

# Models of care for treatment of adult drug misusers: Update 2006



National Treatment Agency for Substance Misuse

July 2006



## The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

## Reader information

<b>Document purpose</b>	An update of Models of Care for Treatment of Adult Drug Misusers (2002) to provide national guidance on the commissioning and provision of treatment for adult drug misusers
<b>Title</b>	Models of Care for Treatment of Adult Drug Misusers: Update 2006
<b>Lead authors</b>	National Treatment Agency for Substance Misuse
<b>Publication date</b>	July 2006
<b>Target audience</b>	Managers, joint commissioners, providers and users of drug treatment services
<b>Circulation list</b>	See above
<b>Description</b>	Models of Care for Treatment of Adult Drug Misusers: Update 2006, to inform the commissioning and provision of drug treatment in England
<b>Cross reference</b>	Models of Care for Treatment of Adult Drug Misusers (NTA, 2002) NTA Business Plan 2005/06 (NTA, 2005) NTA Treatment Effectiveness Strategy Briefing 2005–08 (online at <a href="http://www.nta.nhs.uk">www.nta.nhs.uk</a> ) Treating Drug Misuse Problems: Evidence of Effectiveness (NTA, 2006)
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<b>Gateway/ROCR approval</b>	Gateway clearance number: 6751



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## 1 Introduction

Models of Care for Treatment of Adult Drug Misusers (NTA, 2002)<sup>1</sup> – hereafter Models of Care 2002 – set out the national framework for commissioning the treatment of adult drug misusers in England, describing best practice in drug treatment provision. The NTA has carried out two phases of extensive and wide-ranging consultation (in 2004 and 2005) on an update of Models of Care 2002, involving commissioners, service providers, service users and other key stakeholders in the field. The resulting updated document is Models of Care for Treatment of Adult Drug Misusers: Update 2006 (hereafter Models of Care: Update 2006).

This update is intended to build on the framework and concepts in Models of Care 2002 rather than replace them. It requires drug treatment commissioners and providers to have implemented the key tenets previously described in Models of Care 2002, including:

- The four-tiered model of commissioning
- Local screening and assessment systems
- The care planning and co-ordination of care at the heart of structured drug treatment
- The development of integrated care pathways.

This update is written in a similar format to Models of Care: Part 1 (2002), and is intended to fully replace it. Models of Care Part 2: Full reference report (2002), summarises much of the evidence base and is still relevant as a valuable reference source.

Models of Care: Update 2006 also incorporates the new strategy to improve the quality and effectiveness of drug treatment. The Treatment Effectiveness strategy, launched in 2006, has cross-government approval and provides a greater focus on improving clients' journeys through more effective drug treatment and reintegration into local communities (housing, education and employment). The two main "units for improvement" for improving treatment effectiveness are local commissioning partnerships and the providers of drug treatment.

While the NTA does not have statutory responsibility regarding drug treatment in prisons, the local primary care trusts do have responsibility for commissioning clinical services. The National Offender Management Service (NOMS) has committed to ensure alignment of services and the implementation of relevant key concepts from Models of Care: Update 2006 in prisons.

Models of Care: Update 2006 outlines:

- The policy context and rationale for updating Models of Care 2002
- The key differences between Models of Care 2002 and Models of Care: Update 2006
- The context of improving treatment effectiveness and improving clients' journeys

- A reiteration of the four tiers
- Updated information on assessment, care planning and integrated care pathways
- Definitions of the full range of treatment interventions in the context of local treatment systems
- Draft quality requirements, which are in line with the NHS policy and performance management structures
- Key references.

This update should be viewed in the context of the NHS Improvement Plan: Putting People at the Heart of Public Services (2004)<sup>2</sup> and the Department of Health's (DH) Standards for Better Health (2004).<sup>3</sup> Models of Care: Update 2006 supports development "standard D2", described in Standards for Better Health (2004), which will be used as the basis of Healthcare Commission and NTA Improvement Reviews of drug treatment. Implementing Models of Care: Update 2006 will contribute to the Government's Public Service Agreement (PSA) target to:

*"...increase the participation of problem drug users in drug treatment programmes by 55 per cent by 2004 and by 100 per cent by 2008, and increase year on year the proportion of users successfully sustaining or completing treatment programmes."*

This final version of Models of Care: Update 2006 is accompanied by a suite of documents, including:

- A separate report, Treating Drug Misuse Problems: Evidence of Effectiveness (Gossop, 2006),<sup>4</sup> reviews the current evidence base. This is not included in detail in Models of Care: Update 2006
- Additional linked guidance on care planning – Care Planning Practice Guide (NTA, 2006)<sup>5</sup>
- A summary for service users and carers (due in summer 2006).

Separate guidance, Models of Care for Treatment of Adult Alcohol Misusers, is due for publication in 2006 following an extensive consultation period. While there are important differences from this document, the overall framework for commissioning treatment services, the division into four tiers of interventions, the description of levels of assessment that can be used and the focus on effective co-ordination of care through care planning are reiterated and remain consistent for both drug and alcohol treatment service provision. Development of integrated care pathways, high-quality commissioning and service delivery, in response to assessments of need and consideration of evidence for effective interventions, are also consistent between the two documents.

## 2 Policy and context

### 2.1 Good-quality drug treatment is effective

National and international evidence consistently shows that good-quality drug treatment is highly effective in reducing illegal drug misuse, improving the health of drug misusers, reducing drug-related offending, reducing the risk of death due to overdose, reducing the risk of death due to infections (including blood-borne virus infections) and improving social functioning. Key references for the effectiveness of drug treatment include the Taskforce Review (Department of Health, 1996),<sup>6</sup> the National Treatment Outcome Research Study (1995–2000)<sup>7</sup> and Treating Drug Misuse Problems: Evidence of Effectiveness (NTA 2006).<sup>4</sup>

### 2.2 Significant improvement in access to and capacity in drug treatment since 2001

Funding for drug treatment has increased significantly since 2001 and has received substantial investment in the last five years. This investment has achieved a rapid expansion in drug treatment to achieve the Government's PSA target to double the number of drug misusers in effective, well-managed drug treatment by 2008. The drug treatment workforce has also grown significantly, from just over 6,000 practitioners and managers in 2002 to over 10,000 in March 2005.

The Audit Commission report Drug Misuse 2004,<sup>8</sup> recognised the impressive progress in the drug treatment system since 2002, including the increased capacity of local drug treatment services, better working partnerships between local agencies, and more integrated services.

The wide variation in access to different types of treatment – as referred to in an earlier Audit Commission report, Changing Habits (2002)<sup>9</sup> – has been largely tackled, with the implementation of Models of Care 2002 leading to a good range of drug treatment services now available in most areas in England.

In 2002, the Audit Commission reported drug treatment as being characterised by lengthy waiting times in most areas. In December 2001, the average national waiting time across all types of treatment was 9.1 weeks. This had been reduced to a national average of 2.3 weeks by June 2005. Furthermore, lower average waiting times were achieved for all clients in intensive Drug Interventions Programme (DIP) DAT areas (1.85 weeks in June 2005).<sup>10</sup>

### 2.3 Drug treatment population trends

Data analysis from the National Drug Treatment Monitoring System (NDTMS) for 2003/04 produced the following key findings on clients in contact with structured drug treatment services.

- In 2003/04, 125,545 individuals were reported to the NDTMS as receiving structured drug treatment. This figure has been revised from the figure published in September 2004 after resubmissions and corrections to the data received during 2004/05
- Heroin was identified as the main problem drug for over two-thirds (67 per cent) of clients receiving drug treatment
- Where heroin was a client's main drug of misuse, 21 per cent reported crack or cocaine as the second drug of misuse
- Of clients reporting crack or cocaine as their main drug of misuse, 13 per cent reported heroin as their second drug of misuse
- Cannabis was reported as the main problem drug for clients under 18 (61 per cent), while the figure for adults was nine per cent. One-fifth (20 per cent) of individuals under 18 reported heroin as their main problem drug, five per cent reported crack or cocaine
- There are notable regional differences in the proportions of individuals receiving drug treatment with crack or cocaine recorded as the main problem drug. This ranges from under two per cent of those treated in the NTA's Yorkshire and Humber region, to 23 per cent in the London region
- The most common referral route into treatment was self-referral, representing over two-fifths (43 per cent) of all reported referral sources
- Approximately 17 per cent of clients were referred into treatment via criminal justice agencies
- Over half of all recorded drug treatment (54 per cent) was reported as being through specialist prescribing programmes, provided primarily by mental health trusts
- About half (52 per cent) of all clients discharged from treatment remained in contact for 12 weeks or more following a triage assessment
- A little under three-quarters (72 per cent) of clients presenting were male
- Over two-fifths (41 per cent) of closed Tier 4 treatment episodes resulted in a successful completion.

More information on the data analysis can be found in the report Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2003 to 31 March 2004 (DH, NTA, 2005).<sup>11</sup>

Evidence also indicates that alcohol misuse among those in drug treatment is common and polydrug and alcohol use is common, if not the norm (Gossop, 2005).<sup>12</sup> The National Treatment Outcome Research Study (NTORS, 2000) found that drug treatment services were having little or no impact on drug service users' drinking behaviour, despite half having identified alcohol problems. NTORS (1996) also commented on the "heavy burden" of health problems carried by drug users attending treatment, which



adversely affected their physical and mental health and was accompanied by high rates of unemployment.

## 2.4 Harm reduction

**Injecting behaviour.** The latest Shooting Up report (2005)<sup>13</sup> from the Health Protection Agency (HPA) stated that needle and syringe sharing increased in the late 1990s, and since then has been relatively stable, but with drug users still reporting the sharing of injecting equipment. A 2004 anonymous sample study of injecting drug users (IDUs) in contact with drug agencies found that 28 per cent shared needles or syringes in the previous four weeks. However, sharing of other injecting equipment, such as filters, spoons and flushing water, is more prevalent with 50 per cent of current injectors reporting this in the same study. More recent research (Rhodes, 2006)<sup>14</sup> into drug injecting trends, among those using heroin and crack or cocaine, suggests growing risks of blood-borne virus (BBV) transmission, infections and venous damage.

**Hepatitis C.** Shooting Up (2003),<sup>15</sup> and the 2004<sup>16</sup> and 2005<sup>13</sup> updates, have also reported an increase in the prevalence of hepatitis C infection among injecting drug users both in and out of treatment. This has increased from 36 per cent in 1998 to 41 per cent in 2003 (with only half of those hepatitis C seropositive being aware of this). Furthermore, an increase in the incidence of hepatitis C infection was reported among new injectors, indicating that transmission is increasing. There are marked regional variations in rates of hepatitis C infection among injecting drug users, with prevalence rates of over 50 per cent found in London and north-west England. Even higher rates have been seen in treatment populations – Best *et al* (1999)<sup>17</sup> found an 86 per cent hepatitis C prevalence rate in one London drug treatment service.

**Hepatitis B.** In 2004, infection rates for hepatitis B virus of 21 per cent were found among injecting drug users in England, Wales and Northern Ireland. Infection rates among new injectors were low, but had risen from five per cent in 1998 to nine per cent in 2003 (decreasing to 6.7 per cent in 2004). Increasing hepatitis B vaccination rates were reported by samples of drug users, rising from 25 per cent in 1998 to 54 per cent in 2004.

**HIV.** Shooting Up (2005) reported a recent increase in the prevalence of HIV infection among current IDUs in England. Although HIV infection remains comparatively rare among IDUs there are higher rates among IDUs in London, with around one in 25 infected. Although the numbers of IDUs infected elsewhere in England are much lower, the 2004 prevalence rate (0.6 per cent) is the highest seen outside London in this survey since 1993.

**Site infections.** Shooting Up (2005) noted continuing increases in injecting site infections of various kinds, including tetanus and wound botulism. This indicates both poor hygiene while injecting and also some contaminated doses of drugs (particularly heroin).

**Deaths related to drug misuse.** The total number of deaths related to drug misuse rose to 1,427 in 2004 (from 1,255 in 2003), the first increase since 2000 (ONS, 2006).<sup>18</sup> Although the number of deaths in 2004 was nine per cent lower than the number in the baseline year of 1999, these deaths are preventable and continued efforts should be made to reduce these and avoid further increases.

**A reinvigoration of harm reduction in all tiers of drug treatment.** These trends will require an immediate response from both commissioners and providers to stem the increase of BBVs and drug-related deaths among the drug-using population. Drug treatment clearly also needs to be able to respond to the whole of an individual's pattern of substance misuse, including the misuse of stimulants and alcohol.

## 2.5 Drug treatment and the criminal justice system

### 2.5.1 The Drug Interventions Programme

The Drug Interventions Programme (DIP) is a critical part of the Government's strategy for tackling drugs. DIP involves criminal justice and drug treatment providers working together with other services to provide a tailored solution for adults who commit crime to fund their drug misuse. Its principal focus is to reduce drug-related crime by engaging with problematic drug users and moving them into appropriate drug treatment and support. It aims to break the cycle of drug misuse and offending behaviour by intervening at every stage of the criminal justice system to engage offenders in drug treatment. Special measures for young people are also being implemented. Delivery at a local level is through drug action team partnerships, using criminal justice integrated teams (CJITs) with a case management approach to offer access to treatment and support. This begins at an offender's first point of contact with the criminal justice system, through custody, court, sentencing and beyond, into resettlement.

### 2.5.2 The Drugs Act 2005

New measures have been introduced under the 2005 Drugs Act.<sup>19</sup> These include "testing on arrest", and "required assessment" in all DIP-intensive areas in England, where individuals testing positive for specified class A drugs, following arrest or charge for "trigger offences", will be required to attend an initial assessment (known as a required assessment) of their drug misuse. The aims of the new provisions are to identify more problem drug users (by testing a larger sample of people) and to encourage more people who test positive to attend assessment (by adding a sanction of "failure to attend and remain – the required assessment"). Testing on arrest for people arrested for a trigger offence will enable adults misusing class A drugs to be steered into treatment and away from crime earlier. It will increase the volume of drug-misusing arrestees identified as having drug



problems and will ensure that those who misuse drugs but are not charged are also helped to engage in treatment.

Since 31 March 2006, Restriction on Bail has been “switched on” in all local justice areas across England. This means that any adult who appears before a court in England after testing positive for a specified class A drug, in connection with the offence for which they are charged, could be eligible for Restriction on Bail if they reside in England. The restriction on bail provision provides an opportunity to engage drug-misusing defendants with treatment, by restricting access to court bail if they refuse a drug assessment and any follow-up treatment proposed.

The above provisions only apply to those aged 18 or over. Offenders will be faced with the choice of complying with what is required of them or face criminal sanctions. The expectation is that the majority of people will comply with the requirements rather than risk prosecution.

### 2.5.3 Prison drug treatment

Prisons have a high concentration of problematic drug misusers present in one place at any one time. There is an annual throughflow of approximately 130,000 offenders and an average of 84,500 drug-misusing prisoners may be in custody during the course of a year – with around 49,000 present at any one time.

The drug treatment service framework is a core element of the prison drug strategy and consists of clinical services, CARATs and drug treatment programmes (rehabilitation programmes and therapeutic communities). The range of drug interventions is designed to meet the needs of prisoners with low, moderate and severe drug misuse problems.

Clinical services for drug users in prison are described in Prison Service Order 3550 (HMPS, 2000).<sup>20</sup> Guidance on the commissioning and delivery enhanced clinical services, covering a range of Tier 3 prescribing interventions consistent with the existing Department of Health clinical guidelines (Drug Misuse and Dependence – Guidelines on Clinical Management (1999)<sup>21</sup>) is to be published in 2006 by the Department of Health.<sup>22</sup> This guidance document will also represent part of a framework for the joining together of clinical and CARAT teams in prison under an integrated drug treatment system (see section 3.4).

## 2.6 Variation in the quality and effectiveness of drug treatment

There is a wide variation in the quality of drug treatment provision, which can be seen in differences in the abilities of services to retain clients. Analysis of treatment surveillance data (NTA/NDEC 2004)<sup>23</sup> showed that clients attending one service in the north-west of England were seven times more likely to drop out of treatment than clients in a similar service in the same region.

The Audit Commission report Drug Misuse 2004<sup>8</sup> noted that clients are often unsure about the goals of their treatment and are not fully involved as active partners in treatment, for example through lack of involvement in their care plans.

There is a wide variation in the quality of practice across the drug treatment field. Forthcoming audit and research findings, from the NTA and the NTA and Healthcare Commission Improvement Reviews, will illustrate a wide variation in prescribing practice, care planning, supervised consumption and needle exchange practice. One of the intentions of Models of Care: Update 2006 is to promote more consistently high-quality and effective treatment practice.

A comprehensive review of counselling, assessment, referral, advice and throughcare services (CARATs) undertaken between 2003 and 2005<sup>24</sup> mirrored the above findings. The consultation process of the review found variations in the quality of CARATs delivery working practices across the prison estate. As a result, a CARAT practice manual has been developed which provides workers with minimum agreed and accepted operational guidelines for all component elements of the service.

The NTA has been working in collaboration with the Healthcare Commission to develop a series of Improvement Reviews for substance misuse treatment. These annual reviews will be used to facilitate improvements in key aspects of drug treatment services. The review process started in autumn 2005, focusing on care planning and community prescribing interventions in 2005/06. In 2006/07, it will focus on commissioning and harm reduction.

## 2.7 Improvements required in treatment effectiveness

Given the variable effectiveness of drug treatment services, this update places a greater focus on the need to improve the effectiveness of drug treatment systems. This includes improving interventions to reduce the risk of blood-borne virus (BBV) infection and the risk of overdose. It also focuses on the need to improve engagement and retention in drug treatment, the effectiveness of drug treatment delivery, and the reintegration into communities of those completing treatment or being maintained in treatment.

### 2.7.1 Treatment Effectiveness strategy

This update is also set in the context of the NTA's Treatment Effectiveness strategy, which identifies some of the critical success factors to improving drug treatment and bases a delivery plan for 2005–08 on them.<sup>25</sup> The success factors fall into two main groups:

- Improving clients' journeys through treatment
- Improving local drug treatment systems.

