NHS

National Treatment Agency
for Substance Misuse

Models of care

for treatment of adult drug misusers

Framework for developing local systems of effective drug misuse treatment in England

Part 1: Summary for commissioners and managers responsible for implementation

National Treatment Agency

More treatment, better treatment, fairer treatment

The National Treatment Agency (NTA) is a special health authority, created by the Government on 1 April 2001, with a remit to increase the availability, capacity and effectiveness of treatment for drug misuse in England.

The overall purpose of the NTA is to: double the number of people in effective, well-managed treatment from 100,000 in 1998 to 200,000 in 2008; and to increase the proportion of people completing or appropriately continuing treatment, year on year. This is in line with the UK drugs strategy targets.

Models of care

Models of care sets out a national framework for the commissioning of adult treatment for drug misuse in England. It is published in two parts:

Part one: This document is for drug treatment commissioners and those responsible for local implementation.

Part two: This is a detailed reference document for drug treatment managers and providers, and those responsible for assuring quality and appropriate delivery of local drug treatment services.

An implementation strategy to assist the commissioners of drug treatment services is also available, together with lessons learned from pilot sites. For further details, visit www.nta.nhs.uk

Department of Health

Models of care was initially funded by the Department of Health and has similar status to a national service framework.

To order further copies of *Models of care*, contact: nta.enquiries@nta.gsi.gov.uk

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1 Introduction and definitions

1.1 Introduction

Models of care: part one sets out a national framework for the commissioning of adult treatment for drug misuse in England. It is based on the more detailed reference document - *Models of care: part two*.

The framework of *Models of care* (comprising the four tiers, integrated care pathways, care planning and co-ordination and monitoring) applies equally to drug and alcohol treatment. The more detailed descriptions of treatment modalities and service specifications to guide implementation (described in *Models of care: part two*) has been developed and consulted on for drug treatment only. Further work on developing guidance on alcohol treatment will take place following the consultation around the national alcohol strategy.

1.2 Definitions

Treatment
This term describes a range of interventions that are intended to remedy an identified drug-related problem or condition relating to a person's physical, psychological or social (including legal) well-being.

Structured drug treatment follows assessment and is delivered according to a care plan, with clear goals, which is regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions.

Drugs
The term drugs used in this document refers to psycho-active drugs including illicit drugs and non-prescribed pharmaceutical preparations.

Misuse
The term misuse in this document refers to illegal or illicit drug taking or alcohol consumption that leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug misuse is therefore drug taking that causes harm to the individual, their significant others or the wider community. By definition, those requiring drug treatment are drug misusers.

Substance misuse
Substance misuse is drug and/or alcohol taking that causes harm to the individual, their significant others or the wider community. By definition those requiring drug or alcohol treatment are substance misusers.

These definitions are consistent with previous definitions adopted by the Advisory Council on the Misuse of Drugs (Advisory Council on the Misuse of Drugs (ACMD) 1982) and the Health Advisory Service (HAS 1996).

2 Overview and action required

2.1 What is *Models of care*?

Models of care sets out a national framework for the commissioning of adult treatment for drug misuse (drug treatment) expected to be available in every part of England to meet the needs of diverse local populations. According to the Department of Health, *Models of care* has the same status, in terms of local planning and delivery, as a national service framework for drug treatment.

Models of care provides the framework required to achieve equity, parity and consistency in the commissioning and provision of substance misuse treatment and care in England. It will support drug action teams (DATs), joint commissioners and treatment providers in the development of an efficient and effective treatment and care system for drug misusers. *Models of care* also provides specific guidance to support the co-ordination of drug and alcohol treatment and the effective management of care across drug misuse treatment services and general health, social and other care.

Models of care advocates a systems approach to meeting the multiple needs of drug and alcohol misusers. This is achieved through the development of local systems that maximise the gains achieved through drug and alcohol treatment by having explicit links to the other generic health, social care and criminal justice services, including through-care and aftercare.

Models of care reflects professional consensus of 'what works best' for drug misusers, resulting from an extensive consultative process that was used for its development.

Models of care is based upon current evidence, guidance, quality standards and good practice in drug treatment in England. It was developed from key national documents as well as national and international research evidence. All guidance is in line with the recommendations contained in *Drug misuse and dependence: guidelines on clinical management* (Department of Health et al. 1999a) and other current guidance and legislation. It is also consistent with the NHS Plan (2000) and agendas to modernise health and social care services.

The development of *Models of care* was funded by the Department of Health. Final consultation and dissemination of *Models of care* has been the responsibility of both the Department of Health and the National Treatment Agency for Substance Misuse (NTA). The NTA is responsible for monitoring the national implementation of this service framework for drug treatment.

2.2 What *Models of care* does not cover

2.2.1 Alcohol

The primary focus of the September 2002 edition of *Models of care* is adult drug treatment. *Models of care* does have great relevance to the development of alcohol service provision, but it does not provide specific guidance on the commissioning or implementation of this framework for alcohol treatment generally. However, it is important for commissioners and providers of alcohol treatment to recognise the applicability of the framework elements of *Models of care* (i.e. the four tiers, integrated care pathways, care planning and co-ordination and monitoring) to alcohol treatment services.

