanned, and little further contact is made in some cases.
- There appears to be little or no provision of aftercare following treatment completion.
- There are no service user groups or recovery networks on the island. It is likely to be difficult to foster a recovery community due to people’s fear of the associated stigma.
- There is an Alcoholics Anonymous group and an Al-Anon group for families and others concerned about others alcohol use.
- There is limited access to residential rehabilitation.

### Gap analysis

**Recovery options**
- There is no consistent approach for aftercare following treatment completion in Guernsey.
- There are no community support groups or service user groups such as Alcoholics Anonymous (only for family).
- Not all treatment options are available to everyone.
- Rehabilitation is not offered to everyone.
- There is limited information about and access to residential rehabilitation.
**UK Guidelines around recovery orientated treatment**

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| - Drug and alcohol treatment is not expected to deliver recovery independently and can benefit from an integrated approach with other forms of psychosocial support (11). To promote recovery from alcohol dependence, NICE recommends that families and carers of people who misuse alcohol have their own needs identified.  
-Vital elements in an effective journey of treatment and recovery include:  
* properly assessing and regularly reviewing an individual’s needs (4).  
* planning treatment to respond to these needs as they change during treatment (4).  
* using a range of tailored interventions (4).  
* arranging treatment quickly for those new in treatment (4) (the greatest improvement is achieved during first three months (4).  
* providing options based on need, for example residential rehabilitation may be required for individuals ready for an active change and higher intensity treatment (4).  
* ensuring that there is a rapid and clear route back into structured treatment if an individual experiences difficulties in maintaining their recovery (4).  
* ensuring there is a clear long term aftercare plan (4).  
* creating a system that provides continuity of care between prison, residential and community environments (4).  
- It is important to ensure exits from treatment are visible to patients from the start. Enough information should be provided for them to understand what might comprise a treatment journey (9).  
- Individuals who have successfully completed treatment should be made visible by linking the service to a recovery community (4, 12). Former service users can be employed or can volunteer as recovery mentors and coaches (13).  
- Organisation of recovery orientated alcohol services should take into consideration the perceived stigma of treatment for alcohol dependence (2). | - Care plans are individually tailored to clients’ needs and may include recovery. For example, controlled drinking programmes which focus on harm reduction advice and information differ from abstinence-based programmes followed in residential rehabilitation.  
- It appears that recovery is more likely to be presented to new clients as an option, rather than to clients who have been accessing services for several years. Recovery is not presented as an option to all clients engaged in treatment.  
- Treatment providers’ expectations of their clients, based on their knowledge of clients’ histories, may inadvertently play a role in determining clients’ treatment goals. | - There appears to be a lack of aftercare planning which is essential in the journey to recovery.  
- There is a lack of communication and continuity between services that provide holistic support in recovery.  
- In Guernsey there is a stigma associated to recovery which prevents individuals accessing a peer or community support group which can be vital in this process.  
- Recovery is not presented as an option to all clients engaged in treatment. |
References

8. Scott C and Dennis M. Results from two randomized clinical trials evaluating the impact of quarterly recovery management checkups with adult chronic substance users. Addiction. 2009;104(959-971).
Recommendations

Following consultation with the Bailiwick Drug and Alcohol Strategy Group (BDASG), the group formed the following recommendations:

Prescribing, dispensing and supervised consumption

- Develop a shared care protocol between GPs and CDAT
- Explore the feasibility of developing a GP with special interest in drugs and alcohol role. Have at least GP with one special interest in drugs and alcohol based in each of the three health groups
- Conduct a review of OST prescribing, including a full review of DHC prescribing and licensing practices
- Identify if there is a need and explore the feasibility of a dedicated primary care liaison worker/addictions counsellor. Conduct a scoping exercise to identify levels of drug and alcohol users being treated within primary care and explore data capture of these patients and support they receive
- Conduct a review of Benzodiazepine prescribing practices and identify any requirements for training
- Roll out supervised consumption in pharmacies
- Provide harm reduction training for pharmacy staff to provide harm reduction advice and consider the development of needle exchange service with data capture

Rapid access and inter-agency working

- Establish a single point of access for a referral into treatment
- Develop a better suite of integrated services facilitated by regular network meetings
- Conduct a scoping exercise to identify and review current referral procedures and treatment start dates to identify duration of waiting lists. Decide on a benchmark for waiting times.
- Ensure individuals can access other forms of treatment whilst on waiting lists
- Explore the feasibility of an alternative referral process for GPs
- Continue to develop integrated monitoring systems and consistent data capture
Brief Interventions

- Work with primary care colleagues to audit BI practice and establish training needs and explore a system for data collection
- Provide BI training and materials (information packs and flowcharts) to primary care colleagues

Young people

- Audit the referral process from statutory services to community programmes and raise awareness of what programmes are available
- Conduct a pilot media campaign to raise awareness (in adults) of full effects and harm of alcohol on the brain
- Identify vulnerable young people and ensure they are signposted for early intervention programmes

Criminal justice

- Ensure that all parolees are provided with the full information regarding services they can access. Inform them that services including needle exchange are confidential
- Establish a task and finish group to audit the drug and alcohol offending journey in and out of prison
- Develop an integrated protocol to meet the needs of drug and alcohol using offender to reduce risks
- Identify and fund a project manager to set up project of community activities to support full recovery

Recovery-oriented treatment

- Explore the need for a tier 4 service model to ensure that tier 4 inpatient treatment and rehabilitation are available with a full aftercare programme
- Explore and pilot additional premises for community detoxification services
- Ensure that all treatment options are made available to all individuals and abstinence is always presented as an option