The strategy is designed to deliver a more dynamic treatment system by focusing on the service user's "treatment journey", together with a focus on individuals' holistic needs (including housing, education and employment) to maximise the benefits of treatment. The key components of the strategy are:

#### *Improving clients' journeys through treatment*

**Waiting times.** Since April 2006, the expectation will be that service users voluntarily seeking treatment will be able to access treatment within three weeks, with faster access for priority groups. Partnerships will review any wait of six weeks or longer and report to the local partnership and the NTA.

**Retention.** Retention in structured drug treatment has been built into mainstream health performance management systems. Retention targets are now built into primary care trusts' local delivery plans (LDPs) and are performance managed by strategic health authorities. The Healthcare Commission ratings of mental health trusts now include retention in treatment for 12 weeks.

#### *Treatment delivery*

Drug treatment should encourage and maximise the opportunities for service users to achieve improvements in substance misuse, health and social functioning, and reductions in crime and public health risks. A critical factor to success in delivering improvements in clients' lifestyles is good care planning and frequent review of care plans, with clients as partners in the process. All clients in structured treatment should have an identifiable written care plan, which tracks their progress and is regularly reviewed with them.

#### *Improving treatment completion*

For clients who wish to be drug-free, treatment systems need to be better configured to create better-planned exits from treatment (including drug-related aftercare and support).

#### *Improvements in community integration*

Whether clients wish to be maintained in the community on substitute opioid medication or wish to be drug-free, drug treatment systems should be well integrated with other systems of care and social support, to provide opportunities for drug users to receive appropriate housing, social support, education and employment to maximise treatment gains and enable reintegration into local communities.

#### *Improving commissioning*

The Treatment Effectiveness strategy identifies four critical success factors that are considered important in improving local commissioning partnerships:

- Local commissioning partnerships linking plans with relevant local strategic partnership groups
- Better local needs assessments
- Development of local workforce strategies

- Local commissioners who are competent and enabled to performance manage drug treatment systems with clear routes in, through and out of drug treatment.

#### *Improving service provision*

Four critical success factors that are considered important in enabling drug treatment services in providing the highest quality drug treatment are:

- Ensuring providers have a competent workforce
- Ensuring service providers can work with the diverse needs of their service users
- Ensuring drug treatment is evidence based and underpinned by good audit or clinical governance mechanisms
- Drug treatment services are managed using close to "real-time" data.

For more detail on the NTA's Treatment Effectiveness strategy, visit the NTA website at [www.nta.nhs.uk](http://www.nta.nhs.uk).

## 2.8 Changes to commissioning

### 2.8.1 Wider health policy context

Drug treatment commissioning is taking place within the context of wider changes in the health and social care sector, where the emphasis is now on the NHS moving from being a provider-driven service to a commissioning-driven service. Currently, plans are underway to review and reconfigure health bodies such as PCTs, strategic health authorities and foundation trusts.<sup>26</sup> The Department of Health intends there to be a faster roll-out of practice-based commissioning (PBC), where primary care practices will be given more responsibility for commissioning healthcare services.<sup>27</sup> The intention is that primary care trusts (PCTs) will continue to hold funds, but practices will be responsible for assessing the health needs of local populations and making commissioning decisions on appropriate services to meet those needs. The timetable is set for all changes in the system including reconfiguration of PCTs along local authority boundaries, reconfiguration of strategic health authorities, and universal implementation of PBC, by 2008.

In the longer term, commissioners will also have to be aware of, and be able to respond effectively to, changes to the social care system, as set out in the white paper *Our Health, Our Care, Our Say* (DH, 2006).<sup>28</sup>

### 2.8.2 Drug treatment commissioning partnerships

There have already been changes in the commissioning of drug treatment since 2002 and changes in the priority given to drug treatment in health and criminal justice sectors. Drug treatment has now been prioritised into mainstream health performance management systems. A range of new local strategic

partnerships for the planning of services have been developed. Information systems have improved and resources for drug treatment are planned to continue to increase until 2008.

### **2.8.3 Commissioning criminal justice services**

PCTs are responsible for the commissioning of the healthcare needs of local prison populations, including the clinical element of drug treatment. The commissioning of drug treatment will be an important consideration for prisons. Responsibility for commissioning CARATs and prison drug treatment programmes will soon fall to the new National Offender Management Service (NOMS). Health performance management systems and PCT commissioners will need to work in partnership with NOMS wherever possible, to commission drug treatment for offenders. Currently, commissioning for Drug Rehabilitation Requirements (DRRs) in the community remains through the pooled treatment budget. DRRs are community orders, which have been in force since April 2005 and require the offender to have treatment to reduce or eliminate their drug misuse and undergo drug testing.

### **2.8.4 A step-change in commissioning is required**

In most local areas, commissioning drug treatment is a multi-million pound business. In recognition of the complexity of the task, a step-change is required to develop local commissioning into local drug treatment systems management. Local drug treatment systems have done well to develop in line with Models of Care 2002. Now, Models of Care: Update 2006 calls for a greater focus on service users' journeys and "flow" through drug treatment systems, and improvement in delivery of effective pathways of care. This will require improved strategic partnerships between health and criminal justice, as well as improved partnerships with those responsible for housing, education and employment services. Access to such mainstream provision is vital for drug misusers in treatment, to maximise treatment gains and prevent relapse into illegal drug misuse.

## 3 Commissioning substance misuse services

### 3.1 A revised framework for drug treatment services

Models of Care 2002 outlined the four-tiered framework for commissioning drug treatment. This was intended to provide a conceptual framework and be applied to local areas with flexibility. Implementation of the four-tiered framework has contributed in a large part to ending the wide variation in access to different types of treatment, so that each local area now has a broadly similar basic range of drug treatment interventions.

The four-tiered framework has been well received and has enabled a better articulation of provision of treatment. However, the four tiers were a conceptual framework and were not intended to be a rigid blueprint for provision. They have been interpreted rather rigidly at times, with some unintended consequences which need rectifying. It is important to note that the tiers refer to the level of the *interventions* provided and do not refer to the provider organisations (e.g. referring to a “Tier 3 agency” may not be appropriate as many agencies will need to provide Tier 2 interventions alongside Tier 3 interventions).

### 3.2 Key differences between Models of Care 2002 and Models of Care: Update 2006

#### 3.2.1 More focus on harm reduction with interventions integrated into all tiers

Feedback from consultation indicates that some harm reduction activities have been marginalised into being provided only by what have been called “Tier 2 services” (such as needle exchanges), at a time when there is evidence that rates of BBV infection are rising. Models of Care: Update 2006 advocates a far greater emphasis on the need to reduce drug-related harm including risks of BBV infection, overdose and other infections at all points in the treatment journey, alongside other interventions and across a range of tiers. Harm reduction interventions are required for drug users before, during and after all structured drug treatment.

The term “harm reduction” can also cover a wide spectrum of interventions. Models of Care: Update 2006 advocates the commissioning and provision of a wide range of interventions to reduce the adverse effects of drug misuse on drug users, with particular focus on reducing the risk of immediate death due to overdose and risks of morbidity and mortality due to BBVs and other infections. This may include responses at a commissioning and strategic planning level, and expansion and improvements in the provision of interventions to reduce drug-related harm. The latter may include increasing the availability of clean injecting equipment, interventions to encourage drug injectors not to share injecting equipment, to use ingestion methods as an alternative to

injecting, and to attract drug users into oral substitute treatment when appropriate.

Widespread vaccination of drug users at risk of hepatitis B infection is advocated and it is recommended that treatment services encourage and enable clients already infected with BBVs to take action to improve their health, reduce risks of transmission of BBVs to others and link into appropriate medical services. Initiatives that involve empowering service users or ex-users in initiatives to reduce the risks of BBV infection and overdose, through peer support or peer-led interventions, are generally welcomed by service users.

Models of Care: Update 2006 also advocates a harm reduction approach is adopted with local communities (e.g. minimising discarded used injecting equipment) and service users’ families and significant others (e.g. minimising risks to the children of drug-misusing parents).

#### 3.2.2 The four tiers revisited

In Models of Care 2002, the four tiers were based upon a combination of setting, interventions and the agency responsible for providing the interventions. This has led to some differing interpretations and particularly over-rigid interpretation. In Models of Care: Update 2006, the tiers describe drug “interventions” and the context for those interventions is described.

##### *Providers spanning tiers*

Some commissioners and providers have viewed community-based agencies as delivering only one tier of interventions. Models of Care 2002 clearly stated that an agency may provide interventions from more than one tier, or a range of interventions within a tier. Many community based specialised providers now, appropriately, provide a range of interventions spanning Tier 2 and Tier 3. This flexibility is welcomed.

##### *More flexible opening times*

With Tier 2 being classified as “open access”, there may also have been a loss of focus on commissioning and providing flexible access to some Tier 3 community structured interventions – the majority of which are still only available during office hours. We would welcome an extension of the opening hours of community-based services to include evenings and weekends.

##### *Tier 1 drug interventions and generic services*

The emphasis in Models of Care: Update 2006 is that Tier 1 interventions are not the generic services themselves (e.g. housing, social services). Rather, Tier 1 consists of a range of drug-related interventions that can be provided by generic providers depending on their competence and partnership arrangements with specialised drug services. Given this change in emphasis, interventions that were previously described as “Tier 4b” (e.g. care provided in inpatient hepatology units for drug users

suffering from problems caused by hepatitis C infection) in Models of Care 2002 are re-designated as Tier 1 in Models of Care: Update 2006.

### *Tier 2 drug interventions*

Consultation on Models of Care has suggested the need for a wider recognition of the valuable role of open access Tier 2 drug interventions that may just stop short of being classified as structured drug treatment. In keeping with this, Models of Care: Update 2006 advocates that Tier 2 interventions should be strengthened. Within a local system, Tier 2 interventions should include:

- Interventions to engage people into drug treatment
- Interventions to support people prior to structured treatment
- Interventions to help retain people in the treatment system
- A range of drug misuse harm reduction interventions
- Interventions to support active drug users who may not want or need intensive structured drug treatment at that point in their lives.

These interventions can include health interventions to meet clients' immediate health needs and a range of brief interventions targeted at engaging clients in treatment. It is important that the interventions are simple and can be provided quickly. Clients can also be engaged in treatment through outreach services, which can also seek to re-engage former service users who have dropped out of treatment.

There is some perception that Tier 2 interventions have focused solely on those who are still actively using illegal drugs. Models of Care: Update 2006 recommends that Tier 2 open access interventions should also be delivered to those who are drug-free (and wish to remain so). Tier 2 interventions can be a component of aftercare. Aftercare is described as:

- Drug-related support, such as relapse prevention, support groups and individual support for those wishing to remain drug-free, and access to user groups and advocacy mechanisms (such as Narcotics Anonymous or equivalent)
- Non-drug-related support, such as access to education or training, support from advisory services, helping develop social networks and employment support.

Such aftercare follows the completion of care-planned drug treatment.

It is expected that both interventions with an explicit abstinence oriented approach and those that target active drug users are commissioned locally. These interventions may be provided on the same or different service sites. How these services are delivered is a local treatment planning decision.

### *Community-based Tier 2 and Tier 3 interventions*

Some consultation responses called for the creation of "tier two-and-a-half", in recognition of work that practitioners undertake with clients that does not quite reach the threshold for care-planned treatment (e.g. two or three "sessions" of brief interventions). Rather than create a new tier, Models of Care: Update 2006 advocates a more careful consideration of whether Tier 2 or Tier 3 interventions are being provided and a recognition that providers can and do provide a range of interventions at different tiers.

The main difference between Tier 2 and Tier 3 interventions is that Tier 3 refers to the provision of care-planned interventions that meet the threshold for structured drug treatment, determined following comprehensive assessment. The definitions of care planning and of the various forms of structured treatment have been amended and updated to aid clarity in Models of Care: Update 2006. There are additional reporting requirements for Tier 3 interventions, including the completion of National Drug Treatment Monitoring System (NDTMS) returns.

It is recognised that, in reality, the differences in some cases between more structured forms of Tier 2 support and simpler forms of Tier 3 interventions can be subtle. While care planning is a requirement of structured treatment, it can also be used, if appropriate, for some Tier 2 interventions (e.g. planned brief motivational interventions). Some brief interventions, for example for alcohol or cannabis use, may be provided in both tiers. In this, and other equivocal cases, it will be the degree of structure of the care plan and of the treatment intervention that will usually be the best guide to determine the tier of intervention being provided. If a service provider is delivering care-planned structured treatment following comprehensive assessment, the interventions provided should be classified as Tier 3.

Tier 2 interventions may not require the same degree of commitment from the client. The level of assessment may be lower (although there may be some). Tier 2 interventions may not require the same degree of consent as for a planned course of treatment and they often will not have the same level of duty of care for the practitioner (though they should still carry some). Therefore, there are different reporting requirements. Care plans should be used, if appropriate, for Tier 2 interventions.

To maximise engagement and motivation following assessment, all DATs and CJITs have been funded to build Tier 2 treatment capacity to facilitate access to structured drug treatment.

If a service provider is providing care-planned care following comprehensive assessment, the interventions provided should be classified as Tier 3. Tier 3 interventions comprise care-planned treatment, where an individual assessed has been found in need of structured treatment and has a care plan, which involves the client consenting to treatment. The client then receives drug treatment and other interventions (sequentially or concurrently)



according to the care plan drawn up with the keyworker, together with scheduled keyworking sessions, and any co-ordination of care or case management required.

The most appropriate guide to deciding whether interventions are Tier 2 or Tier 3 is whether interventions are provided in the context of a comprehensive care plan, following a comprehensive assessment. Models of Care: Update 2006 contains a range of definitions to help clarify the process of decision making, including care planning, keyworking, the treatment interventions and how they fit together.

### ***All substitute prescribing interventions are Tier 3***

Clinical experience, supported by consultation responses, has indicated that all substitute prescribing interventions, including those previously described as “low threshold” in Models of Care 2002, should be redefined as Tier 3 interventions, including those delivered by prison healthcare. This is because they require comprehensive assessment, should be care planned and carry a high duty of care for the clinician prescribing controlled drugs.

### **3.3 The Drug Interventions Programme (DIP)**

The Drug Interventions Programme (DIP) provides an enhanced Tier 2 service by offering the client ongoing support, through the case management arrangements, in order to facilitate engagement in structured treatment.

One of the key drivers for the development of the DIP was the need to bridge the gap between assessment and referral from the criminal justice system and effective engagement into structured treatment. Evidence from the arrest referral scheme evaluations (July 2002) consistently recorded high levels of attrition for clients referred to drug treatment from the criminal justice system, with an engagement rate of 20–25 per cent.

Criminal justice integrated teams (CJITs) are the key local delivery mechanism of the DIP. They are established by the DATs as multi-agency partnerships, comprising members from a range of disciplines with a range of competences and skills. There is no one model but a typical team might include drug workers based in police custody suites or courts; case managers; those with specialist knowledge of housing issues, mental health, education, training and employment, and family support; outreach workers working in the community, and dedicated prolific and persistent offender (PPO) case managers.

Improving continuity of care for the individual is reliant upon seamless case management through the effective provision and communication of the right information at the right time to the right people, throughout the “journey” of the drug misuser. Case management should reflect the key elements of keyworking and care planning. This process is facilitated through the use of the Drug Interventions Record (DIR) by CJIT workers in the

community and CARATS or healthcare in prisons. The DIR has three main roles. They are:

- To facilitate and improve standards of continuity of care for drug users, and minimise duplication of assessments, especially when they are moving between custody and community but also when information is passed between case managers and/or treatment providers
- To support the monitoring and research functions around the Drug Interventions Programme, in line with the programme's, and other related, Performance Management Frameworks
- To be the form on which substance misuse triage assessment is recorded in prison, whether or not the individual agrees to the sharing of information with the CJIT for continuity of care purposes.

Where a client is assessed by a CJIT worker following a triage level assessment, the worker will use the DIR to record the summary and outcomes from the assessment. Where clients require structured treatment, they will be taken onto the CJIT caseload and allocated a case manager or keyworker. Initial care plans are then agreed with clients to identify what steps need to be taken to engage them in treatment and what support can be provided in the interim. This might involve ongoing contact with the case manager to maintain the client's motivation and address social support needs, such as housing, employment and training.

The transition to structured treatment (Tier 3) is achieved when a comprehensive assessment, followed by a full care plan, is completed by the treatment provider. The CJIT worker who is the case manager, with the client's informed consent, can contribute to this process and will continue to work with the client until they are actively engaged in treatment with the Tier 3 provider.

### **3.4 Drug treatment based in prisons**

A comprehensive framework of drug treatment services, spanning Tiers 1–4, should be available in prisons to address the varying needs of drug misusers. In principle, delivery of drug treatment in prisons is very similar to providing treatment in the community. However, there are specific factors that need to be taken into account, given the different environment in which prison treatment is provided.

As with any drug treatment, prisoners must be provided with continuity of care both in custody and on release. It is vital that any drug treatment, especially relapse prevention and release planning, takes into account the differences that exist within prison and community environments, in order to best prepare prisoners for release.

There are three main types of drug treatment within prisons.

### 3.4.1 Clinical services

There is currently a range of clinical services (Tiers 2, 3 and 4) available to:

- Provide appropriate clinical management of substance misuse problems in all local (remand) prisons
- Address the associated wider health issues, which arise from drug use, such as blood-borne viruses, deep vein thromboses, abscesses and dental disease
- Engage in the care programme approach (CPA) to those substance users with serious mental health problems (dual diagnosis).

### 3.4.2 CARAT services

CARAT (counselling, assessment, referral, advice and throughcare) services are available in all prisons holding those over the age of 18 and provide Tier 2 and Tier 3 treatment. CARAT services use a keyworking role, working with prison clinical services, community treatment providers and others as appropriate. The CARAT service will:

- Build on previous assessments of the individuals' needs
- Provide a range of psychosocial support and interventions
- Refer to drug treatment programmes in custody where these are available and appropriate, and maintain contact while the client is participating in these programmes
- Build and maintain effective throughcare arrangements with drug service providers in the community – through CJITs where appropriate.

A model has been developed for the closer linking of clinical and CARAT services in prisons to form an Integrated Drug Treatment System (IDTS).