More than half of all drug and alcohol services are currently commissioned by DATs' joint commissioning mechanisms. Many drug services are drug and alcohol (or substance misuse) services, many quality standards cover both drugs and alcohol (e.g. Quality in Alcohol and Drugs Services (QuADS) and the drugs and alcohol national occupational standards (DANOS), and many drug service users require alcohol misuse to be addressed within this framework. Given this reality, it is neither feasible nor desirable to develop a different conceptual commissioning framework for alcohol services. The conceptual

framework elements of *Models of care* thus refer to drug and alcohol treatment or substance misuse treatment and should be used by commissioners and providers of alcohol treatment in informing future developments.

2.2.2 **Prescription drugs, nicotine etc.**

Models of care does not address detailed consideration of the misuse of prescribed drugs (particularly benzodiazepines), volatile substances (or solvents), or steroid misuse. However, all drugs and alcohol misuse should be considered, including hallucinogens and cannabis, when assessing the needs and planning care of an individual. Nicotine dependence is also not considered by this document. However, this is an important issue for drug treatment services as many clients are nicotine dependent and would benefit from treatment for addiction.

2.2.3 **Young people under 18**

Models of care focuses on commissioning drug treatment for adults (i.e. those aged 18 years and older). The provision of drug and alcohol treatment for adolescents and young people is extensively covered elsewhere (Health Advisory Service 1996, 2001). Commissioning these services should be within the existing frameworks for commissioning health and social care for young people, to provide adequate links to generic services for children and families. There should be explicit links to DATs and commissioning processes for adult drug and alcohol treatment, with particular reference to commissioning interface services for those in transition from adolescence to adulthood (for those aged 16 to 21).

2.2.4 **Treatment in prisons**

Models of care does not currently cover drug treatment within prisons. However, *Models of care* does have specific relevance to the commissioning and provision of drug treatment in prisons. It is hoped that prisons and the community will have equity of quality and explicit interfaces to enhance the quality and effectiveness of through-care for those leaving or entering prison or custody. The NTA and the prison drug strategy unit are committed to working together to take this agenda forward in partnership. *Models of care* does cover drug treatment as commissioned and provided as part of drug treatment and testing orders (DTTOS).

2.3 *Models of care* in two parts

Models of care is being published as two documents.

2.3.1 ***Models of care: part one***

This document is for drug treatment commissioners and those responsible for local implementation of *Models of care* (this document).

This document will enable the implementation of *Models of care* for drug treatment and is accompanied by a more detailed implementation strategy.

2.3.2 ***Models of care: part two***

This document is the full document for *Models of care*. It is over 200 pages in length, and is meant to be used as a detailed reference document. This document is for drug treatment managers and providers and those responsible for assuring quality and appropriate delivery of local drug treatment services. The full document contains:

- *An extended summary of Models of care*: *part one*
- *Drug treatment modalities*
  Open access services, advice and information services, needle exchange facilities, care planned counselling, structured day programmes, community prescribing, inpatient drug misuse treatment and residential rehabilitation.

- *Special group considerations*
  Stimulant misusers, women drug misusers, black and minority ethnic populations, young drug misusers, substance misusing parents, alcohol misuse in drug misusers.

- *Cross-cutting issues*
  Interface with criminal justice (arrest referral, drug treatment and testing orders and prison through-care and aftercare), blood-borne disease, psychiatric co-morbidity (dual diagnosis), outreach work, users, carers and self-help groups, and complementary (alternative) therapies.

2.4 Development of *Models of care*

Models of care was initially commissioned from the Department of Health, and development work was undertaken by a team of drug and alcohol specialists (see Appendix 1). The team drafted an initial document outlining the key principles of *Models of care* and consulted with a wide range of stakeholders using paper consultation and regional events. The final documents were then written and a three-month formal consultation was conducted by the Department of Health and the National Treatment Agency (NTA). The *Models of care* project has also been informed by early learning from the regional *Models of care/enhancing treatment outcomes* pilot sites.

2.5 Implementation of *Models of care*

The NTA has issued guidance on developing local implementation plans for *Models of care*. This guidance outlines what is expected from DATs and joint commissioners and should be considered alongside *Models of care: part one*.

It is expected that DATs and joint commissioners will use local resources, including the central government's pooled budget for drug treatment, to implement *Models of care* as appropriate to their local needs and local matrix of drug treatment services.

2.6 The role of the NTA in implementation

The NTA will support the implementation of *Models of care* in a number of ways, including:

- hosting a series of regional events between October and December 2002 for those responsible for implementing *Models of care*
- sharing early learning from the regional pilot sites on a quarterly basis and creating an interactive site on the NTA website (www.nta.nhs.uk)
- publishing guidance and updates on national progress on implementation
- bringing existing DAT treatment planning and monitoring mechanisms into line with *Models of care*. This will inform the national monitoring system for the implementation of *Models of care*
- monitoring implementation via local drug treatment planning processes and via NTA regional managers. This includes allocation of the drug treatment pooled budget to ensure planning and spending in line with *Models of care*. NTA regional managers will also act as a conduit and support for local areas on implementation.
- supporting professionals implementing *Models of care* through the NTA workforce strategy. The NTA's national leadership and development programme running in each region from December 2002 will enhance the ability of commissioners and managers to manage change. The new drug and alcohol national occupational standards (DANOS) are fully consistent with *Models of care*, and training modules consistent with DANOS will be available from December 2002. The NTA recruitment initiatives, including the development of the new modern apprenticeship in drug treatment, will attract extra practitioners.