The principal features of IDTS are integrated screening, triage assessment, comprehensive substance misuse assessment and care planning to provide access to a wide range of prescribing and psychosocial treatment, incorporating early effective clinical intervention and enhanced psychosocial support for the first 28 days of custody. Guidance on the psychological support in IDTS will be available from NOMS.<sup>29</sup> The clinical elements of IDTS are described in detail in Department of Health guidance – Clinical Management of Drug Dependence in the Adult Prison Setting – scheduled for publication in 2006.<sup>22</sup>

### 3.4.3 Drug treatment programmes

These are available in over 100 prisons and provide a range of programmes, including:

- Short duration programmes (Tier 3) available for those on remand or short sentences, who are unable to engage in longer programmes. These will be an important component of the short custodial periods available under the Custody Plus

sentence when this is implemented in 2006. Short duration programmes may also be used as a booster, prior to release, for those who have previously completed another programme (Tier 3)

- Cognitive-behaviour therapy programmes (Tier 3), e.g. P-ASRO (Prison – Addressing Substance-Related Offending), for those serving longer sentences, designed to give the thinking skills needed to help drug misusers to overcome drug dependency and to adopt a more sustainable lifestyle
- The 12-Step programme (Tier 3 and Tier 4), based on the Minnesota Model of addiction (e.g. as used by Alcoholics Anonymous)
- Therapeutic communities (Tier 4), designed for those with the most severe drug-misuse needs, delivered over eight months to a year.

## 3.5 Primary care

### 3.5.1 Primary care interventions across four tiers

Many clients' initial or main contact with drug treatment is through primary care. GPs and primary healthcare teams are valuable in delivering a wide range of interventions and can provide interventions covering all four tiers, where appropriate, provided the GPs or practitioners are competent to do so. This may involve:

Tier 1 interventions – screening drug-using clients and referring them on to other service providers; provision of general medical services (GMS). Under the terms of the GP contract, all GPs must provide Tier 1 interventions.

Tier 2 interventions – triage assessments, harm reduction. All practices can provide at least some Tier 2 interventions via the primary healthcare team as a whole (e.g. simple harm minimisation advice, brief interventions and immunisations).

Tier 3 interventions – prescribing for drug users within the context of a care plan. Many GPs provide Tier 3 services under specific contractual arrangements.

Tier 4 interventions – medical monitoring of residential rehabilitation or detoxification services, provided by a few GPs where there is local need.

### 3.5.2 Different contractual arrangements for shared care and primary care based treatment

Changes in GP contracts since Models of Care (2002) have implications for the commissioning and delivery of drug treatment services. Changes introduced as a result of the new contracts should ensure the stability, ongoing development and continued expansion of drug treatment systems to meet the key targets of doubling the number of people in treatment and increasing the proportion appropriately retained or completing treatment.



As well as providing the core general medical services to substance misusers, a number of different contractual arrangements may be utilised to commission appropriate primary care-based drug treatments, including shared care, to meet local needs. These include:

- Contracts for nationally enhanced services (NES) or locally enhanced services (LES) under the new GP Contract (nGMS) for GPs in shared care schemes with specialist support.
  - Nationally enhanced services (NES) for drug misusers have nationally negotiated specifications and payments, including requirements for GPs to engage in limited clinical governance activities and remuneration arrangements based on treatment modalities, which may be used if suitable
  - Locally enhanced services (LES) for drug misusers, which allow wide flexibility in determining service specifications. Many PCTs have negotiated LES contracts in preference to NES contracts, in response to an emerging evidence base on best practice, improved clinical governance and remuneration packages suited to a local context.
- Personal medical services (PMS) contracts are another well-established mechanism for arriving at locally negotiated service level agreements. These can provide different levels of care, from simple prescribing in shared care arrangements to full packages of care delivered by whole teams from a primary care base or from separate clinics. PMS arrangements have been set up to deliver services to specific vulnerable patient groups, such as homeless people, refugees and sex workers. These services will be based in an established primary care base or a separate setting with a strong primary care ethos, and provide a range of services including drug treatment.

Either type of contract may allow for a GP practice to collaborate in a shared care arrangement with drugs workers who are either employed by specialist agencies, or for the more autonomous practice to employ such staff directly.

For more information on drug treatment and the new GMS (nGMS) contract, with NTA recommendations and consensus reached at a provider summit held by the NTA in December 2003, see the NTA website [www.nta.nhs.uk](http://www.nta.nhs.uk).

Additionally, doctors with a primary care background may be employed by voluntary or non-statutory agencies, criminal justice agencies, or independent sector providers to provide a range of levels of care, with individually negotiated service level agreements.

### 3.5.3 Competences for doctors in primary care drug treatment

Commissioners should ensure local treatment systems have a complete spectrum of medical provisions to meet the range of

needs and the numbers of substance misusers entering treatment. This requires a variety of skills and competences at various levels, from simply providing general medical skills, to GPs offering less complex drug treatments, to specialist addictions skills and addiction psychiatry skills. This is a key message arising from the consensus document produced by the Royal College of General Practitioners and the Royal College of Psychiatrists – Roles and Responsibilities of Doctors in the Provision Of Treatment for Drug and Alcohol Misusers (2005)<sup>30</sup> – as summarised in an NTA briefing note on its website, [www.nta.nhs.uk](http://www.nta.nhs.uk). The consensus document specifies a hierarchy of roles for GPs, with increasing competency levels:

- **GPs providing core services.** A doctor providing general medical care only to substance misusers
- **GPs providing enhanced services.** A doctor providing basic medical care plus care to substance misusers, in accordance with locally agreed shared care guidelines
- **GPs with special clinical interest (GPwSI) providing enhanced services.** GPwSIs have received specific higher level training in the management of substance misusers in primary care, usually the GP Certificate in Management of Drug Use Part 2. GPwSIs delivering locally enhanced services or nationally enhanced services are able to work more autonomously and take responsibility for more complex cases in substance misuse than other GPs
- **Substance misuse specialist (primary care).** A doctor with a general practice background and an extensive postgraduate training in substance misuse working as a specialist GP lead or director employed by a PCT or mental health trust. These doctors are able to take on most complex cases, and where competences and accreditation allow, highly specialised areas, such as management of severe and enduring mental illness (in conjunction with specialist psychiatric support and appropriate clinical governance) and prescribing of heroin for treatment of addiction (under license). These doctors have responsibility for the full range of clinical governance activities and service development for substance misuse in their parent NHS trust. They are expected to have extensive postgraduate training in substance misuse, regular clinical supervision, CPD and peer support.

### 3.5.4 Models of drug treatment in primary care

A number of actual models of primary care drug treatment have evolved in the context of local resources and identification of need. These models include various types of shared care services in which GP services are supported by more specialist service provision, and primary care-led drugs services, which may or may not have shared care arrangements with a secondary care provider.

### Shared care services

Commissioners should ensure that every local area has shared care arrangements in place. There are many different models of shared care but the underpinning principles are:

- Patients in all local areas should have access, where clinically appropriate (usually the more stable patients), to long-term care – even after exit from drug treatment – and community-based multidisciplinary support inherent in the primary care setting
- There should be unobstructed transfer of patients between the services sharing their care as their clinical needs change.

There are a wide range of models of shared care, which may include the following variations:

- GPs or non-medical prescribers commissioned as providers of drug treatment, and depending on arrangements and level of competence, offering different levels of care from long-term maintenance prescribing in shared care arrangements to more specialised packages of care for complex needs
- Drug treatment delivered from a base in a primary care setting by a multidisciplinary team, to patients registered with those GPs or patients registered with other GPs in the locality
- Support for specialist provision from primary care, or more usually secondary care-led services, which provide shared care support and direct care for more severe and complex cases
- Arrangements set up to deliver services to specific vulnerable patient groups, such as homeless people, refugees and sex workers. These services will be based in primary care and provide a range of services including drug treatment and have often been commissioned as personal medical services. They are supported by specialist secondary care drug services, which provide direct care, particularly for more severe or complex cases.

Whatever models of shared care are commissioned locally, they should be commissioned according to local needs, and in line with medical competences<sup>30</sup> and appropriate clinical governance arrangements. These shared care arrangements should be reviewed, refined and developed regularly.

### Primary care-led services

Some areas may have a primary care-led service depending on the local configuration of specialist services. In these services, GPs act as clinical leads for community drug services, where there is no formal secondary care or specialist addiction psychiatry leadership available within the service or through shared care arrangements.

Commissioners may support such arrangements because of the advanced specialist competence of the particular GPs involved (e.g. as described in Roles and Responsibilities of Doctors in the

Provision of Treatment for Drug and Alcohol Misusers).<sup>30</sup>

Sometimes the GP may act as a clinical lead in substance misuse for their area in conjunction with specialist psychiatric support. This may be in a service overseen by or in partnership with an addiction psychiatry team.

Primary care-led services may sometimes be commissioned in this role because it has not been possible to obtain suitable shared care support in the area. However, this is not ideal and suitable shared care services should be encouraged and developed in every area.

It is important to ensure that the needs of the most severe and complex patients are adequately addressed in any system. There are clearly advantages for patients in having access to a range of provision, from GPs with a range of competences and from secondary care specialists across an integrated system of care.

## 3.6 Inpatient treatment and residential rehabilitation: The need for expansion

Inpatient substance misuse treatment and residential rehabilitation (Tier 4) interventions have not expanded at the same rate as Tier 2 and Tier 3 drug treatment provision in the last few years. The coverage of Tier 4 interventions in England is still inconsistent and substance misuse inpatient treatment and residential rehabilitation are sometimes only (incorrectly) used as a last resort for drug misusers, when Tier 4 interventions should be available to clients at different stages in their treatment journeys. Commissioning to expand Tier 4 is crucial to improve clients' journeys and to maximise treatment exits and access to abstinence-based aftercare. The development of inpatient treatment and residential rehabilitation services is of increasing importance for a number of reasons:

- There is high level of expressed need for residential provision from service users and carers
- Specialist inpatient interventions – assessment, stabilisation and assisted withdrawal/detoxification – are necessary to provide the optimal local drug treatment system for clients with complex drug, alcohol and other health needs; those in crisis; those requiring medication stabilisation (e.g. on injectable or high-dose opioids, or for effective detoxification)
- Inpatient detoxification followed by residential rehabilitation is the most effective way for drug misusers to become drug-free, if they are motivated and this is the agreed objective (NTA, 2005)<sup>31</sup>
- There is evidence to show that detoxification in specialist substance misuse facilities is more effective than in general hospital or psychiatric wards, which are associated with low success rates<sup>32</sup>
- It is recognised that service users must have social support upon leaving rehabilitation units and secure adequate housing

to maximise the benefits of treatment and to reduce risk of relapse and fatal overdose.

The commissioning of all Tier 4 interventions requires improvement. Some of the services (mainly residential rehabilitation units) providing these interventions have national catchment areas, and can be particularly vulnerable if they are continually “spot purchased”. It is important to note that these interventions can be purchased using pooled treatment budget funding, community care funding, mainstream health funding, or some combination of these. The commissioning of inpatient and residential rehabilitation services should be undertaken within an integrated care pathway approach that is embedded within local strategic annual treatment planning process and joint commissioning systems. These pathways should be commissioned with clear routes into inpatient services, which lead to residential rehabilitation (if required) followed by a substance misuse support package, including housing if necessary.

From 2006, new regional or sub-regional commissioning arrangements will be developed, which will require working across strategic partnerships on a regional or sub-regional basis to strategically plan and commission Tier 4 treatment.

Initial guidance for commissioning Tier 4 treatment<sup>33</sup> was issued in February 2006 (further guidance is planned for later in 2006). This guidance emphasises the need to increase inpatient and residential rehabilitation provision to create more planned exits from drug treatment for those who want it, in line with the Treatment Effectiveness strategy. It focuses on:

- The effectiveness of Tier 4 treatment
- The importance of commissioning integrated care pathways for Tier 4 treatment
- Commissioning based on assessment of need for Tier 4 treatment
- Using a mixed economy to purchase or commission Tier 4 treatment. In particular, sole reliance on community care funding for residential rehabilitation will not be enough, and other funding arrangements should also be used
- A mixture of block and spot purchasing of residential rehabilitation places
- A move towards contracting with preferred providers who demonstrate quality
- Improved performance management arrangements (including standard contracts and NDTMS compliance).

Future guidance is planned which will further emphasise strategic regional and sub-regional commissioning of Tier 4 treatment.

### 3.7 Greater emphasis on aftercare

Models of Care: Update 2006 seeks to clarify and describe aftercare as both drug related and non-drug related support (see

section 9.10 for more details). To aid effective and well coordinated commissioning, drug-related aftercare provision (i.e. support to specifically address a person’s drug dependency issues) should be commissioned through inclusion in DAT partnership annual treatment plans. Non-drug related aftercare support (i.e. support that does not directly address drug dependence) is provided by partner agencies and is not usually directly commissioned through drug treatment plans. Commissioners should ensure that necessary local partnership arrangements are in place to enable adequate service provision for clients leaving drug treatment.

Aftercare is increasing in importance as more drug users are entering and going through treatment programmes. This raises the need for both drug-related and non-drug related aftercare support to be in place when they leave treatment, so that positive changes they have achieved in drug use – criminal activity, health and social functioning – are maintained. In strategic planning and commissioning of aftercare services, it is important that commissioners give consideration to the following areas, which can also be key to client engagement and retention:

- Ensuring continuity of care for those leaving treatment, finishing a community sentence or moving between the community and custody
- Making clear links to housing provision through local authority homelessness strategies
- Establishing access and links to local and mainstream programmes for wraparound support (such as housing, employment, training and education)
- Establishing links to other services (such as alcohol and mental health services) as appropriate
- Developing relapse prevention support (outside existing treatment provision), support for families, peer support for drug users leaving treatment, and providing mentors.

It is particularly important that housing and support services are in place, where required, for people leaving inpatient treatment and residential rehabilitation. Agencies providing Tier 4 interventions need to have good connections with social care and other services that can provide, or can facilitate provision of, the aftercare a client needs when they leave treatment. Guidance has been issued by ODPM and the Home Office,<sup>34</sup> which emphasises that Supporting People funding should be considered in tandem with other funding streams, such as the drug pooled treatment budget and the DIP main grant, and in line with the drug action team treatment plans, local homelessness strategy and Supporting People strategy, to provide the basis for a locally joined-up approach. The Home Office and ODPM have also issued a briefing outlining further examples of joint working and practice.<sup>35</sup>

### 3.8 The four tiers reiterated

The following reiteration of the tiers describes:

- The drug interventions it is best practice to commission and provide in each local area
- The range of settings these are normally provided in
- The competence or level of drug treatment skills and training that is normally required.

Commissioners need to ensure that all tiers of interventions are commissioned to form a local drug treatment system to meet local population needs. Local systems should allow for some flexibility in how interventions are provided, with the crucial factors being the patterns of local need and whether a service provider is competent to provide a particular drug treatment intervention.

### 3.9 Treatment effectiveness: Improving clients' journeys

#### 3.9.1 Evidence for treatment effectiveness

Models of Care: Update 2006 has a greater focus on improving clients' treatment journeys through systems. Drug treatment is not an event, but a process usually involving engagement with different drug treatment services, perhaps over many years. Each client's drug treatment journey is different and depends on a range of factors including health status, relationships, nature of the drug problem and the quality of the drug treatment they receive. However, drug treatment use is often episodic, with service users dipping in and out of treatment over time. Evidence from the US<sup>36</sup> suggests that an average time in treatment for someone with a heroin or crack dependence problem is five to seven years, with some heroin users requiring indefinite maintenance on substitute opioids. Evidence also tells us that service users gain cumulative benefit from a series of treatment episodes. However, the biggest improvements in client outcomes are likely to be made in the first six years of treatment (DATOS).<sup>37</sup>

Evidence indicates that entry into treatment has an immediate positive impact on drug use and crime, particularly for someone prescribed substitute medication. However, this is not sustained if the client is not retained in treatment. Optimised treatment usually involves retaining clients in drug treatment for a minimum of three months. This is the point at which treatment begins to accrue generalised long-term benefit. Engaging the service user sufficiently in a therapeutic relationship enables positive lifestyle changes to occur. This approach requires a partnership between the treatment provider and the client or service user, with both working towards common explicit goals. This also requires a concerted effort on behalf of the treatment provider to enable all of the clients' needs to be met, not just their drug treatment needs. This may include addressing alcohol misuse, health needs due to blood-borne virus infections such as hepatitis C, treatment for underlying anxiety or depression, building social support

networks, and providing access to appropriate housing, education or employment. All of these may be crucial to prevent relapse back to illicit drug misuse.

While much of the focus of outcome research has been on identifying key individual characteristics that predict better treatment outcomes, such as higher levels of personal and social capital and lower levels of problem severity, increasing attention is being paid to service characteristics that can improve outcomes. The National Drug Evidence Centre research (2004)<sup>23</sup> for the NTA showed that the best predictor of retention in community treatments in the north-west of England was related to service factors rather than client characteristics. Similarly, Meier (2005)<sup>38</sup> has also reported that much of the variability in retention in residential rehabilitation services derives from the service itself rather than the service user. This is consistent with empirical research conducted in the US, which shows that organisational development work can lead to significantly enhanced treatment outcomes across patient populations.<sup>37</sup>

## Tier 1 interventions

<b>Definition</b>	Tier 1 interventions include provision of drug-related information and advice, screening and referral to specialised drug treatment.
<b>Interventions</b>	<p>Commissioners need to ensure that a range of generic services provide, as a minimum, the following Tier 1 drug interventions:</p> <ul style="list-style-type: none"> <li>• Drug treatment screening and assessment</li> <li>• Referral to specialised drug treatment</li> <li>• Drug advice and information</li> <li>• Partnership or “shared care” working with specialised drug treatment services, to provide specific drug treatment interventions for drug misusers within the context of their generic services. Specific drug treatment liaison schemes may need to be commissioned to fully realise partnership work.</li> </ul> <p>Generic services should also provide their own services to drug misusers and some may be specifically designed for drug misusers (e.g. housing projects for those leaving rehabilitation). Commissioners should ensure that drug misusers are not marginalised from generic services by developing local strategic partnerships.</p>
<b>Settings</b>	Tier 1 interventions are provided in the context of general healthcare settings (e.g. liver units, antenatal wards, Accident and Emergency and pharmacies), or social care, education or criminal justice settings (probation, courts, prison reception) where the main focus is not drug treatment.
<b>Competency</b>	<p>Staff require competence to screen and identify drug misuse and refer into local specialised drug treatment systems, in accordance with local protocols, to provide drug-related advice and information and to work in partnership with specialist drug treatment services.</p> <p>Commissioners may need to ensure competency-based training, information on local systems and drug liaison workers to support partnership projects.</p> <p>Of particular relevance are DANOS<sup>39</sup> Standards (Drug and Alcohol National Occupational Standards): AA1 “Recognise indication of substance misuse and refer to specialists”; AB2 “Support individuals who are substance misusers”; AB5 “Assess and act on risk of danger to substance misusers”, and AF1 “Carry out screening and referral assessment”.</p>

Tier 1 interventions: Drug-related information and advice, screening and referral by generic services

## Tier 2 interventions

<b>Definition</b>	Tier 2 interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.
<b>Interventions</b>	<p>Tier 2 interventions that should be commissioned in each local area include:</p> <ul style="list-style-type: none"> <li>• Triage assessment and referral for structured drug treatment</li> <li>• Drug interventions which attract and motivate drug misusers into local treatment systems, including engagement with priority groups, such as pregnant women, offenders and stimulant users</li> <li>• Interventions to reduce harm and risk due to BBVs and other infections for active drug users, including dedicated needle exchanges and the support and co-ordination of pharmacy-based needle exchanges</li> <li>• Interventions to minimise the risk of overdose and diversion of prescribed drugs</li> <li>• Brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if it does not require structured treatment)</li> <li>• Brief interventions for specific target groups including high-risk and other priority groups</li> <li>• Drug-related support for clients seeking abstinence</li> <li>• Drug-related aftercare support for those who have left care-planned structured treatment</li> <li>• Liaison and support for generic providers of Tier 1 interventions</li> <li>• Outreach services to engage clients into treatment and to re-engage people who have dropped out of treatment</li> <li>• A range of the above interventions for drug-misusing offenders.</li> </ul>
<b>Settings</b>	<p>Tier 2 interventions may be delivered separately from Tier 3 but will often also be delivered in the same setting and by the same staff as Tier 3 interventions.</p> <p>Other typical settings to increase access are through outreach (general detached or street work, peripatetic work in generic services or domiciliary (home) visits) and in primary care settings.</p> <p>Pharmacy settings are important due to their unique role in pharmacy based needle exchange schemes and their role in supervised consumption of prescribed drugs.</p> <p>Criminal justice settings – including initial contact and assessment by CJIT workers in police custody suites, magistrates courts and crown courts – working closely with probation as well as CARATs and prison healthcare provision within the prisons estate.</p> <p>Drug treatment interventions for offenders may be delivered in the community by CJIT workers and in prison by CARATs and some drug treatment programmes.</p>
<b>Competency</b>	<p>Tier 2 interventions require competent drug and alcohol specialist workers who should have basic competences in line with DANOS.<sup>39</sup></p> <p>Competency also depends on what cluster of services are provided. Normally, frontline staff would have competence in motivational techniques and drug and alcohol brief interventions. Those advising on injecting techniques should be DANOS competent with, as best practice, some members of the team having nursing or medical qualifications.</p> <p>Those providing extended pharmacy-based services for drug misusers, including interactive needle exchange and supervised consumption services, would normally have drug specific competence, may have specific contractual arrangements with drug treatment commissioners and work in partnership with other community-based drug services.</p>

Tier 2 interventions: Open access, non-care-planned drug-specific interventions



## Tier 3 interventions

<b>Definition</b>	Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison.
<b>Interventions</b>	<p>Tier 3 interventions that should be commissioned in each local area include:</p> <ul style="list-style-type: none"> <li>• Comprehensive drug misuse assessment</li> <li>• Care planning, co-ordination and review for all in structured treatment, often with regular keyworking sessions as standard practice</li> <li>• Community care assessment and case management for drug misusers</li> <li>• Harm reduction activities as integral to care-planned treatment</li> <li>• A range of prescribing interventions, in the context of a package of care and in line with Drug Misuse and Dependence – Guidelines on Clinical Management,<sup>21</sup> known as “the clinical guidelines”. This will be updated alongside the relevant forthcoming National Institute for Clinical Excellence (NICE) guidelines and technology appraisals, and in line with other evidence-based clinical standards with specific interventions, including: prescribing for stabilisation and oral opioid maintenance prescribing; community based detoxification; injectable maintenance prescribing, and a range of prescribing interventions to prevent relapse and ameliorate drug and alcohol-related conditions</li> <li>• A range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour</li> <li>• Structured day programmes and care-planned day care (e.g. interventions targeting specific groups)</li> <li>• Liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health and hepatitis services)</li> <li>• Liaison services for social care services (e.g. social services (child protection and community care teams), housing, homelessness)</li> <li>• A range of the above interventions for drug-misusing offenders.</li> </ul>
<b>Settings</b>	<p>Tier 3 interventions are normally delivered in specialised drug treatment services with their own premises in the community or on hospital sites. Other delivery may be by outreach (peripatetic work in generic services or other agencies or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.</p> <p>Some of the Tier 3 work is based in primary care settings (shared care schemes and GP-led prescribing services), as well as pharmacies, but drug specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care.</p> <p>Drug treatment interventions for offenders may be delivered in prison settings by CARATs and some drug treatment programmes</p> <p>Community criminal justice programmes, such as DRRs, are delivered in contracted community drug treatment services (statutory or voluntary) or in-house by probation staff on probation premises.</p>
<b>Competency</b>	<p>Tier 3 services require competent drug and alcohol specialised practitioners who should have competences in line with DANOS.<sup>39</sup> The range of competences required will depend upon job specifications and remits.</p> <p>Medical staff (usually addiction psychiatrists and GPs) will require different levels of competences depending on their roles in drug treatment systems and the needs of the client, with each local system requiring a range of doctor competences (from specialist to generalist) in line with joint guidance from the Royal College of General Practitioners and the Royal College of Psychiatrists.<sup>30</sup></p>

*Tier 3 interventions: Structured, care-planned drug treatment*



## Tier 4 interventions

<b>Definition</b>	Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.
<b>Interventions</b>	<p>Tier 4 interventions that should be commissioned to meet local area needs include:</p> <ul style="list-style-type: none"> <li>• Inpatient specialist drug and alcohol assessment, stabilisation, and detoxification/assisted withdrawal services</li> <li>• A range of drug and alcohol residential rehabilitation units to suit the needs of different service users</li> <li>• A range of drug halfway houses or supportive accommodation for drug misusers</li> <li>• Residential drug and alcohol crisis intervention units (in larger urban areas)</li> <li>• Inpatient detoxification/assisted withdrawal provision, directly attached to residential rehabilitation units for suitable individuals</li> <li>• Provision for special groups for which a need is identified (e.g. for drug-using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness). These interventions may require joint initiatives between specialised drug services and other specialist inpatient units</li> <li>• A range of the above interventions for drug-misusing offenders.</li> </ul>
<b>Settings</b>	<p>Ideal settings to provide inpatient drug detoxification and stabilisation are specialised dedicated inpatient or residential substance misuse units or wards.</p> <p>Inpatient provision in the context of general psychiatric wards may only be suitable for some patients with co-morbid severe and enduring mental illness, but many such patients will benefit from a dedicated addiction specialist inpatient unit.</p> <p>Those with complex drug and other needs requiring inpatient interventions may require hospitalisation for their other needs – for example pregnancy, liver problems and HIV-related problems – and this may be best provided for in the context of those hospital services (with specialised liaison support).</p> <p>Continuity of care is essential for preserving gains achieved in residential treatments. Therefore, there is a compelling argument for providing, for suitable patients, inpatient detoxification beds attached to residential rehabilitation units (provided there are adequate medical supports). Other patients need inpatient detoxification first in an addiction specialist inpatient unit (e.g. because of severity and complexity), but this still requires significant strengthening of the links with residential rehabilitation provision, to ensure the seamless transition of clients between the two.</p> <p>Service users requiring residential rehabilitation or halfway houses may wish to be located away from their area of residence and drug misusing networks.</p> <p>Within prisons, specialist detoxification units, therapeutic communities (drug specific) and some (residential) 12-Step programmes are Tier 4 interventions.</p>
<b>Competency</b>	<p>Inpatient or residential interventions providing detoxification and pharmacological stabilisation would normally require medical staff with specialised substance misuse competency (rather than be provided by generalist GPs). The level of specialised medical staff competence required will depend on the types of services provided and the severity of the problems of the clients. Addiction specialist competences will be needed for inpatient units for severe and complex problems, but suitably competent GPs can provide support to some units for patients with less complex needs.</p> <p>Staff in residential rehabilitation units that are registered care homes will need to meet relevant social care National Occupational Standards and relevant standards currently inspected and monitored by the Commission for Social Care Inspection. Hospital-based services will also be required to meet practitioner standards for independent or NHS hospitals currently inspected and monitored by the Healthcare Commission.</p> <p>Non-registered residential rehabilitation services should meet other appropriate standards, where applicable, e.g. Supporting People arrangements, EATA accreditation.</p> <p>All staff working in all residential settings are advised to demonstrate competence against DANOS<sup>39</sup> at both manager and practitioner levels.</p>

*Tier 4 interventions: Drug specialist inpatient treatment and residential rehabilitation*

### 3.9.2 Component parts of the treatment journey

In addition to implementing the framework advocated in Models of Care 2002, the NTA is committed to pushing for an improvement in drug treatment effectiveness. The Treatment Effectiveness strategy, with a focus on improving clients' journeys through drug treatment, is integrated in Models of Care: Update 2006. The treatment journey is conceptualised into four overlapping components, each with key objectives. These components are illustrated in Figure 1 and comprise:

- Treatment engagement
- Treatment delivery (including maintenance)
- Community integration (which underpins both delivery and treatment maintenance or completion)
- Treatment completion (for all those who chose to be drug-free and who can benefit).

Although it will be useful to see these phases of the treatment journey as conceptually separate, there is room for considerable overlap. It is important to note that the phases do not mean that treatment is a linear journey, with service users progressing through the three main phases of engagement, delivery and completion. Instead, these are the main elements of a treatment journey which may occur in a variety of combinations during a client's time in treatment. Considering these phases can be particularly helpful in informing the focus of care plans at different stages and in maintaining a focus on the treatment journey.

#### *Treatment engagement*

The treatment system needs to be able to engage people rapidly and retain them once they have entered treatment. Two issues important to improving treatment engagement are timely access to treatment and a focus on supporting retention for at least three months in structured treatment for adults with dependent drug misuse. Each drug treatment system will be assessed on its ability to engage service users on these two issues, through performance management on national waiting times and retention targets by the NTA, as outlined in the Government's treatment effectiveness strategy.

During the engagement phase of treatment, service users will need to be assessed to ensure treatment can be tailored to their needs and at this stage they may benefit from motivational work focused on maximising engagement. Particular consideration may need to be given to preventing disengagement of certain drug users (e.g. those from some Black and minority ethnic groups, younger drug users and clients with mental health and substance misuse problems). The engagement of service users may be enhanced by a specific process of induction into treatment, so it is made clear and comprehensible for individuals what are the roles and responsibilities of the service provider and what are the expectations on service users themselves.

Following assessment, care plans will be agreed with the clients and structured treatment will begin. There also needs to be more explicit commissioning of interventions that engage service users and build "therapeutic alliances", which are crucial to treatment retention and positive changes in treatment.

A range of interventions to support engagement could be explicitly commissioned, including brief interventions, services for the children of drug users, advocacy and support arrangements and interventions to contact, engage and follow up people (e.g. outreach for rough sleepers, motivational interventions).

#### *Drug treatment delivery*

Drug treatment providers need to deliver effective and evidence-based drug treatment interventions, following completion of a care plan that has been agreed with the client. Drug treatment practitioners should work to build an effective therapeutic alliance with service users, encouraging full participation by them in delivering their own care plans. Good-quality drug treatment should be associated with improvement across a range of domains, including an individual's substance use, health, social functioning and in reduced public health and offending risks posed to others.

In delivery of drug treatment, a greater emphasis is required on improving service users' physical and mental health, importantly for those with hepatitis C infection and for those misusing alcohol. Increases in the use of cocaine and crack cocaine by service users may have a negative impact on client outcomes, unless this is addressed, particularly with injecting drug users.

The children, carers or significant others of service users should also be considered during care-planned treatment. The needs of the children of drug-misusing parents also require greater attention (ACMD, 2004).<sup>40</sup>

During this phase, clients should begin to receive other interventions to meet their wider needs. These interventions could include improving housing status, getting other healthcare needs met by other health specialists (e.g. liver disease and dentistry), help with children and family issues, and provision of assistance to enable service user back to work or education. These non-drug treatment interventions should be set out in the client's care plan and links made with appropriate services to ensure the client receives them. This includes the initiation of elements of community integration.

To ensure that the delivery of drug treatment meets the client's needs in a timely way, local treatment systems must ensure continuity of care between the criminal justice system and drug treatment. This is particularly relevant for clients entering and leaving prison.

Clients who are on long-term maintenance (ideally in shared care) should be considered to be continuing in the delivery phase of treatment.

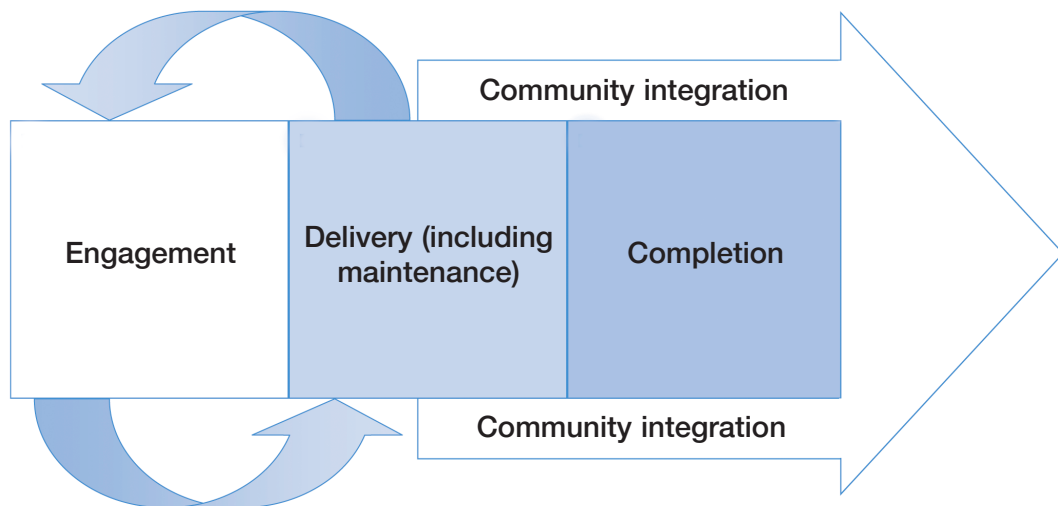


Figure 1: The client's journey

### Improving community integration

Whether service users are in treatment (e.g. maintained on substitute opiate medication) or leaving treatment they should have access for social support (e.g. housing support, educational support, employment opportunities) to maximise positive gains they have made in treatment.

Service users who are stable but who wish to be maintained on substitute opioid medication should have opportunities to receive social support, education and employment where appropriate. For stable individuals who do not need to continue in specialised drug treatment services, there should be clear pathways into maintenance and monitoring in primary care settings with ongoing community integration interventions and support. However, it is vital that such service users have explicit accessible pathways back into specialised structured drug treatment services if needed (e.g. in case of relapse).

DAT partnerships should consider linking their drug treatment targets to wider mainstream targets, that relate to housing, education and employment for drug users (e.g. Office of the Deputy Prime Minister for Supporting People, Department of Work and Pensions for Jobcentre Plus and Progress2Work).

### Improving treatment completion

Few service users who enter drug treatment intend to be in specialist drug treatment indefinitely. For those who wish to be drug-free, commissioners and providers need to create better pathways and exits from specialist drug treatment.

These pathways should include drug-related and non-drug-related support. Drug treatment providers and commissioners are responsible for the drug-related support, and should form the necessary local strategic links to enable clients to access non-drug-related support, including improved social support, housing, education and employment opportunities to maximise treatment gains.

This approach will require treatment systems to be configured both to create effective exit routes out of specialised drug treatment, including efficient access to Tier 4 provision for those who wish to be drug-free, and to be well integrated with primary care and other systems of support and care for those in maintenance treatment.

Drug-related aftercare support, such as support groups or individualised sessions or alternatively from mutual aid groups run by Narcotics Anonymous or non-12-Step equivalent groups, has been demonstrated to sustain abstinence.

Improving community integration and treatment completion may require some drug treatment system or service redesign, including:

- As well as planning for numbers in treatment and numbers of clients retained in treatment, commissioners should plan for numbers of planned client exits from treatment
- Investing in quality drug treatment delivery to maximise gains and service users' improvement in treatment (whether achieving stability on maintenance treatment or achieving effective abstinence)
- Enhancing routes to treatment completion or, for stable patients who no longer need specialist care, better routes to community maintenance in primary care settings
- Commissioning a range of aftercare provision for service users to follow structured treatment, as a development of Tier 2 interventions, and ensuring a range of other support mechanisms for ex-service users (e.g. drug-free support such as Narcotics Anonymous or equivalents)
- Investing in strategic partnerships with housing, education and employment, together with bespoke initiatives for drug misusers aimed at reintegration.

## 4 Substance misuse assessment

Substance misuse assessment is a process to establish the nature and extent of drug and alcohol misuse, what level of need an individual may have and what interventions are required. Assessment varies in its depth and level of detail, depending on the purpose and anticipated outcome of the assessment process. Models of Care 2002 identified three levels of assessment: screening, triage and comprehensive assessment, and provides a detailed description of each level of assessment. The majority of respondents to the consultations found the different levels in Models of Care 2002 to be meaningful and useful. These are reiterated here.

### 4.1 Screening assessment

Screening assessment is a brief process that aims to establish if an individual has a drug and alcohol problem, related or co-existent problems and whether there is any immediate risk for the client. The assessment should identify those who require referral to drug treatment services and the urgency of the referral. Screening assessment may include an element of brief opportunistic intervention aimed at engaging or preparing the client for treatment. Screening assessment is likely to be carried out in generic settings.