- supporting reductions in waiting times. The NTA waiting times initiative with the Modernisation Agency will bring together the two agendas of reducing waiting for drug treatment and developing local drug treatment systems. Implementation of *Models of care* in each local area is seen as the long-term solution to reducing waiting times. This joint initiative between the NTA and the Modernisation Agency will produce regular guidelines and training, as well as providing active consultancies in each region from autumn 2002.
- developing drug treatment service user and carer involvement. The NTA aims both to provide guidance on user and carer involvement and also to develop regional users' and carers' networks to feed into national groups, and ultimately into the NTA Board. In this context, the NTA will enable users and carers to be informed about *Models of care* and supported in participating in its implementation as local stakeholders
- future work such as the development of a new information strategy (by March 2003) and a new accreditation system (March 2004), will be consistent with *Models of care* and will support its ongoing implementation and maintenance.

2.7 Target audiences

Models of care is targeted at the following groups for action or information as highlighted below.

Commissioners and joint commissioners of drug misuse treatment services (strategic health authorities/primary care groups and primary care trusts (PCGs and PCTs); social services departments; probation service; prison service; joint commissioning managers; Drug Prevention Advisory Service staff	For action
Drug (and alcohol) action team members; drug (and alcohol) reference group members; D(A)AT co-ordinators	For action
Managers of specialist drug treatment and care services in the statutory, voluntary and independent sectors	For action
Chief executives of primary care groups and primary care trusts; directors of social services; chief probation officers; police area commanders	For action
Directors of public health	For action
General practitioners and primary care teams involved in drug treatment, including shared care monitoring groups	For action
Providers of allied and ancillary services (acute medical care, housing, employment and leisure services, general psychiatry, child and adolescent mental health psychiatry, children and family services); chief executives of strategic health authorities	For information
Service users of drug treatment services	For information

3 Policy and context

3.1 Drug policy context

The *Models of care* project was established to enhance the planning, commissioning and provision of drug treatment services to meet the objectives of the government's ten-year drugs strategy (UKADCU 1998). The national drugs strategy emphasises the central importance of drug treatment as the main means of assisting people with drug misuse problems to "reduce and overcome their problems and live healthy and crime-free lives" (UKADCU 1998). Cross-government commitment to tackling drug misuse is based on recognition of the value of well-implemented treatment and on investment in the further development of drug treatment services in the community and in prison.

A key national target set in 1998 was to increase participation of drug misusers in treatment by 100 per cent by 2008. This target was recently broadened to include increasing the proportion successfully completing or appropriately continuing treatment, year on year.

At local level, drug action teams (DATs) are expected to co-ordinate a strategic response to meet the aims of the national drugs strategy. Joint commissioning between health, social care and criminal justice agencies is now expected, and all DATs are expected to have a dedicated joint commissioning manager.

The NHS Act 1999 now allows for pooled funds, 'lead commissioning' by one health and social care commissioner on behalf of another, and integrated provision. A central pooled budget for drug treatment has been created to supplement the existing funding allocated by individual health, social care and criminal justice agencies. There has been a substantial increase in funding by the government, through the spending reviews, to increase drug treatment capacity; an extra £217 million was invested over three years from 1999. The 2002 investment will consolidate and build on these resources, and will be used to increase drug treatment capacity and implement *Models of care*. Other funding has, and continues to be, allocated to complement available drug treatment and support drug misusers by enhancing the aftercare and re-integration of drug misusers into housing, employment and education.

3.2 Wider policy agendas

The national agenda to improve the quality and capacity of drug treatment has been heavily influenced by wider developments for improving health and social services in general. In 1998, drug treatment services were identified for the first time in *NHS priorities and planning guidance. Models of care* and the development of the National Treatment Agency (NTA) are consistent with the NHS guidelines and the *NHS Plan* (Department of Health 2000) with its ten-year action plan to put patients at the heart of the health service.

In line with the *NHS Plan*, *Models of care* takes into account the need to reduce waiting times for treatment and the need to develop consistent, high-quality care centred on patients. It highlights partnerships between health, social services and other agencies, investment in staff and provision of a voice for service users. It also promotes the reduction of inequality and identifies work across statutory, voluntary and independent sectors.

Models of care mirrors other national policies that encourage all treatment and care services to strive to deliver higher quality and more effective services that are closely informed by research evidence and guided by performance monitoring (Department of Health 1997 and 1999). Clinical governance (NHS Executive 1999) established the need to focus on activities that lead to the delivery of high-quality care. It is the framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an

environment in which excellence in clinical care will flourish. The Commission for Health Improvement (CHI) regularly inspects every NHS trust against agreed standards, and the Modernisation Agency provides a wide range of initiatives to improve the quality and effectiveness of the NHS.