### 4.2 Triage assessment

Triage assessment usually takes place when a drug misuser first contacts specialist drug treatment services. The aim of triage assessment is to determine the seriousness and urgency of a client's problems and the most appropriate type of treatment for the client. It involves a fuller assessment of the individual's drug and alcohol problems than is conducted at screening, as well as assessment of a client's motivation to engage in treatment, current risk factors and the urgency of need to access treatment. As a result of a triage assessment, a client might be offered services within the assessing agency or onward referral to another service. A further outcome of triage assessment is that, where appropriate, work is undertaken to further engage and prepare the client for treatment.

#### 4.2.1 Assessment in the Drug Interventions Programme

Assessments of clients seen by CJIT workers in the community and CARAT teams in prison are to be carried out within the Models of Care framework.

A summary of the information from the assessment is collected on the Drug Interventions Record (DIR). An effective DIR-based assessment addresses the range of the client's presenting needs and covers health and social issues as well as drug use.

In the context of the DIR, the assessment is the key step towards the development of an initial care plan and is also the first

important stage in gathering together, in a consistent way, the information that will facilitate effective continuity of care for drug users in the community and between community and prison.

Criminal justice integrated teams (CJITs) should all be able to undertake assessments up to triage level and should have resources available to the team to carry out more complex and comprehensive assessments. It is important that practitioners only carry out assessments according to their qualifications or competence, and use the expertise of colleagues when necessary.

### 4.3 Initial care plan

Following triage-level assessment, it may be good practice to produce an initial care plan for clients. For clients taken onto the CJIT caseload this will be essential, but it may also be useful in other treatment services, particularly for clients who are identified as at high risk, who have complex drug-related problems or are likely to be hard to engage. Within prisons, initial care plans may be appropriate for prisoners in the very early days of custody, or those who are due to be released shortly after the triage is undertaken.

The initial care plan is to facilitate a focus on a client's engagement in the treatment system, to ensure their immediate needs are met, to build a therapeutic alliance and to ensure appropriate support if they are waiting to undergo comprehensive assessment. Not all clients will be required to undergo a comprehensive assessment, and some may remain on their initial care plan and be reviewed until they are discharged from treatment.

The initial care plan is particularly relevant to CJIT/CARAT clients, all of whom will receive an initial care plan after triage-level assessment if taken onto the caseload. The initial care plan is set at Tier 2 interventions level. If an initial care plan identifies the need only for Tier 2 interventions, this will need to be reviewed with the client at regular intervals. If the presenting needs increase, the client may have to be referred for a comprehensive assessment.

Where a prisoner is in custody for a short period of time – up to 28 days – and there is insufficient time to progress to a comprehensive assessment and care plan, an initial care plan may be drawn up to ensure their immediate and throughcare needs are met.

### 4.4 Comprehensive assessment

Comprehensive assessment is targeted at drug misusers with more complex needs and those who will require structured drug treatment interventions. The assessment aims to determine the exact nature of the client's drug and alcohol problems, and co-existing problems in the other domains of health (mental and physical), social functioning and offending. A full risk assessment

should also be conducted. Comprehensive assessment may be conducted by more than one member of a multidisciplinary team, because different competences may be necessary to assess different areas of client need (e.g. a doctor needs to assess clients for prescribing interventions involving controlled drugs – a supplementary prescriber may also be involved; or a psychologist may need to carry out psychometric assessment).

Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out when a client may:

- Require structured and/or intensive intervention
- Have significant psychiatric and/or physical co-morbidity
- Have significant level of risk of harm to self or others
- Be in contact with multiple service providers
- Have a history of disengagement from drug treatment services
- Be pregnant or have children “at risk”.

Comprehensive assessment provides information that will contribute to the development of a care plan for a client.

#### 4.5 Risk assessment

It is best practice to carry out risk assessment as part of screening, triage and comprehensive assessment. Risk assessment aims to identify whether the individual has, or has had at some point in the past, certain experiences or displayed certain behaviours that might lead to harm to self or others. The main areas of risk requiring assessment are:

- Risk of suicide or self-harm
- Risks associated with substance use (such as overdose)
- Risk of harm to others (including harm to treatment staff, harm to children and domestic violence)
- Risk of harm from others (including domestic violence)
- Risk of self-neglect.

If risks are identified, risk management plans need to be developed and actioned to mitigate immediate risk. If a service has concerns about the needs and safety of children of drug misusers, local protocols should be followed, for example if there are concerns about risk of significant harms, social services would normally be involved in further assessment of risk. As with comprehensive assessment, risk assessment is an ongoing process and requires integration into care planning. Issues of risk highlight the need for appropriate information sharing across services and therefore the need for cross-agency policies and plans, and for clarity with a client around the limits of confidentiality.

#### 4.6 Competences required to conduct assessments

The Drug and Alcohol National Occupational Standards (DANOS)<sup>39</sup> outline the basic competences for professionals to undertake different levels of drug and alcohol assessment. Comprehensive assessment is intended to be a multidisciplinary process to ensure a holistic approach to client need. Where a medical intervention is required, such as substitute prescribing or a psychiatric evaluation, the assessment must be undertaken by an appropriately trained doctor.

For more information on assessment, see the Care Planning Practice Guide (NTA 2006).<sup>5</sup>



## 5 Care planning

This section should be read alongside the Care Planning Practice Guide,<sup>5</sup> which contains more detailed information and guidance on care planning.

### 5.1 The need for good-quality care planning and co-ordination of care

In Models of Care: Update 2006 there is a stronger focus on care planning as central to drug treatment and a defining characteristic of structured treatment. The Audit Commission report Drug Misuse 2004 outlines the good progress that has been made since 2002 to meet the recommendations of the 2002 report. However, one of the areas that Drug Misuse 2004 highlights as needing improvement is consistency in the quality of care planning. The report concludes that care planning is frequently *ad hoc* and should be a routine activity monitored by local drug partnerships, in order to deliver the vision of integrated care envisaged in current national guidance. It also recommends that there should be performance indicators that focus on effective care planning and aftercare outcomes.

The NTA has identified care planning as a key tenet in its Treatment Effectiveness strategy, recognising that the combination of good care planning, good co-ordination of care and frequent reviews of care plans with service users, is the vehicle to deliver improvements to individuals' health and social functioning and reduce the public health and crime risk they pose to others. The NTA's Business Plan 2005/06<sup>25</sup> sets an objective that, by 2008, all individuals in treatment have an identifiable written care plan, which tracks their progress and is regularly reviewed with them.

### 5.2 Care planning in Models of Care: Update 2006

This section sets out key principles for care planning and co-ordination of care, and a summary of the process as it relates to a client's treatment journey. Further details on the NTA's recommendations for care planning are contained in the NTA Care Planning Practice Guide. Consultation confirmed that people in the drugs field wanted to see more emphasis on clients achieving treatment goals through the delivery of a care plan and the client treatment journey. Therefore, although the key principles of care planning and the co-ordination of care set out in Models of Care 2002 remain the same, there are some differences in focus, which are consistent with the overall greater focus on the client's treatment journey. These are:

- The care planning process as the essential component of the client treatment journey
- The importance of all clients receiving keyworking as a crucial element of care-planned treatment

- A greater focus on clients' participation in the care planning process, where they are involved in producing and agreeing their care plans. This is consistent with the consultation response where an overwhelming majority of respondents wanted to see more service user involvement in care planning and review
- Ensuring the care plan actively covers meeting client needs in the four key domains of – substance misuse, health (physical and psychological), social functioning (including employment and education), and offending behaviour. This will require providers to work together to meet these multiple needs and greater co-ordination of elements of the care plan
- The focus in care plans and keyworking on the main elements in the treatment journey: engagement, delivery, and completion or maintenance.

### 5.2.1 Care co-ordination

The previous levels of "standard" and "enhanced" care co-ordination are no longer referred to in Models of Care: Update 2006. It is clear that clients have a range of needs, from simple to highly complex, and this must be reflected in the care plan and the intensity of care co-ordination. It is expected that the keyworker would co-ordinate care in most cases. External care co-ordination may be required where a client has multiple needs or is under statutory obligations via the criminal justice system, Care Programme Approach (CPA) etc. This enables services to reflect on case mix in a more flexible way taking into account the staff competences, client characteristics and client needs, as well as the systems of multidisciplinary working that are in place.

## 5.3 Care planning

### 5.3.1 The care planning process

Care planning is a process for setting goals based on the needs identified by an assessment and planning interventions to meet those goals with the client. Care planning is a core requirement of structured drug treatment.

### 5.3.2 The care plan

A care plan is an agreement on a plan of action between the client and service provider. It should be a paper document which is available to the client and kept on the client's file. Care plans should document and enable routine review of client needs, subsequent goals and progress across four key domains:

- Drug and alcohol misuse
- Health (physical and psychological)
- Offending
- Social functioning (including housing, employment and relationships).

A care plan should be brief and readily understood by all parties involved and should be a shared exercise between the client and service.

The care plan should explicitly identify the roles of specific individuals and services, and the client, in the delivery of the care plan. Care plans should be reviewed both routinely and opportunistically when a change in a client's circumstances makes it necessary.

For more details on care planning, see the Care Planning Practice Guide.

Some clients, particularly those in contact with CJITs or CARAT services, may have an initial care plan which has been drawn up to address any immediate needs the client may have, or to ensure their engagement in treatment. The initial care plan is specific and targeted and may not address all four key domains above, but it should still be an agreed plan between the client and the worker from the CJIT, CARAT or treatment provider, and recorded and be made available to the client. It should also be easily understood and reviewed regularly.

### 5.3.3 Care planning and the treatment journey

This section describes the client treatment journey represented in Figure 2 overleaf.

Clients may make contact and enter the treatment system through a wide range of service providers, which may be providing interventions across the tiers. These services should provide screening and brief initial risk assessment to identify drug and alcohol problems, problems in line with that described in Models of Care: Update 2006 (and previously in Models of Care 2002). Up-to-date posters and leaflets should be available in these services, concerning drug and alcohol issues. These will include health promotion messages, harm reduction strategies (including for example overdose prevention) and information on where to get help. If necessary, referral to a more specialist service should occur. Ideally, this should occur in line with a written protocol or policy including referral criteria agreed with the local DAT.

Some services, such as A&E departments and maternity services, are particularly likely to have contact with drug users who have not been in touch with specialist provision. NHS trusts providing these services should ensure that they have policies in place to ensure that they can make available to patients up-to-date advice and information relating to drug misuse and specifically:

- The potential physical and psychological complications of drug and alcohol misuse
- How to reduce safely the harms associated with drug use, particularly overdose and blood-borne viruses
- How to reduce safely and stop the misuse of various illicit drugs and alcohol

- How and where to access help for problems associated with drug and alcohol misuse.

Once the drug problem has been identified (and if necessary, referral has taken place) the client will receive a triage assessment and brief initial risk assessment to identify the nature and extent of their drug use, the seriousness and urgency of their problems and the most appropriate type of treatment.

The issue of engaging and retaining a client in the early phases of treatment may be addressed after either (or both) screening and triage assessment. The need for a focus on continuing engagement may continue beyond the comprehensive assessment. Where interventions are required to engage the client these may include:

- Psychosocial interventions (e.g. contingency management, motivational interventions)
- Advice and information
- Harm reduction interventions
- Rapid access to prescribing
- Other interventions focused on engagement
- Interventions to help the client prepare for change
- Interventions to address specific needs that may impact on a client remaining in treatment
- Access to pharmaceutical services or supervised consumption of treatment medications and needle exchange.

In some situations, following the triage assessment, an initial care plan may be drawn up by the keyworker to enable the client's engagement and to help retain them in the treatment system. The initial care plan will ensure immediate needs are met and support structures are in place, until they receive a comprehensive assessment, where appropriate. This will apply to CARATs when release is imminent and there is insufficient time to progress to a comprehensive assessment and full care plan while in custody.

Clients in some service settings may not, at first, be considered to require Tier 3 or Tier 4 interventions or to require a comprehensive assessment (e.g. some CJIT or CARAT clients) and may not have complex needs. In these cases, the clients will receive interventions to address their identified needs. However, on review of the initial care plan, a client may present with more complex needs and therefore be considered to need a comprehensive assessment, which should be arranged with the treatment provider. Alternatively, the client may be discharged following regular reviews of the initial care plan.

The comprehensive assessment will build on the engagement work commenced in any initial care plan.

The comprehensive care plan will identify a range of interventions to meet client needs in the four key domains. Regular keyworking should either deliver or co-ordinate provision of the treatment



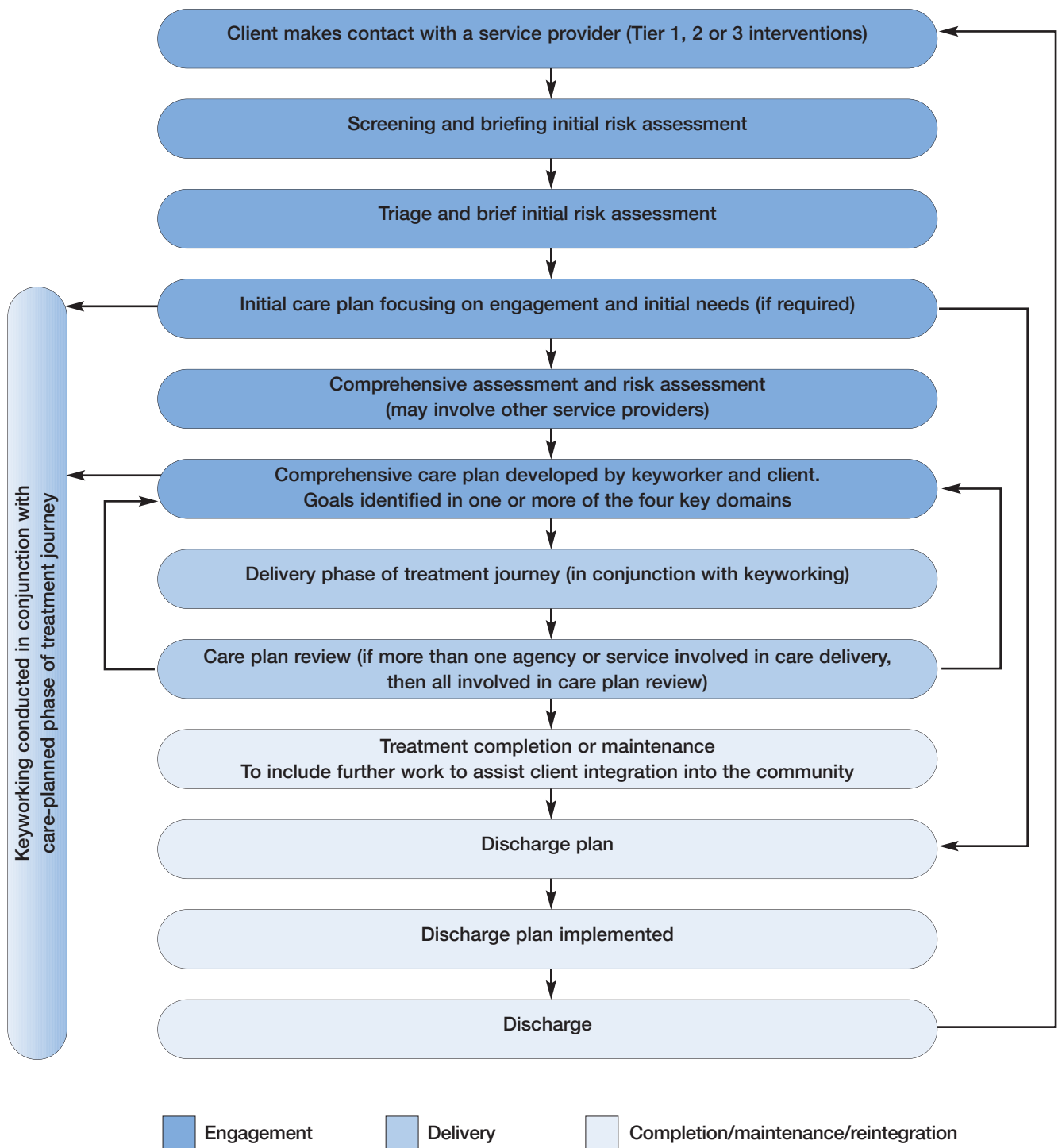


Figure 2: Standard client treatment journey – with initial care plan option included

interventions outlined in the care plan. Once the interventions have started, treatment moves into the “delivery phase”, which includes regular review of the care plan.

The final stage in the treatment journey is the “treatment maintenance or treatment completion” phase. Clients should be assisted to leave structured drug treatment when appropriate and

to maintain the changes they have achieved. This may involve helping the client access a range of non-care-planned community-based services, such as mutual aid groups, housing support, employment, and training and education opportunities (if they are not already receiving them).

It may also be appropriate for a proportion of opiate-using clients to remain on maintenance prescribing regimes in the community, i.e. remain in the treatment maintenance phase of structured treatment. These clients will continue to have a keyworker and a care plan which covers their needs across the four domains.

Clients who are being discharged from treatment should have an aftercare plan covering both drug-related and non-drug-related support, which is implemented through ensuring all the necessary links are in place for the client to receive all the aftercare they require.

For more detailed information on this process and how it works, see the Care Planning Practice Guide.

#### 5.3.4 Keyworking and the care planning process

The keyworker is the dedicated and named practitioner who is responsible for ensuring the client's care plan is delivered and reviewed. This would normally be the practitioner in most regular contact with the client. However, given the range of settings in which structured treatment is provided, the keyworker may be a drugs worker, nurse, doctor, or other health or criminal justice professional.

Keyworking is a process undertaken by the keyworker to ensure the delivery and ongoing review of the care plan. This would normally involve regular meetings between the keyworker and the client where progress against the care plan would be discussed and goals revised as appropriate. The keyworker would normally be a member of the multidisciplinary team responsible for delivering most of the client's care. Keyworking and care planning are key elements of case management currently delivered by CJITs and CARATs. These elements will also be aligned with NOMS' offender management arrangements where appropriate.

As good practice, keywork involves building a therapeutic relationship with the client. This may involve drawing up an initial care plan following triage to address immediate needs, followed by developing and implanting a comprehensive care plan.