In relation to social care, Best Value has made it a statutory duty for local authorities to deliver services by the most effective, economical and efficient means possible, taking into account quality and cost. The National Care Standards Commission has a range of standards for services, which they inspect on a regular basis. The Supporting People policy framework for supported housing provides further opportunities to support drug misusers in the community.

Finally, there are multiple initiatives to improve the competence and numbers of skilled and qualified professionals in health, social care and criminal justice. The role of the national training organisations and others has been to promote national workforce strategies, standards and qualification frameworks in many fields including drugs and alcohol. The drugs and alcohol national occupational standards (DANOS, Skills for Health 2002) provide competency-based occupational standards for drug and alcohol commissioners and for practitioners. In the NHS, initiatives to improve working lives and create work environments that foster reflexive, life-long learning are paramount, including the role of workforce confederations.

Models of care is published at a time when many organisations are undergoing major structural changes. Primary care trusts (PCTs) now play a pivotal role in drug (and alcohol) treatment and are central to the development of effective systems. PCTs have a central strategic and commissioning responsibility and a role in overseeing the clinical practice of doctors and other health care professionals.

Other new health policy initiatives that will affect drug treatment include the introduction of salaried options for general practitioners (GPs) in England, local development schemes, GP commissioning pilots and the conversion of GPs' general medical services (GMS) to personal medical services (PMS). The Health and Social Care Act 2001 mentions care trusts, which will provide integrated health and social care in one agency. Similarly, nurse prescribing may offer new ways of delivering and managing drug treatment services.

The new strategic health authorities will also play an important role in substance misuse treatment through their performance monitoring. It is also expected that DATs will work more closely with Crime and Disorder Reduction Partnerships, and there are plans to bring the work of these two organisations together (Home Office 2001) from October 2002.

It is also imperative for drug treatment commissioners and services to adopt the principles and recommendations of the Race Relations (Amendment) Act 2000 (Home Office 2000), which extends the scope of the 1976 Race Relations Act to include all functions of all public authorities. The 2000 Act places a general duty on all major public authorities to promote racial equality and also sets out specific duties with which they must comply.

3.3 Drug treatment effectiveness

In 1996, the influential Task Force to Review Services for Drug Misusers examined the evidence base for drug treatment. It reported that there was a clear evidence base that drug treatment was effective in reducing harm to individual drug misusers and communities. Maximum gains were achieved by drug treatment which embraced clinical care and support as well as clinical interventions. The National Treatment Outcome Research Study (Gossop 1998) calculated that for every £1 spent on drug treatment, £3 was saved in costs to the criminal justice system and victims of crime. The NTORS follow-up study of 1,100 drug misusers in treatment found that a wide range of drug treatment interventions commonly employed in England are effective in reducing drug misuse, criminal activity and health risks. Significant reductions were also found in drug injecting and the sharing of injecting equipment. Improvements in drug misuse were largely maintained at four to five years after treatment, with 47 per cent of those who had attended drug residential rehabilitation services and 35 per cent of those who attended community drug treatment reporting abstinence from illicit opiate use. NTORS

also found that less than half (44 per cent) of those who attended drug treatment for problems with crack-cocaine were still misusing crack at four to five years follow-up. However, NTORS also found that some individual drug treatment services achieved markedly better client outcomes than others.

The recent Audit Commission report (2002) *Changing habits*, which looked at the commissioning and management of community drug treatment services for adults, found a range of problems with drug treatment services. While some effective approaches and innovation were found, many areas in England had limited drug treatment options, had lengthy waits for access, and were characterised by "underdeveloped care management" which "allowed too many people to fall through the net". The Audit Commission found that the needs of crack misusers, black and minority ethnic drug misusers, women drug misusers, and drug misusers with alcohol problems were poorly met in many areas. Some drug treatment was also found to be inflexible and poorly co-ordinated within and between services, especially for drug misusers leaving prison. Shared care schemes with GPs were also underdeveloped in some areas. The planning, co-ordination and commissioning of drug treatment were also found to be lacking, with improved joint commissioning relationships required in many DAT areas. The Audit Commission recommended a range of solutions to rectify and improve drug treatment over time. These include the National Treatment Agency "promoting improvements in the national framework and developing more coherent models of service standards and good practice". *Models of care* is cited as a solution to many of the difficulties in drug treatment with implementation needing to be "incremental and well-planned".

3.4 Drug misusers: the in-need population

The prevalence of drug misuse in Britain is a changing picture which is difficult to assess. The British Crime Survey indicates that in 2000, around one-third of those aged 16 to 59 had taken illegal drugs at some time in their lives, with eleven per cent using in the past year and six per cent describing themselves as regular users. Most drug use is cannabis use, with only one per cent of the population reporting the use of heroin and crack-cocaine. Only a minority of those who use drugs will develop problems and require drug treatment.

Estimating the number of people who require drug treatment is highly problematic. The National Drug Treatment Monitoring System (NDTMS) reflects those seeking help and existing biases in drug treatment. The Audit Commission (2002) reports that 0.5 per cent of the population of Britain may be drug dependent, that is, 226,000 people.

While drug misuse can affect rich and poor alike, deprivation and social exclusion are likely to make a significant contribution to the causes, complications and intractability of drug misuse. Deprivation relates statistically to the types and intensities of drug misuse that are problematic. Similarly, poor housing, or lack of access to affordable housing, is another contributory factor in drug misuse. Other important factors include educational disadvantage, criminal involvement, unemployment and low income (ACMD 1998).

Recent research indicates that many drug misusers are also offenders, although the relationship between drugs and crime is complex. The criminal justice system is increasingly a referral source and venue for the provision of drug treatment

Drug misuse has been called a chronic relapsing condition (Task Force to Review Services for Drug Misusers 1996). While many drug misusers do successfully recover from drug dependency or addiction, most make several attempts to do so, lapsing or relapsing into drug misuse in intervening periods.

Drugs of misuse include: opiates (e.g. heroin and illicit methadone); stimulants (e.g. amphetamines, cocaine and crack-cocaine); and alcohol misused by drug misusers. Many drug misusers, however, take a cocktail of drugs and alcohol including hallucinogens, cannabis and prescribed drugs such as benzodiazepines. The use of heroin together with cocaine or crack-cocaine is also becoming increasingly common, with NDTMS reporting an increase in the use of both drugs, from 18 per cent of those presenting for drug treatment in 1998, to 24 per cent in 2001.

Drug misusers present with a myriad of other health and social problems, particularly in relation to physical and psychiatric co-morbidity and social care needs. Drug misusers may present with: physical health problems (e.g. thrombosis, abscesses, overdose, hepatitis B and C, HIV, weight loss, respiratory problems); mental health problems (e.g. depression, anxiety, paranoia, suicidal thoughts); social problems (e.g. relationship problems, unemployment, homelessness; and criminal problems including (legal and financial problems). Thus, a multi-disciplinary range of health, social care and other responses is required.

3.5 Treatment domains and hierarchy of goals

The range of difficulties experienced by drug misusers are sometimes conceptualised as domains. These are often grouped into four key domains to assess whether drug misusers are improving or achieving better outcomes in these areas. The four key domains are as follows:

Drug and alcohol use

- Drug use, including type of drug(s), quantity/frequency of use, pattern of use, route of administration, source of drug.
- Alcohol use, including quantity/frequency of use, pattern of use, whether above 'safe' level, alcohol dependence symptoms.

Physical and psychological health

- Psychological problems, including self-harm, history of abuse/trauma, depression, severe psychiatric co-morbidity, contact with mental health services.
- Physical problems, including complications of drug/alcohol use, pregnancy, blood-borne infections/risk behaviours, liver disease, abscesses, overdose, enduring or severe physical disabilities.

Social functioning

- Social problems (including childcare issues, partners, domestic violence, family, housing, employment, benefits, financial problems).

Criminal involvement

- Legal problems (including arrests, fines, outstanding charges/warrants, probation, imprisonment, violent offences, criminal activity).

For some years now a range, or hierarchy, of goals of drug treatment has been identified in the UK (ACMD 1988, 1989; Task Force to Review Services for Drug Misusers 1996). These relate to the above domains and are:

- reduction of health, social and other problems directly related to drug misuse
- reduction of harmful or risky behaviours associated with the misuse of drugs (e.g. sharing injecting equipment)
- reduction of health, social or other problems not directly attributable to drug misuse
- attainment of controlled, non-dependent, or non-problematic, drug use
- abstinence from main problem drugs
- abstinence from all drugs.

This hierarchy of drug treatment goals endorses the principle of harm minimisation, which refers to the reduction of the various forms of drug-related harm (including social, medical, legal, and financial problems) until the drug misuser is ready and able to come off drugs (Department of Health 1999). Harm minimisation strategies in this country have achieved considerable success in preventing a more severe HIV epidemic in the UK (ACMD 1998).

Reviews of commissioning and practice may be required, given the rates of hepatitis C and overdose, together with reports from the Advisory Council on the Misuse of Drugs (ACMD) on reducing drug-related death and from the Department of Health (2002) on hepatitis C.

4 Commissioning a four-tiered framework

4.1 A four-tiered framework for all areas in England

Some drug action teams (DATs) commission services for alcohol treatment alongside their drug treatment services. The conceptual framework described in this section applies to drugs and alcohol, and therefore has relevance for the commissioning of all substance misuse services.

Models of care provides a conceptual framework to aid rational and evidence-based commissioning of drug treatment in England. Services for drug misusers can be grouped into four broad bands of tiers. Tiers for drug treatment are also described in the forthcoming NHS executive framework document on needs assessment.

Commissioners should ensure that drug misusers in all local areas or drug action teams (DATs) in England have access to the full range of tiers 1 to 4 services and to the types of generic and drug treatment modalities outlined below. Drug treatment services to address a range of drug problems should be provided, including problems with: opiates (e.g. heroin and illicit methadone); stimulants (e.g. amphetamines, cocaine and crack-cocaine); and poly-drug and alcohol misuse. In planning the overall range of care provision for drug misusers, commissioners need to take account of the high level of need that drug misusers present with, particularly in relation to physical and psychiatric co-morbidity and social care needs.