As a minimum, the following should be delivered during keywork sessions:

- Developing and agreeing the care plan with the client, implementation of the care plan and checking progress against milestones in the care plan
- Information and advice on drug and alcohol misuse
- Harm reduction work and motivational interventions
- Other psychosocial and medical interventions may also be delivered during keywork sessions, depending on the competency of the keyworker.

In primary care, the keyworker may be the GP but more commonly would be a drugs worker supporting the GP in a shared care arrangement. In this setting, the keyworker will still

work within a care planning framework that adheres to the principles described above. Therefore, the care plan will describe how the specific roles and responsibilities of the GP, the shared care worker and any others involved will be shared in delivering co-ordinated care. Shared responsibilities will include monitoring of compliance and continuity of care. The GP is likely to lead on prescribing interventions, changes and additions to medication, and the shared care worker is likely to lead on monitoring progress against treatment goals, developing a holistic treatment plan and in ensuring multidisciplinary discussion when appropriate. For GPs working at a more specialist level (e.g. GP with special interest) the roles may be different but in all cases this will be clear in the care plan.

A keyworker role will be undertaken by a worker in the criminal justice integrated team (CJIT), for those clients taken onto the caseload following a triage assessment e.g. in a custody suite or court. The worker will take the responsibility for agreeing the initial care plan with the client, providing the motivational engagement, referring the client to other specialist treatment interventions, where appropriate, and co-ordinating links with other services (e.g. housing and employment). If a client is successfully referred to another specialist treatment service, that provider will usually take on the keyworking responsibilities. However, the CJIT keyworker may retain a role and be ready to re-engage the client if they drop out of treatment, in negotiation with the treatment provider.

Providers of wraparound support alongside CJITs may contribute to aftercare planning and handover of keywork arrangements as appropriate. This should be reflected in the care plan.

CARATs will take on the role of the keyworker while the client is in custody, to ensure continuity of care between both the community and prison and during transfers between prisons. Clients who are assessed as needing ongoing access to drug treatment services in the community will be referred to the single point of contact in the relevant CJIT, as long as the individual has given their consent for information to be passed to the CJIT.

The CJIT will consider whether the individual is to be taken onto the caseload of the CJIT. In those cases where it is appropriate for the individual, this decision is based on the drug-related needs of the individual and the capacity of the CJIT. The CJIT will provide or broker access to treatment and wraparound services as appropriate.

#### 5.3.5 The three phases of keyworking

The treatment journey has three main phases. The keyworker has a crucial role in ensuring the care plan adequately reflects the important stages in care. This may be through delivering these elements of care directly or by ensuring the care delivered by others is adequately co-ordinated and reflects these elements. We recognise that in many services the term keyworker is used to

mean both the co-ordinator of the care plan and the main deliverer of care.

Key elements the keyworker needs to address in developing the care plan at each stage:

**Treatment engagement phase.** Actions taken should include interventions to engage the individual, building a therapeutic relationship, ensuring risks of leaving treatment early are identified and addressed, drawing up an initial care plan following triage-level assessment to meet immediate needs (if this is required) and developing and agreeing the care plan following comprehensive assessment and initial implementation of the care plan.

**Treatment delivery phase.** The therapeutic relationship with the client continues to be developed by the keyworker and others, with the aim of active changes in drug use and lifestyle improvement. The care plan is regularly reviewed and revised in line with any changing needs, and liaison and collaboration with other providers of care takes place, and risk of disengagement continues to be addressed.

**Long-term treatment or treatment completion.** The keyworker should ensure the care plan enables the client to remain in long-term treatment when appropriate. This part of the care plan would usually involve clients who are stable on maintenance on substitute medication moving into shared care arrangements and being maintained in primary care. The keyworker should also address action to support clients who want to be drug-free, leave treatment and maintain changes they have made while in treatment. Alternatively, they may have to arrange the transfer of a client to another service provider to continue treatment.

### 5.3.6 Care planning and co-ordination of care in the criminal justice system

Continuity of care is vital to the treatment and support given to problematic drug-using offenders as they move between different criminal justice and treatment agencies. Improving continuity of care for clients is reliant upon seamless case management through the effective provision and communication of timely, targeted and correct information.

Ensuring that a drug-misusing offender is supported throughout their contact with the criminal justice system, or treatment, is essential to maximising their chances of remaining engaged in treatment. Various individuals and agencies may be involved in the case management of an offender at different stages and it is essential that the process is as continuous and uninterrupted as possible for the individual concerned. The Drug Interventions Record (DIR) establishes a common recording tool for use by CJITs in the community, and counselling, assessment, referral, advice and throughcare services (CARATs) in prisons. It contains a minimum set of data for monitoring and provides information on continuity of care, including continuity between the prison and the

community treatment. In prison, the DIR is used as a means to record the substance misuse triage assessment.

It is important that at each stage of the care plan the keyworker considers whether other professionals are also involved with the individual and whether (within the legal framework) they should be liaising and exchanging information with other individuals or agencies. Offenders on statutory supervision should have links with the appropriate offender management arrangements.

For more on the roles of CJITS and CARAT teams in care planning, see section 5.3.6, and the Care Planning Practice Guide.

### 5.3.7 Care planning in other groups with externally co-ordinated care

Some other groups of individuals require particular co-ordination of care with other agencies.

Individuals with severe mental health problems whose care is co-ordinated under the care programme approach (CPA), particularly those on “enhanced” CPA, will have a named mental healthcare co-ordinator. The structured drug treatment providers usually contribute to elements of the mental health CPA plan of care.

Those who are under supervision or treatment orders from the criminal justice system will need careful integration of planning of their structured treatment to optimise outcomes (e.g. in the case of those on Drug Rehabilitation Requirements). The probation service may have information (particularly regarding risk issues and offending behaviour) that may need to be incorporated into the care plan.

Clients receiving community care funding, with a community care manager (sometimes drug specific) responsible for their treatment (e.g. someone in residential rehabilitation), may have the co-ordination of care and case management provided by a community care manager (sometimes drug-specific). The drug service interventions and care plan will then be provided in the context of that formal process of planning care.

In these, and other similar cases, a decision will still need to be made about the level of planning and monitoring required by the provider of the structured drug treatment, and the care plan will need to reflect arrangements for contributing to the external plans of care.

## 6 Integrated care pathways

### 6.1 Commissioning integrated care pathways

An integrated care pathway (ICP) describes the nature and anticipated course of treatment for a particular client and a predetermined plan of treatment. A system of care should be dynamic and able to respond to changing individual needs over time. It should also be able to provide access to a range of services and interventions that meet an individual's needs in a comprehensive way. Previous consultation has shown that the majority of respondents found that the ICPs set out in Models of Care 2002 had been useful to them in their work.

ICPs should be developed for drug and alcohol misusers for the following reasons:

- Drug and alcohol misusers often have multiple problems that require effective co-ordination of treatment
- Several specialist and generic service providers may be involved in the care of a drug and alcohol misuser simultaneously or consecutively
- A drug and alcohol misuser may have continuing and evolving care needs requiring referral to services providing different tiers of intervention over time
- ICPs ensure consistency and parity of approach nationally (i.e. a drug misuser accessing a particular treatment intervention should receive the same response wherever they access care)
- ICPs ensure that access to care is not based on individual clinical decisions or historical arrangements.

Models of Care 2002 Part 2 encouraged commissioners and providers to develop and publish local ICPs by March 2004. ICPs may need to be revised in the light of this update and in the light of changes in treatment systems (particularly in relation to offenders), changes for clients requiring Tier 4 treatment and for those requiring active interventions for prevention or management of blood-borne virus infection.

### 6.2 Elements of integrated care pathways

Commissioners should ensure that each drug and alcohol treatment intervention should have an ICP, which should be agreed with and between local providers, and built into service specifications and service level agreements. Integrated care pathways should contain the following elements:

- A definition of the treatment interventions provided
- Aims and objectives of the treatment interventions
- A definition of the client group served
- Eligibility criteria (including priority groups)
- Exclusions criteria or contraindications

- A referral pathway
- Screening and assessment processes
- Development of agreed treatment goals
- A description of the treatment process or phases
- Co-ordination of care
- Departure planning, aftercare and support
- Onward referral pathways
- The range of services with which the interventions interface.

These elements are designed to provide clarity as to the type of client the drug treatment intervention caters for, what the client can expect treatment services to provide, and the roles and responsibilities of the service within the integrated care system and towards the individual client.

### 6.3 ICPs and the treatment journey

An ICP will not necessarily be the whole description of a person's treatment journey. An individual ICP will be focused on one treatment intervention in a client's care plan, within which a client may receive a range of interventions. Therefore, it is important that the development of local ICPs takes into account the client treatment journey through care-planned treatment and represents it in a way that clients can understand and see their experience reflected.

Figure 2 sets out an overall representation of client's journey through treatment. This can assist with the planning of ICPs. However, this figure and the ICPs for drug treatment described in Models of Care 2002: Part 2 are illustrative rather than prescriptive. Local ICPs should describe the structure and content of drug treatment interventions, but these should be adapted to local needs and drug treatment providers as appropriate.

As well as ICPs for specific treatment types, there will also need to be local ICPs developed for specific client groups, particularly excluded groups of service users who may have difficulty in gaining access to treatment because they have complex needs and because they are vulnerable. Models of Care 2002: Part 2 has some examples of these (e.g. ICPs for drug and alcohol misusing parents and pregnant drug users). Again, these must be developed using the above principles to fit in with local need.

## 7 Quality criteria and improvement reviews

Drug treatment should be seen as integral to the NHS and other social care and criminal justice provision. Realising links to other quality initiatives is important, as the majority of drug misuse treatment will be commissioned by local mechanisms for commissioning healthcare. Primary care trust commissioning structures and local joint commissioning structures and partnerships are crucial to drug treatment.

### 7.1 The Department of Health's Standards for Better Health

Drug treatment should be provided in line with the Department of Health's Standards for Better Health (2004). The purpose of the standards is to provide a common set of requirements applying across all healthcare organisations, to ensure that health services are safe and of an acceptable quality and provide a framework for continuous improvement.

There are two sets of standards:

- **Core standards** describe a level of service that is acceptable and must be universal. Meeting the core standards is mandatory. Healthcare organisations must comply with them from the date of publication
- **Developmental standards** are designed for a world in which patients' expectations are increasing. Progress is expected to be made against the developmental standards across much of the NHS as a result of the NHS Improvement Plan and the extra investment in the period to 2008. The Healthcare Commission will, through its criteria for review, assess progress by healthcare organisations towards achieving the developmental standards.

These standards cover seven domains – safety, clinical and cost-effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities and public health. The Healthcare Commission will focus assessments around these performance areas to measure outcomes, outputs and process quality.

Models of Care: Update 2006 specifically supports service development towards development standard D2.

#### **Standard D2: Patients receive effective treatment and care that:**

- Conforms to nationally agreed best practice, particularly as defined in the national service frameworks, NICE guidance, national plans and agreed national guidance on service delivery

- Takes into account their individual requirements and meets their physical, cultural, spiritual and psychological needs and preferences
- Is well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations
- Is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

### 7.2 NTA and Healthcare Commission Improvement Reviews

The NTA works in partnership with the Healthcare Commission, developing detailed criteria for reviewing drug and alcohol treatment services, and carrying out these reviews. These criteria are developed during the process of each themed annual Improvement Review of drug treatment systems. Improvement Reviews will review local providers and commissioning functions against these criteria and against Standards for Better Health (2004).

The reviews for 2005/06 were piloted and developed in consultation with the drugs field. Detailed criteria have been developed for reviewing care planning and co-ordination and community prescribing, and were published in 2005. They are available on the NTA website at [www.nta.nhs.uk](http://www.nta.nhs.uk). Criteria for future reviews will also be available from the NTA website.

Upcoming themes are:

- 2006/07: systems management (across the key elements of risk management, patient choice, diversity and effective partnerships) and harm reduction provision
- 2007/08: Tier 4 treatment and diversity (to be confirmed).

There are two parts to an Improvement Review. In the first part, the performance of all organisations taking part in the review is assessed. Using a standard framework, an initial assessment is made of the performance of each DAT and participating healthcare organisation. Wherever possible, this is done using nationally held data to reduce the burden on treatment providers. In the second part, the minority of organisations or treatment systems (approximately ten per cent) that have the weakest assessments are helped in developing an action plan to improve their performance.

The assessments are focused on a small number of key outcomes and quality measures, which matter most to patients and the public, and on the key features of services that are necessary to achieve good outcomes and quality for patients and the public.

More detailed information on the review process can be found on the NTA website at [www.nta.nhs.uk](http://www.nta.nhs.uk) and the Healthcare Commission website at [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk).



### 7.3 National standards for professionals working in drug services

A range of quality frameworks are relevant and used by drug treatment services to demonstrate quality or meet national requirements for registration or inspection. These include the following:

#### 7.3.1 NHS Knowledge and Skills Framework

The NHS Knowledge and Skills Framework (NHS KSF)<sup>41</sup> defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff. The NHS KSF and its associated development review process lie at the heart of the career and pay progression strand of the NHS Agenda for Change. Specific professional registration criteria and qualifications or accreditation programmes exist for groups such as nurses, pharmacists, general practitioners and addiction psychiatrists involved in substance misuse treatment, which relate to differing levels of competence. These involve accreditation by the Nursing and Midwifery Council, the Royal Pharmaceutical Society of Great Britain (RPSGB), the General Medical Council, the Royal College of General Practitioners and the Royal College of Psychiatrists and most recently additional training and accreditation for supplementary non-medical (nurse and pharmacist) prescribers. The Royal College of General Practitioners and the Royal College of Psychiatrists, in conjunction with the NTA, published a set of competences for doctors in 2005.<sup>31</sup>

#### 7.3.2 Drugs and Alcohol National Occupational Standards

The Drugs and Alcohol National Occupational Standards (DANOS) guidance gives clear descriptions of the standards of performance required of people in the drugs and alcohol field. The guidance also describes the knowledge, understanding and skills workers need in order to perform to those standards. The DANOS standards describe all the functions and activities involved in improving the quality of life for individuals and communities by minimising harm associated with substance misuse. There are three key categories in DANOS: service delivery, management of services and commissioning services. More information on DANOS, and the standards, can be found at [www.skillsforhealth.org.uk/danos](http://www.skillsforhealth.org.uk/danos).

Training providers increasingly provide programmes which are linked to National Occupational Standards, which will assist employers to ensure new workers can be quickly inducted and existing workers can be provided with the knowledge and skills needed to perform their roles competently.

#### 7.3.3 National minimum standards for care homes for younger adults

The national minimum standards for care homes for younger adults<sup>42</sup> were issued under the Care Standards Act 2000 (CSA). The Commission for Social Care Inspection (CSCI) currently has the remit to inspect and regulate individual establishments, agencies and institutions for which registration as care homes is required. The standards specifically apply to care homes for people with alcohol or substance misuse problems and cover choice of home, individual needs and choices, lifestyle, personal and healthcare support, concerns, complaints and protection, environment, staffing, conduct and management of the home.

They also specify the national occupational standards for staff. In order to meet registration criteria, staff and managers are required to have relevant TOPSS NVQ qualifications, or demonstrate they are working towards them.

#### 7.3.4 Commissioning Standards for Drug and Alcohol Treatment and Care

In 1999, the Substance Misuse Advisory Service (SMAS), on behalf of the Department of Health, developed the Commissioning Standards for Drug and Alcohol Treatment and Care<sup>43</sup> document as a tool for commissioners of drug treatment. The document provides guidance on the commissioning of comprehensive and evidence-based alcohol and drug treatment and care systems, and is available on the NTA website at [www.nta.nhs.uk](http://www.nta.nhs.uk).

#### 7.3.5 Quality in Drugs and Alcohol Services (QuADS)

QuADS<sup>44</sup> was developed jointly by Alcohol Concern and DrugScope for the DH (1999) and is still widely used by alcohol and drug treatment services throughout England as the set of quality standards for organisations in the sector. Organisations use the standards for self-assessment and also for peer review. QuADS is particularly relevant when considering the management and quality assurance of drug and alcohol treatment services.

#### 7.3.6 Other quality frameworks and standards

Other quality improvement frameworks, standards or accreditation systems are also be relevant to alcohol intervention and treatment systems. These may include clinical governance mechanisms in NHS providers, Investors in People, criminal justice accredited programmes, standards and registration for independent hospital provision, and RPSGB standards as set out in the Medicines, Ethics and Practice guidance.<sup>45</sup>

Commissioners and providers should be clear about which quality initiatives are required and how other quality initiatives (e.g. Investors in People), can contribute to demonstrating the quality of local provision. Commissioners should minimise duplication of effort for providers in reporting requirements where possible.

## 7.4 Quality requirements for drug treatment

The following section outlines criteria to summarise key quality requirements for drug treatment that represents nationally agreed best practice, consistent with this guidance and with other nationally recognised guidance. Therefore, these can be used to support commissioners, services, and the Healthcare Commission in making progress in achieving a number of developmental standards in drug misuse treatment.

There are 15 key quality criteria for drug treatment outlined. The quality criteria are divided into two sections: those for commissioners, and those for providers of drug treatment. The 15 broad quality criteria for drug treatment are:

### 7.4.1 Quality requirements for commissioners

#### *QRC1: Strategic partnerships*

Local commissioning mechanisms should have formal strategic partnerships with key stakeholders including health, social care, housing and employment services, drug treatment providers, and local drug user and carers.

#### *QRC2: Local needs assessments*

There is a shared understanding of the local need for drug treatment, based upon annual needs assessment reports in line with a nationally agreed methodology. The needs assessment profiles the diversity of local need for drug treatment, including rates of morbidity and mortality (e.g. infection with BBVs), the degree of treatment saturation or penetration, and impact of treatment on individual health, public health and offending.

#### *QRC 3: Drug treatment systems are developed in line with national frameworks*

Local commissioners for drug treatment develop local drug treatment system plans annually in line with the Models of Care: Update 2006, with focus on reducing harm to individuals and communities, improving clients' journeys through treatment, predicting client flow through local systems and improving the effectiveness of local drug systems.

#### *QRC 4: Local commissioning partnerships demonstrate good practice in managing public finance and contracts*

Local commissioners demonstrate best practice in handling public money, contracting with providers and monitoring service level agreements.

#### *QRC 5: Performance management of local drug treatment systems*

Local commissioning partnerships performance manage local systems of drug treatment using data and key performance indicators in partnership with local strategic partners and plans.

#### *QRC 6: Local commissioning functions are "fit for purpose" and competent*

Local commissioning partnerships are "fit for purpose", have involvement from key stakeholders at an appropriate level of seniority and ensure commissioners are competent against national quality standards and other relevant professional frameworks.

### 7.4.2 Quality requirements for providers

#### *QRP 1: A person-centred service*

All those with drug misuse problems have access to appropriate drug treatment irrespective of their background and characteristics and each service user is supported to improve their health, social circumstances and wellbeing by the provision of individually tailored drug treatment.

#### *QRP 2: Screening and assessment*

Individuals with drug misuse problems are screened and/or assessed in sufficient detail to identify their drug treatment needs and inform individual care plans (where required).

#### *QRP 3: Reducing harm to drug misusers*

Individuals with drug misuse problems receive information, advice, injecting equipment where appropriate and brief interventions and treatment to help them reduce potential harm due to the transmission of blood-borne viruses (HIV, hepatitis B and C), drug-related infections and overdose, and other drug related deaths, and to improve their physical and mental health

#### *QRP 4: Reducing drug-related harm to others*

- Drug treatment providers ensure that drug service users' significant others have access to support and interventions to reduce harm related to drug misuse. This includes intervening to reduce the risk of (significant) harm to the children of drug misusers and ensuring partners and families of service users have access to support in their own right
- Drug treatment providers collaborate with criminal justice colleagues to ensure drug-misusing offenders have access to appropriate drug treatment, and appropriate interventions addressing risk of harm
- Drug treatment providers work with local authorities and communities to minimise other, potential drug related harm, e.g. discarded injecting equipment and public nuisance
- Drug treatment providers work within Area Child Protection Committee guidelines

#### *QRP 5: Providing brief interventions*

Brief drug-related interventions are provided to drug misusers, as required, to address drug and alcohol problems (e.g. for some cannabis misuse problems), to increase access to and motivation



for structured treatment, and to reduce drug or alcohol related harm (as appropriate).

***QRP 6: Improving engagement with structured drug treatment***

Access to structured drug treatment should be within national waiting times for drug treatment and those accessing structured drug treatment should usually be retained for at least 12 weeks.

***QRP 7: Structured treatment delivery: A care planning approach to deliver positive change in clients' lives***

All individuals in structured drug treatment have an identifiable written care plan, which tracks their progress and is regularly reviewed. Clients in drug treatment should show measurable positive change while in drug treatment across a range of domains. This should include: less illegal drug misuse; better health; less risk of infection and transmission of BBVs, reduced risk of behaviours associated with overdose; fewer drug-related offences committed; better social functioning and evidence of reintegration into the community.

***QRP 8: Improving reintegration and treatment completion***

Service users who need to remain in structured treatment are retained while achieving improvements in their health and social functioning. Service users who can progress out of drug treatment are supported to complete treatment via a planned exit with aftercare support. Drug services have defined pathways to enable service users to integrate into the community during and following the completion of treatment, including access to appropriate housing, education, employment and mainstream health.

***QRP 9: Provision of aftercare and reintegration***

All those that have left structured drug treatment should have access to drug-related support and mutual aid groups. This should include easy access back to structured drug treatment in the case of relapse.

## 8 Performance monitoring and management

### 8.1 Monitoring drug treatment

#### 8.1.1 NDTMS

Structured drug treatment (apart from treatment in prisons) is monitored through the National Drug Treatment Monitoring System (NDTMS). This system involves the process of collecting, collating and analysing information from the drug treatment sector. There is an NDTMS centre to cover each region, with the majority being hosted by public health observatories. One regional centre is housed within a mental health trust, while two regions are hosted by the NTA. The purpose of the NDTMS centres is to obtain accurate, good-quality, timely information for reporting structured drug treatment activity

#### 8.1.2 Numbers in treatment and retained in treatment

Through the NDTMS, the NTA monitors the performance of the structured drug treatment system at national and regional level. It reports on the numbers of people in contact with services providing structured drug treatment, and those retained for 12 weeks or more – this data is required so performance can be measured against the national target. A detailed breakdown of the data collected on clients in treatment is published in the form of an annual report on the NTA website at [www.nta.nhs.uk](http://www.nta.nhs.uk).

#### 8.1.3 Waiting times

Until March 2006, quarterly reported waiting times figures have been based on DAT partnership self-reports. However, from April 2006 figures will be reported via NDTMS.

Since January 2006, the NTA has been publishing a range of monthly drug treatment performance data, including numbers in treatment and numbers retained in treatment for over 12 weeks. The NDTMS website will make available an increasing amount of regularly published performance data (including waiting times) throughout 2006/07. See [www.ndtms.net](http://www.ndtms.net) for more details.

#### 8.1.4 Minimising the data collection burden

As a matter of principle, commissioners should endeavour to use NDTMS (and other nationally collated data such as DIRWeb) wherever possible, in service level agreements and performance monitoring with providers. This is to minimise requirements on providers to collect and provide two different sets of data.

### 8.2 Performance management of drug treatment

#### 8.2.1 NHS local delivery plans

Local delivery of National Health Service priorities is ensured via the local delivery plan process. The LDP contains all the Government's PSA targets on health, including drug misuse, and is the key vehicle for the local PCT to set its priorities for improving health, developing services and involving local people and agencies in the planning and delivery of healthcare. PCT plans for increasing the numbers of drug misusers accessing and retained in structured treatment are aggregated with the plans of other PCTs within a strategic health authority (SHA) area to form their overall LDP for increasing the numbers in treatment and improving retention.

On top of the PSA targets, DAT partnerships and the NTA have agreed local "stretch targets", which are intended to better reflect local situations and need. The PCT and the SHA have included these stretch targets in their planning.

The SHAs are performance managed by the Recovery and Support Unit (at the Department of Health) and, in turn, the SHAs performance manages PCTs to ensure they meet the targets set. The plans must ensure year-on-year increases in numbers of drug users entering treatment and drug users retained in treatment for 12 weeks or more.

Details of local numbers in treatment and retention targets are available from SHAs and PCTs. Contact details for these can be found at the NHS website [www.nhs.uk](http://www.nhs.uk)

#### 8.2.2 Healthcare Commission performance ratings

The Healthcare Commission provides an independent assessment of the extent to which primary care trusts and provider trusts perform against national targets as part of the annual health check. In 2006/07, the following assessments will be made:

- **PCTs:** Performance against LDP of "in treatment" and "percentage retained in treatment" figures
- **Mental health trusts:** The improvement over the previous year of the "percentage retained in treatment" figure
- **Acute trusts:** A process indicator looking at screening, advice, information and referral.

More information on these indicators, including detail on the measurements and data required, is set out on the Healthcare Commission's website at [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk).

#### 8.2.3 NTA performance management

Drug treatment monitoring data is used by NTA regional teams to performance manage and support local DAT partnerships in achieving the targets agreed in their annual adult drug treatment

plans. The DAT partnership should develop strategies through the treatment planning process to achieve year-on-year increases in the numbers of people entering treatment, improvements in the percentages of clients retained in treatment for 12 weeks or more, improved waiting times, and other locally relevant partnership performance expectations.

Draft treatment plans are submitted to NTA regional teams, who work with the DATs to refine these plans in the light of available resources, local assessments of need, and consultation with regional partners such as SHAs, the regional offender manager and public health bodies. The plans agreed with each DAT are used by the NTA to help monitor the progress of drug treatment at a local and regional level. The NTA fulfils the performance management role on these targets alongside the SHAs and other local and regional partners in performance managing the plans set by DAT partner organisations on targets, including those on numbers in treatment and client retention.

The monitoring of targets, though important, is part of a more complex performance management process. NTA teams work with partnerships to arrive at a better understanding of need using available data – determining treatment saturation (i.e. how many of those potentially in need of treatment are in the treatment system) and having a knowledge of treatment flow (i.e. numbers in treatment, retained in treatment and exiting treatment through planned exits from the system). A range of stakeholders, including service providers, and users and their carers, help to inform and define this process.

The NTA makes the first part of each DAT partnership's adult drug treatment plan (Part 1: Strategic Summary, National Targets, Partnership Performance Expectations and Funding Profile) publicly available via its website, [www.nta.nhs.uk](http://www.nta.nhs.uk).

#### **8.2.4 NTA and Healthcare Commission Improvement Reviews**

The NTA and Healthcare Commission Improvement Reviews will contribute to the performance management of drug treatment. These reviews use a range of data to rate DAT partnerships against specific criteria. This includes data from NDTMS, annual audit information, bespoke data compiled specifically for the review process, and other existing data sources (e.g. the NTA's prescribing audit).

Each DAT partnership is sent a report with their performance scores and the detail behind them, from the assessment and scoring done by the NTA and the Healthcare Commission. The scoring is based on a range of data collected for the assessment framework and scores for each criterion are worked out by applying pre-determined rules.

For more on the process of Improvement Reviews, see section 9.2 and the NTA website [www.nta.nhs.uk](http://www.nta.nhs.uk).

The DATs and healthcare organisations (around ten per cent) that have the weakest assessments will be asked to create action plans to address performance problems identified in the assessment, unless they already have convincing action plans in place. NTA regional teams will work with the Healthcare Commission and DATs to improve the performance of these DATs.

## 9 Drug treatment interventions

### 9.1 Drug treatment interventions as part of a local treatment system

The following section outlines the key drug treatment interventions and describes how they fit into the local treatment system. The NTA has clarified and defined the specific drug treatment interventions to assist a common understanding. These definitions below are consistent with Models of Care 2002 but provide additional clarity and a summary of key issues. They are also updated to reflect new guidance materials e.g. DANOS and Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers (2005).<sup>30</sup> This section should be read in conjunction with the sections on care planning and the treatment journey, and integrated care pathways.

Specific interventions in local treatment systems should combine to form the client's treatment journey. The integrated care pathways for each intervention should be designed in a way that ensures good links across a range of interventions can be made effectively to provide joined-up treatment for each client.

Commissioners should ensure that the full range of these treatment interventions are available to clients in their DAT partnership area, according to identified local need. These separate interventions need to fit together in a complementary way, as part of a local drug treatment system.

Some of these interventions are open access (i.e. advice and information, harm reduction interventions) and should be available and accessible for all people with drug problems in a particular area. However, these may also be component parts of a client's care plan, and are therefore delivered as part of structured treatment. The other interventions included in this chapter (apart from aftercare) are "structured treatment" interventions and have to be delivered as part of a coherent care plan agreed between the client, their keyworker and other practitioners involved in delivery.

A client may receive a number of these interventions as identified by their care plan, either sequentially (e.g. inpatient treatment followed by residential rehabilitation) or concurrently (e.g. specialist prescribing alongside psychosocial interventions and harm reduction interventions).

### 9.2 Substance misuse related advice and information

Drug and alcohol (substance misuse) related advice and information interventions should provide appropriate advice and accurate up-to-date information on a range of substance misuse related issues, including:

- Information about different drugs and alcohol, and their effects
- Advice about stopping misuse of drugs and alcohol

- Information on how to reduce the potential harm from drug misuse (e.g. safer injecting and reducing overdose risks)
- How and where to access help for drug problems
- How and where to access help for other problems (e.g. housing and sexual health)
- Information for clients' carers, partners and family members on drug problems and treatment.

The information provided must be accessible and meaningful to the recipient (e.g. using appropriate language, and written at a suitable literacy level), and if possible, available in alternative formats if required.

Advice and information interventions should be available to all substance misusers on an open-access basis, and may be provided by treatment services providing interventions across all four tiers. Commissioners should ensure that advice and information is available across a range of treatment interventions. The provision of drug related advice and information may be incorporated into a client's care plan.

Open access drug and alcohol advice and information services need to be commissioned to work closely with generic mainstream services – for example, they could be commissioned to provide training and information to non-specialist services to ensure they have up-to-date information, and that staff in mainstream services are able to adequately deliver drug-related advice and information.

### 9.3 Harm reduction interventions

In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs (UKHRA, 2005).<sup>46</sup>

A harm reduction approach recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse, by a range of measures such as reducing the sharing of injecting equipment, support for stopping injecting, provision of substitution on opioid drugs for heroin misusers and support for abstinence from illegal drugs.

Harm reduction interventions should be integrated into all drug treatment service specifications via contracts or service level agreements, so that harm reduction interventions are available at the full range of locally commissioned treatment services. Harm reduction interventions should also be integrated into structured drug treatment according to an individual client's needs and should be incorporated into a care plan agreed with the client.

Most harm reduction interventions specifically aim to prevent diseases due to blood-borne virus (BBV) infections (most particularly HIV and viral hepatitis infections) and other drug-related harm, including overdose and drug-related death. All drug

treatment services, residential or community based, should provide as part of core treatment, distinct harm reduction interventions aimed at reducing the spread of BBVs and risk of drug-related deaths.

Specific harm reduction interventions to reduce the spread of blood-borne viruses and reduce overdose include:

- Needle exchange services – the provision and disposal of needles and syringes and other clean injecting equipment (e.g. spoons, filters, citric acid) in a variety of settings
- Advice and support on safer injection, on reducing frequency of injecting and on reducing initiation of others into injecting
- Advice and information to prevent transmission of BBVs (particularly hepatitis A, B and C, and HIV) and other drug misuse-related infections
- Availability of advice, information and counselling, as appropriate, for viral hepatitis and HIV testing (pre and post test)
- Access to testing for blood-borne viruses
- Provision of hepatitis B vaccination
- Provision of hepatitis A vaccination if appropriate
- Access to assessment and treatment for hepatitis B, C and HIV infection
- Counselling relating to HIV testing (pre and post test)
- Advice and support on preventing risk of overdose and drug-related death
- Risk assessment and referral to other treatment services.

Harm reduction interventions such as needle exchange, advice and information on safer injecting, reducing injecting and preventing overdose should also be available as open-access services in each local area. These are available as part of specialist statutory sector drug treatment services, voluntary sector services and pharmacy needle exchanges. Needle exchange services often have contact with drug misusers who are not in touch with structured drug treatment services. Guidance on what services should be available from pharmacy needle exchanges is available in Best Practice Guidance for Commissioners and Providers for Pharmaceutical Services for Drug Users (NTA, 2006).<sup>47</sup> Advice and information on harm reduction should also be available to carers of drug users, as appropriate.

The Department of Health has recently done work on raising the awareness of risks, detection and treatment of hepatitis B and C. In 2004, primary care trusts were required to use, as standard, a combination of treatments for hepatitis C with fewer side-effects than older treatments, which has been found to be effective in clearing the infection in a substantial proportion of cases. See the Chief Medical Officer's Update Number 39, August 2004.<sup>48</sup>

The National Institute for Health and Clinical Excellence (NICE) has produced a guidance document on treatment for people with hepatitis C: Guidance on the Use of Ribavirin and Interferon Alpha for Hepatitis C (NICE, 2000).<sup>49</sup>

The Department of Health has published Hepatitis C: Guidance for Those Working With Drug Users (2001),<sup>50</sup> which gives information on hepatitis C and on approaches to prevention and management that is of relevance to provider services and commissioners, and which is due to be updated in 2006.

Drug treatment commissioners should liaise with hepatitis C treatment commissioners to ensure adequate provision of Hepatitis C treatment for drug misusers. Drug treatment commissioners should also liaise and develop agreements with mainstream non-specialist services (e.g. A&E, liver disease units, HIV services), to ensure that people who have been at risk of exposure to hepatitis B through injecting drugs have access to testing, and arrangements are in place within the PCT area for the immunisation of drug users. Immunisation programmes should be targeted and need to be accessible to current injectors, those at risk of becoming injectors and close contacts (e.g. sexual partners), who may be at risk.

#### 9.4 Community prescribing interventions: GP prescribing and specialist prescribing

Community prescribing involves the provision of care-planned specialised drug treatment, which includes the prescribing of drugs to treat drug misuse. The range of community prescribing interventions can include the following:

- Stabilisation on substitute opioids, including dose titration
- Prescribing for a sustained period to substitute illicit drugs, such as methadone and buprenorphine (maintenance prescribing)
- Prescribing for withdrawal from opioids with opioid or non-opioid medications such as buprenorphine or lofexidine (community detoxification)
- Prescribing to prevent relapse
- Stabilisation and withdrawal from sedatives, such as benzodiazepines
- Prescribing for assisted withdrawal from alcohol where appropriate
- Treatment for stimulant users, which may include symptomatic prescribing
- Non-medical prescribing (by nurses or pharmacists).

All prescribing interventions must be carried out in line with Drug Misuse and Dependence – Guidelines on Clinical Management (DH, 1999),<sup>21</sup> also known as the “clinical guidelines” or the “orange book”. Attention should also be paid to the forthcoming (2007) NICE guidelines on opiate detoxification, and the NICE

technology appraisals of methadone and buprenorphine (for opiate maintenance treatment) and of naltrexone (for relapse prevention). The “clinical guidelines” will be updated alongside the development of the NICE work for 2007.

Substitute prescribing alone does not constitute drug treatment (NTA expert prescribing group, 2002). A community prescribing intervention should be provided within a care-planned package of care with an identified keyworker. It should be aimed at addressing the range of identified needs. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning. Interventions to tackle drug misuse problems may include:

- Hepatitis B vaccination and HIV and hepatitis testing
- Treating drug-related infections, e.g. abscesses
- Harm reduction and health promotion interventions e.g. overdose prevention, use of naloxone, sexual health advice and needle exchange
- Provision of, or access to, psychosocial interventions and support, e.g. motivational interventions.

The care plan may also include interventions to tackle problems in the other domains, and may include:

- Provision of, or access to, interventions to address other psychological health needs, or mental health needs
- A range of abstinence-oriented interventions e.g. mutual support groups (including 12-Step)
- Assisting with access to suitable housing, employment, education and training opportunities, and childcare, as required.

The keyworker is responsible for ensuring that all components of the community prescribing treatment programme work together to help clients achieve the goals set out in their care plans.