The *Models of care* four-tier framework is not intended to be a rigid blueprint for provision. It is expected that local commissioners will be able to demonstrate that local services have been commissioned to cover each treatment modality within the four tiers. The balance of local drug treatment services and their detailed delivery mechanisms should be tailored to fit the needs of the local population. This will provide equitable access to drug treatment services across the country.

4.2 Description of the tiers and services required

4.2.1 **Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment**

Tier 1 services work with a wide range of clients including drug and alcohol misusers, but their sole purpose is not drug or alcohol treatment. The role of tier 1 services, in this context, includes the provision of their own services plus, as a minimum, screening and referral to local drug and alcohol treatment services in tiers 2 and 3. Tier 1 provision for drug and alcohol misusers may also include assessment, services to reduce drug-related harm, and liaison or joint working with tiers 2 and 3 specialist drug and alcohol treatment services. Tier 1 services are crucial to providing services in conjunction with more specialised drug and alcohol services (e.g. general medical care for drug misusers in community-based or residential substance misuse treatment or housing support and aftercare for drug misusers leaving residential care or prison).

Tier 1 consists of services offered by a wide range of professionals (e.g. primary care or general medical services, social workers, teachers, community pharmacists, probation officers, housing officers, homeless persons units). Such professionals need to be sufficiently trained and supported to work with drug (and alcohol) misusers who, as a group, are often marginalised from, and find difficulty in, accessing generic health and social care services.

Commissioners should ensure tier 1 professionals have clear local guidelines on the referral of drug misusers to specialist drug treatment services. It may be beneficial to have 'link' professionals, (particularly from tier 2 and tier 3 services) who can train and support tier 1 professionals. Where prevalence of drug misusers is high, there may be a need for a

specialised drug treatment or 'addiction' liaison service to provide a co-ordinated response. Models of such services include drug misuse pregnancy and antenatal liaison nurses in localities with high rates of pregnant drug misusers or women in drug treatment.

Drug misusers in all DATs in England must have access at local levels to the following tier 1 services located within local general health and social care services:

- a full range of health (primary and secondary), social care, housing, vocational and other services
- drug and alcohol screening, assessment and referral mechanisms to drug treatment services from generic, health, social care, housing and criminal justice services
- the management of drug misusers in generic health, social care and criminal justice settings (e.g. police custody)
- health promotion advice and information
- hepatitis B vaccination programmes for drug misusers and their families.

Commissioners of alcohol services are advised to ensure that alcohol misusers have access to a range of tier 1 services as appropriate.

4.2.2 Tier 2: Open access drug and alcohol treatment services

Tier 2 services provide accessible drug and alcohol specialist services for a wide range of drug and alcohol misusers referred from a variety of sources, including self-referrals. This tier is defined by having a low threshold to access services, and limited requirements on drug and alcohol misusers to receive services. Often drug and alcohol misusers will access drug or alcohol services through tier 2 and progress to higher tiers.

The aim of the treatment in tier 2 is to engage drug and alcohol misusers in drug treatment and reduce drug-related harm. Tier 2 services do not necessarily require a high level of commitment to structured programmes or a complex or lengthy assessment process. Tier 2 services include needle exchange, drug (and alcohol) advice and information services, and ad hoc support not delivered in the context of a care plan. Specialist substance misuse social workers can provide services within this tier, including the provision of access to social work advice, childcare/parenting assessment, and assessment of social care needs. Tier 2 can also include low-threshold prescribing programmes aimed at engaging opioid misusers with limited motivation, while offering an opportunity to undertake motivational work and reduce drug-related harm.

Tier 2 services require competent drug and alcohol specialist workers. This tier does not imply a lower skill level than in tiers 3 and 4 services. Indeed, many of the functions within this tier require a very high level of professional training and skills.

Drug misusers in all DATs in England must have access to the following tier 2 open-access specialist drug interventions within their local area:

- drug- and alcohol-related advice, information and referral services for misusers (and their families), including easy access or drop-in facilities
- services to reduce risks caused by injecting drug misuse, including needle exchange facilities (in drug treatment services and pharmacy-based schemes)
- other services that minimise the spread of blood-borne diseases to drug misusers, including service-based and outreach facilities
- services that minimise the risk of overdose and other drug- and alcohol-related harm
- outreach services (detached, peripatetic and domiciliary) targeting high-risk and local priority groups
- specialist drug and alcohol screening and assessment, care planning and management

- criminal justice screening, assessment and referral services (e.g. arrest referral, CARATS)
- motivational and brief interventions for drug and alcohol service users
- community-based, low-threshold prescribing services.

Commissioners of alcohol services are advised to ensure that alcohol misusers have access to a range of tier 2 services as appropriate.

4.2.3 **Tier 3: Structured community-based drug treatment services**

Tier 3 services are provided solely for drug and alcohol misusers in structured programmes of care. Tier 3 structured services include psychotherapeutic interventions (e.g. cognitive behavioural therapy, motivational interventions, structured counselling, methadone maintenance programmes, community detoxification, or day care provided either as a drug- and alcohol-free programme or as an adjunct to methadone treatment). Community-based aftercare programmes for drug and alcohol misusers leaving residential rehabilitation or prison are also included in tier 3 services.