There are a number of treatment settings where community prescribing takes place, which can be broadly grouped as **GP prescribing** and **specialist prescribing**.

Commissioners should ensure local treatment systems have a complete spectrum of medical provision to meet the range of needs and numbers of substance misusers. This requires a variety of skills and competences at various levels, from general medical skills to GPs offering less complex drug treatments under enhanced contracts, to specialist addictions skills and addiction psychiatry skills. This is a key message arising from the consensus document produced by the Royal College of General Practitioners and Royal College of Psychiatrists’ Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers (2005),<sup>30</sup> as summarised in an NTA briefing note on the NTA’s website. [www.nta.nhs.uk](http://www.nta.nhs.uk).

#### 9.4.1 GP prescribing

GP prescribing is community prescribing for drug misuse which may be carried out in a primary care setting through a primary healthcare team, consisting of GPs and other primary care staff (depending on contractual arrangements). This is normally assisted or supported by a specialist drug team. The clinical guidelines advise against GP prescribing without such support.

A number of models of primary care drug treatment have evolved in the context of local resources and identification of need. These models include various types of shared care services in which GP services are supported by more specialist service provision, and primary care-led drugs services which do not have shared care arrangements with a secondary care provider. For more details on these, see section 3.5.4.

GP prescribing should be provided within a care plan with regular keyworking, and provision of appropriate psychosocial or other interventions as required. Different degrees of care planning may be appropriate in different primary care arrangements (NTA/RCGP 2004)<sup>51</sup>. The care plan should also address drug and alcohol misuse, health needs, offending behaviour and social functioning. In some practices, the GP will assume the keyworker role, but more commonly the shared care or primary care worker will take on this responsibility in collaboration with the GP. For more on care planning in primary care, see the Care Planning Practice Guide.

GP prescribing should be guided by the Department of Health’s clinical guidelines. These cover arrangements for daily dispensing, for shared care support and for the provision of supervised consumption through community pharmacies.

The client group in primary care has traditionally been drug users who are stable on substitute medication or whose problem level is mild to moderate. However, the exact nature of the clients treated and how the prescribing takes place will depend on the skills and competences of the GP and the degree of skilled multidisciplinary support. The guidance document Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers (2005) specifies a hierarchy of roles for GPs, with increasing competency levels:

- GPs providing core services
- GPs providing enhanced services
- GPs with special clinical interest (GPwSI) providing enhanced services
- Substance misuse specialist (primary care).

These competency levels are described in more details in section 3.5

GP prescribing services may also be supported by non-medical prescribers, such as nurses and pharmacists, as well as other staff who are competent to provide drugs interventions, such as



harm reduction, interventions for blood-borne viruses and psychosocial interventions.

#### 9.4.2 Specialist prescribing

Specialist prescribing is community prescribing for drug misuse in a specialist drug service setting, which normally comprises a multidisciplinary substance misuse team. Specialist prescribing interventions normally include comprehensive assessments of drug treatment need and the provision of a full range of prescribing treatments in the context of care-planned drug treatment. The specialist team should also provide, or provide access to, a range of other care-planned healthcare interventions including psychosocial interventions, a wide range of harm-reduction interventions, BBV prevention and vaccination, and abstinence-oriented interventions.

The client group should be comprised of drug misusers whose problem level is mostly moderate to severe.

The teams include specialist doctors who are usually consultant addiction psychiatrists “with a Certificate of Completion of Training (CCT) in psychiatry, with endorsement in substance misuse working exclusively to provide a full range of services to substance misusers”. Such teams sometimes have other specialists including:

- Consultants in general psychiatry with a special interest in addiction
- Consultants in general psychiatry
- Other doctors on the specialist register (associate specialists)
- Senior clinical medical officers (see Roles and Responsibilities)
- Doctors in training.

Since the specialist team should provide or enable access to other drug-related interventions identified in the client’s care plan, the team may contain a range of staff including clinical psychologists, counselling psychologists, general and psychiatric nurses, pharmacists, social workers and drug workers.

Specialist prescribing services may also be supported by non-medical prescribers, such as nurses and pharmacists). For more information on nurse prescribing, see Nurse Prescribing in Substance Misuse (NTA, 2005)<sup>52</sup> – this will be updated in 2006 to include pharmacists and will be issued as guidance on non-medical prescribing in substance misuse. Further guidance on prescribing for pharmacists is available in the RPSGB’s Clinical Governance Framework for Pharmacist Prescribers and Organisations Commissioning or Participating in Pharmacist Prescribing.<sup>53</sup>

### 9.5 Structured day programmes

The term “structured day programmes” replaces the old term “structured day care” and will be the intervention name used for NDTMS monitoring from April 2006. Introduction of an additional

category of “other structured treatment” can be used for less extensive or less structured “day care” provided in the context of a structured care plan (see section 9.7 for further discussion).

Structured day programmes (SDPs) provide a range of interventions where a client must attend 3–5 days per week. Interventions tend to be either via a fixed rolling programme or an individual timetable, according to client need. In either case, the SDP includes the development of a care plan and regular keyworking sessions. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

SDPs usually offer programmes of defined activities for a fixed period of time. 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. Some clients may be attending the SDP as a follow-on or precursor to other treatment types, or may be attending as part of a criminal justice programme supervised by the probation service (e.g. DRR), or community rehabilitation.

**Settings:** SDPs are normally community-based services, set in centres that have been specifically designated for the programme (purpose-built or converted) and have rooms designated for specific parts of the programme (e.g. group work and life skills). They may be attached to other drug treatment services if they are part of a larger treatment agency. Structured day programmes are also used in prisons, and in prisons the majority of drug treatment programmes would fall into this category.

### 9.6 Structured psychosocial interventions

The term “structured psychosocial interventions” replaces the old term “structured counselling” and has been the intervention name used for NDTMS monitoring since April 2006. Introduction of an additional category of “other structured treatment” allows use of this term for less clearly defined counselling in the context of a structured care plan (see the relevant section below for further discussion).

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 alcohol using behaviour. 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.

Structured psychosocial interventions should be identified within a care plan. These interventions can be delivered in individual or group settings, and by any practitioners who have appropriate training and supervision. A number of these interventions can be

developed and delivered through use of protocols to improve consistency and ease of delivery.

Evidence-based psychosocial interventions include:

- Cognitive-behaviour therapy (CBT)
- Coping skills training
- Relapse prevention therapy
- Motivational interventions
- Contingency management
- Community reinforcement approaches
- Some family approaches.

Psychosocial treatment skills (e.g. particular relapse prevention techniques) may be used in face-to-face sessions (e.g. by a keyworker), but this would not reach the threshold to be considered a “structured psychosocial intervention”. If such a skill were used as part of a clearly defined, consistent and evidence-based package of psychological treatment, especially when delivered by a demonstrably competent practitioner, it would then be part of a “structured psychosocial intervention”. Examples of structured psychosocial interventions could include four sessions of family therapy, or a manualised relapse prevention package.

In this definition, psychosocial interventions are to be differentiated from a number of other interventions:

- While psychosocial interventions may be delivered by a keyworker, this activity is not part of the keyworking process *per se*. The keyworker may provide a level of ongoing face-to-face therapeutic support involving the use of some psychological techniques. If keyworkers do not deliver complete and consistent psychological treatment packages as part of their work with individual clients, it does not constitute a “structured psychosocial treatment”. For example, a keyworker helping a client draw up a list of pros and cons is not delivering a full motivational interviewing intervention, merely using one technique commonly associated with the approach. Where keyworkers do deliver a planned, structured and coherent evidence-based psychosocial intervention (for which they have received training and supervision) this is likely to comprise a number of sessions and this constitutes a structured psychosocial intervention.
- 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-drug 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. This would be delivered as part of the care plan but would not constitute a “structured psychosocial intervention” for problem drug use itself

- Psychosocial interventions also differ from advice, information, simple psycho-education or other low-threshold support, which may be provided by a range of practitioners in a range of treatment settings.

**Settings:** A range of community and residential services. Some structured psychosocial interventions may be delivered as part of the process of engaging and preparing clients for change and during the “delivery” phase of the client’s treatment journey. Therefore, they may be delivered in different settings for individuals at different stages of their treatment journey. In prisons, structured psychosocial interventions would generally be provided through CARATs.

## 9.7 “Other structured treatment”

“Other structured treatment” describes a package of interventions set out in a client’s care plan which includes as a minimum regular planned therapeutic sessions with the keyworker or other drugs worker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning. “Other structured treatment” describes structured therapeutic activity not covered under the alternative specific intervention categories set out in Models of Care: Update 2006.

The creation of this “other” category of intervention 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.

Clients in receipt of community prescribing interventions, residential rehabilitation, inpatient treatment, structured day programmes or structured psychosocial interventions should not be additionally recorded as receiving “other structured treatment”. Care-planned support usually provided by the keyworker is integral to all such interventions anyway.

Most clients receiving “other structured treatment” will receive a range of interventions to meet needs identified in their care plan. These will involve a range of interventions to address their drug 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 community 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 assessed as needing “structured psychosocial interventions” for their problem drug use, but who receive sessions with keyworkers to address their social needs and offending behaviour.

“Other structured treatment” 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 (e.g. GP prescribing), 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 “other structured treatment”. Day care is distinct from structured day programmes, because it has a lower requirement to attend than structured day programmes (usually 1–2 days). Some clients may have a care plan that specifies regular attendance at day care with regular sessions with keywork. 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.

A client should not be recorded as receiving “other structured treatment” if the interventions are not being delivered as part of a care plan. It is also important to note that “other structured treatment” requires a more rigorous approach to “keyworking”. As good practice, keywork involves the building of a therapeutic relationship with the client, which should include:

- Following triage, drawing up an initial care plan if required to address immediate needs (e.g. providing information and advice on drug and alcohol misuse)
- Harm reduction interventions
- Motivational interventions to enhance retention
- Developing and agreeing the care plan with the client and ensuring implementation of the care plan – with interventions relevant to each stage of the treatment journey and regular care plan reviews.

Other structured treatment involves the delivery of a package of structured interventions that are beyond the level that would be required for Tier 2, but do fall into the other categories of structured interventions described in this section.

**Settings:** Other structured treatment could take place in a wide variety of different treatment settings, including settings that may normally be known for delivering Tier 2 interventions.

## 9.8 Inpatient drug treatment

Inpatient drug treatment interventions usually involve short episodes of hospital-based (or equivalent) drug and alcohol medical treatment. This normally includes 24-hour medical cover and multidisciplinary team support for treatment such as:

- Medically supervised assessment
- Stabilisation on substitute medication
- Detoxification/assisted withdrawal from illegal and substitute drugs and alcohol in the case of poly-dependence
- Specialist inpatient treatments for stimulant users
- Emergency medical care for drug users in drug-related crisis.

The multidisciplinary team can include psychologists, nurses, pharmacists, occupational therapists, social workers, and other activity and support staff.

Inpatient drug treatment should be provided within a care plan with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

Care-planned inpatient treatment programmes may also include a range of additional provisions such as:

- Preparing the client for planned admission to inpatient treatment (if this is not carried out by a suitably competent community worker as part of the agreed care plan leading to admission)
- Psychosocial interventions, including relapse prevention work
- Interventions to tackle excessive levels of drinking
- Appropriate tests or vaccination (if appropriate) for hepatitis B, C and HIV
- Other harm reduction interventions
- Educational work
- Physical and mental health screening
- Linking inpatient treatment to post-discharge care, which may involve preparation for referral to residential rehabilitation or community treatment, aftercare or other support required by the client.

Inpatient drug treatment is an important intervention for enabling adequate assessment of complex needs and for supporting progression to abstinence.

It is very important to have effective discharge care planning, and to ensure appropriate referrals to mainstream medical services (e.g. liver clinic and psychiatric services) or social and community

services (e.g. housing, legal advice, social services), as well as harm reduction and relapse prevention advice as required.

**Settings:** The three main settings for inpatient treatment are:

- General hospital psychiatric units
- Specialist drug misuse inpatient units in hospitals
- Residential rehabilitation units (as a precursor to the rehabilitation programme).

Research evidence has demonstrated that clients who receive treatment in dedicated substance misuse units are more likely to have better outcomes than those who receive treatment in general psychiatric wards.

For further information and guidance on inpatient treatment, refer to:

- Opiate detoxification in an inpatient setting (NTA, 2005)<sup>32</sup>
- SCAN Consensus Project 1: Inpatient Treatment of Drug and Alcohol Misusers (forthcoming).

## 9.9 Residential rehabilitation

Drug residential rehabilitation consists of a range of treatment delivery models or programmes to address drug and alcohol misuse, including abstinence orientated drug interventions within the context of residential accommodation.

Residential rehabilitation programmes should include care planning with regular keyworking with an identified keyworker. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning.

There is a range of residential rehabilitation services, which include:

- Drug and alcohol residential rehabilitation services whose programmes to suit the needs of different service users. These programmes follow a number of broad approaches including therapeutic communities, 12-Step programmes and faith-based (usually Christian) programmes
- Residential drug and alcohol crisis intervention services (in larger urban areas)
- Inpatient detoxification directly attached to residential rehabilitation programmes
- Residential treatment programmes for specific client groups (e.g. for drug-using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness). Interventions may require joint initiatives between specialised drug services (Tier 3 or 4, depending on local arrangements) and other specialist inpatient units
- Some drug-specific therapeutic communities and 12-Step programmes in prisons
- "Second stage" rehabilitation in drug-free supported accommodation where a client often moves after completing

an episode of care in a residential rehabilitation unit, and where they continue to have a care plan, and receive keywork and a range of drug and non-drug-related support

- Other supported accommodation, with the rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different nearby site(s).

Residential rehabilitation programmes normally combine a mixture of group work, psychosocial interventions and practical and vocational activities. These components are also used in specialist residential programmes for particular client groups (e.g. parent and child programmes).

Clients usually begin residential rehabilitation after completing inpatient detoxification. Sometimes the detoxification will take place on the same site as the rehabilitation programme, to enhance continuity of care. Prior to starting the rehabilitation programme, the client should be supported by their keyworker (or other substance misuse professional) to prepare for admission, so as to minimise disengagement and maximise benefit, but there may also be preparation input from the rehabilitation service.

**Settings:** The main settings for residential treatment are purpose-built or refurbished units, which may be freestanding or converted residential houses. They vary in size, and clients are received from a wide (often national) catchment area. Some residential units have medical facilities for inpatient pre-residential programme detoxification treatment.

## 9.10 Aftercare

Aftercare, as described in Models of Care, is a package of support that is planned with the client to support them when they leave structured treatment. The aim of aftercare is to sustain treatment gains and further develop community reintegration. Aftercare may include drug-related interventions such as open access relapse prevention or harm reduction. It may also include non-drug-related support such as housing, access to education, and generic health and social care. It is important to note that aftercare is not necessarily what a client receives after leaving Tier 4 treatment or prison, as they may still have an active care plan, involving community interventions. Only once the client's care plan is complete do they enter planned aftercare.

During a period of care-planned treatment, clients will receive a range of interventions to address their drug and alcohol-using behaviour and interventions to target non-substance use domains of functioning (e.g. housing, family support). Some of these interventions will come to an end when the care plan comes to an end, but some may need to continue.

As long as clients have an active care plan they are considered to be "in treatment". When their care plan with the treatment provider comes to an end, they may continue to receive a range of services that they were receiving as part of the care plan, and

in this context, these will be deemed to be aftercare. These include drug-related support and non-drug-related support.

There is a need to ensure the client has access to support pathways (e.g. for housing and training) If links to all appropriate support services are not already in place during a client's care-planned treatment, drug treatment agencies should assist the client to make these links before their treatment comes to an end. The keyworker or service should work closely with local agencies providing aftercare and support services to enable all necessary support to be in place in time for the client leaving treatment.

During the completion or exit phase of treatment, an aftercare plan should be drawn up by the keyworker and agreed with the client, based on assessment of ongoing support needs, and informed where possible by related professionals (e.g. housing and CJIT workers).

The aftercare plan should include measures that cover possible relapse and ensure swift access back to treatment if required. The aftercare plan must be passed from the drug treatment agency to the agencies responsible for delivering the aftercare, and key staff in this agency should ensure that the plan is implemented and clients receive what is outlined in the aftercare plan.

**Drug-related support** could include open-access relapse prevention, mutual support groups (e.g. AA/NA or equivalent user-led groups), and advice and harm reduction support. In addition a range of open-access and low-threshold interventions should be available to provide specific interventions to people who have completed treatment, but who may want or need to have occasional non-care-planned support.

**Non-drug-related support** can cover a range of issues such as access to housing, supported accommodation, relationship support, education and training, support to gain employment, and parenting and childcare responsibilities. In addition, women's services, peer mentor programmes and other social and activity groups can form elements of non-drug-related support.

Further details on how aftercare provision has been progressed can be found in *Developing Peer Led Support For Individuals Leaving Substance Misuse Treatment (2005)*,<sup>54</sup> which gives an outline of emerging themes and findings from five peer-led support projects, and the *Addaction Aftercare Consultation 2005: The Service User Perspective*,<sup>55</sup> which builds upon the findings of Addaction's national survey of drug and alcohol treatment providers, published in 2004. Other useful references on aftercare provision include:

- The Addaction National Aftercare Research Project Year 3 (2006)<sup>56</sup>
- The 24/7 client single point of contact – Case Examples of Good Practice (Home Office, 2005)<sup>57</sup>

- Promoting Practice between DAT partnerships and Education Training and Employment provision for Drug Interventions Programme clients (Home Office, 2006)<sup>58</sup>



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## Acknowledgements

Models of Care: Update 2006 is an update of Models of Care for Treatment of Adult Drug Misusers (2002). The original project team that developed Models of Care 2002 was comprised of Dr Dima Abdulrahim, Jan Annan, Richard Cyster, Annette Dale-Perera, Prof Colin Drummond, Fiona Hackland, Don Lavoie, Dr John Marsden, Dr Sally Porter and Prof John Strang, with contributions from Prof Hamid Ghodse, Pauline Bissett, Jill Britton and Sherife Hasan.

Models of Care: Update 2006 was redrafted by Annette Dale-Perera and Tim Murray (NTA), with key input from NTA, Department of Health and Home Office colleagues, and following extensive consultation with the drug treatment field.



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