Tier 3 services require the drug and alcohol misuser to receive a drug assessment and to have a care plan which is agreed between the service provider and client. The drug and alcohol misuser attending tier 3 services will normally have agreed to a structured programme of care which places certain requirements on attendance and behaviour (e.g. a certain number of days or hours attendance per week, review of programme is triggered if attendance is irregular). The drug and alcohol misuser should also expect the care plan to be provided by the agency as agreed. For clients whose needs cross several domains, there should be a care co-ordinator, responsible for co-ordination of that individual's care on behalf of all the agencies and services involved. Changes to the care plan would take place in consultation with the drug and alcohol misuser.

Like the other tiers, tier 3 services will need to take account of urban and rural differences. For example, structured day programmes may be more difficult to provide in rural areas and will need to be adapted for this setting.

Tier 3 services may be required to work closely with other specialist services to meet the needs of specific client groups. For example, tier 3 services and mental health services should work closely together to meet the needs of drug misusers with dual diagnosis (psychiatric co-morbidity). In this instance, providers should have access to medical clinical leadership and/or advice from mental health specialists in line with good practice guidelines (Department of Health 2002b).

Drug misusers in all DATs in England must have access to the following tier 3 structured drug treatment services normally provided within their local area and occasionally by neighbouring DAT or regionally located facilities:

- specific community care assessment and care management
- new care co-ordination services for drug misusers with complex needs (provided by suitably trained practitioners)
- specialist structured community-based detoxification services
- a range of specialist structured community-based stabilisation and maintenance prescribing services
- shared-care prescribing and support treatment via primary care
- a range of structured, care planned counselling and therapies
- community-based drug treatment and testing order drug treatment
- structured day programmes (in urban and semi-urban areas)

- other structured community-based drug misuse services targeting specific groups (e.g. stimulant misusers, young people in transition to adulthood, black and minority ethnic groups, women drug misusers, drug misusing offenders, those with HIV and AIDS, drug misusers with psychiatric problems)
- liaison drug misuse services for acute medical and psychiatric sectors (e.g. pregnancy, mental health)
- liaison drug misuse services for local social services and social care sectors (e.g. child protection, housing and homelessness, family services)
- through-care and aftercare programmes or support.

Commissioners of alcohol services are advised to ensure that alcohol misusers have access to a range of tier 3 services as appropriate.

4.2.4 Tier 4 services: Residential services for drug and alcohol misusers

Tier 4a: Residential drug and alcohol misuse specific services

Tier 4 services are aimed at individuals with a high level of presenting need. Services in this tier include: inpatient drug and alcohol detoxification or stabilisation services; drug and alcohol residential rehabilitation units; and residential drug crisis intervention centres. Tier 4a services usually require a higher level of commitment from drug and alcohol misusers than is required for services in lower tiers. Tier 4a services are rarely accessed directly by clients. Referral is usually from tiers 2 or 3 services or via community care assessment.

Tier 4a services may be abstinence-oriented programmes, detoxification services or services which stabilise clients (e.g. on substitute drugs). Access to tier 4a requires careful assessment and preparation of the client in order to maximise readiness, compliance and programme effectiveness. Access to tier 4a may also require sequencing of other care pathways such as detoxification prior to placement in a drug- and alcohol-free residential programme. By definition, such programmes are highly structured. Drug and alcohol misusers receiving tier 4 services will require a designated care co-ordinator, allocated before entry to this tier.

Inpatient provision for drug and alcohol treatment is often in psychiatric wards rather than specialist inpatient units. There is evidence that drug (and alcohol) specialist provision has better outcomes. Commissioning of high-cost, low-volume services such as those at tier 4a should be considered at sub-regional and regional levels.

Tier 4b: Highly specialist non-substance misuse specific services

Tier 4b services are highly specialised and will have close links with services in other tiers, but they are, like tier 1, non-substance misuse specific. Examples include specialist liver units that treat the complications of alcohol-related and infectious liver diseases and forensic services for mentally ill offenders. Some highly specialist tier 4b services also provide specialist liaison services to tiers 1–4a services (e.g. specialist hepatitis nurses, HIV liaison clinics, genito-urinary medicine).

Drug misusers in all DATs in England must have access to the following tier 4 services, most likely provided at a multi-DAT or regional or national level:

- specialist drug and alcohol residential rehabilitation programmes (including a range of 12-step, faith-based and eclectic programmes)
- generic and drug specialist semi-structured residential care (e.g. half-way houses, semi-supported accommodation)
- specialist drug treatment and testing order treatment (residential options)
- inpatient drug misuse treatment, ideally provided by specialist drug misuse units, or alternatively by designated beds in generic (mental) health services

- highly specialist forms of residential rehabilitation units or other residential services (inpatient, prison) with a drug misuse treatment component (e.g. women and children, crisis intervention, dual diagnosis)
- relevant tier 4b services, including HIV or liver disease units, vein clinics, residential services for young people and so forth.

Commissioners of alcohol services are advised to ensure that alcohol misusers have access to a range of tier 4 services as appropriate.

4.3 Principles of the four-tiered system

The four-tiered model of drug and alcohol treatment for adults was developed from the four-tier approach for a variety of mental health and drug misuse services for young people outlined by the Health Advisory Service (1996). Key principles which underpin the four tiers for adult drug and alcohol treatment commissioning are outlined below.

Each local region should have equality of availability to the full range of services described in the tiered framework. Not all drug and alcohol misusers will require access to all types of services or all tiers, but within each locality a proportion will require access to each of these services at any given time. Access to all services should therefore be available in all areas in England.

Service modalities (described above) within the four tiers are not alternatives and commissioners should ensure all modalities are commissioned based upon local need. Each drug treatment modality described in tiers 2, 3 and 4a are complementary. Each is a necessary building block of a comprehensive drug treatment system, together with the interfaces and modalities described in tiers 1 and 4b.

Drug treatment services described within each tier are modalities, not specific agencies. It is possible for one agency in a given locality to provide services located in more than one tier, or provide a range of modalities from within tiers (see table 1, page 20).

Drug and alcohol misusers may require access to services within a number of different tiers simultaneously, for example needle exchange services (tier 2), structured counselling (tier 3) and housing services (tier 1). The care plan or care co-ordinator should facilitate access to a range of services based on client need. Explicit links may be required between different care pathways in order to provide an integrated care pathway approach.

Future commissioning of drug and alcohol misuse services should be needs-led and in line with the four-tier framework rather than being based on historic commissioning patterns. This requires responsive commissioning which can plan and develop new drug treatment responses to cope with changing drug trends (e.g. growing high levels of stimulant misuse or drug misuse effecting new minority groups).

Drug and alcohol treatment services should be commissioned strategically. This means that the impact of the commissioning on any one service should be viewed in the strategic context of the four-tier drug and alcohol treatment system for a locality or region.

Commissioners should seek to ensure that no groups of drug and alcohol misusers have more limited access to relevant drug treatment modalities outlined in the four-tier framework by virtue of their location, gender, ethnicity, or drugs of misuse. All drug treatment services should be easily accessible to substance misusers (by virtue of location, entry criteria, assessment procedures, waiting times, etc).

Commissioners (and providers) should recognise that motivational work may be crucial in engaging clients in drug and alcohol treatment and improving their outcomes in a number of domains. A service provider's ability to motivate a drug misuser is a greater factor in client success than the expressed motivation of the client (Fiorentine et al. 2000). Client motivation should not be used as an

exclusion criterion: it should be a trigger for motivational work which should be commissioned and provided by each drug treatment provider.

Commissioners should ensure that both open access and structured drug treatment services are available in each area. Less structured modalities tend to be more accessible and can act as a 'gateway' to more intensive treatment, provided that interventions to reduce drug-related harm and motivation do work. Some treatments require a more structured setting and/or programme in order to be effective (e.g. cognitive behaviour therapy, inpatient detoxification). Other treatments, however, lend themselves to less structured settings (e.g. motivational interviewing, needle exchange programmes). More structured modalities can involve more costly and more intensive programmes, and hence tend to cater for a smaller proportion of drug misusers. More intensive programmes may also require a higher level of client commitment. Similar principles apply to the alcohol field.

Commissioners and providers should ensure that staff involved in drug treatment are competent. The new drug and alcohol national occupational standards (DANOS) and forthcoming qualification framework will provide national competency benchmarks. An investment approach may be required to build the drug and alcohol treatment workforce to meet local needs. It is important to note that more intensive or structured programmes do not necessarily require more highly skilled staff than less structured or intensive programmes. Indeed the converse may be the case, in that complex and chaotic substance misusers often present to open access services at a time of crisis by virtue of the agency's accessibility, where a high level of competence is needed to provide safe and effective management.

4.4 How the four-tiered system will assist commissioning

The tier system described here will be of most benefit in the rational planning and commissioning of substance misuse services that is undertaken when working towards equity of access to services. The tiers should therefore be viewed as a pragmatic commissioning framework. The four tiers should assist local commissioners and providers in the following ways:

- they define the function of different services and interventions
- they help define entry and exit criteria for each tier
- they help define target groups and maximise targeting of resources
- they assist in planning and commissioning a comprehensive system of care nationally and within each locality and region
- they define the points at which different levels of assessment and care co-ordination take place.

At any given time there are likely to be more substance misusers in contact with tier 1 services (at the base of the 'pyramid') than with tier 4 (the apex). One of the aims of the drug treatment system is to engage drug misusers in specialist drug treatment (tiers 2, 3 and 4b). The more effective and more comprehensively funded the system is, the 'broader' the apex will be.

The client need not be aware of the tier system. Within this framework, drug and alcohol misusers should be able to move seamlessly between services within and across tiers. At any given time, drug and alcohol misusers should be able to attend simultaneously services that span across tiers in a way that best meets their needs.

4.4.1 Commissioning standards

The commissioning of drug (and alcohol) treatment services should be in line with existing commissioning standards (Substance Misuse Advisory Service 1999). As such, commissioners must take into account local needs, the configuration of existing services, and gaps in service provision.

It is the responsibility of DATs, through their joint commissioners and joint commissioning groups (JCGs), to ensure that the diverse range of drug and alcohol misusers within their locality are catered for. Local variations in provision will include: demographic and socio-economic factors (e.g. population age, ethnic diversity, levels of deprivation); substance

misuse trends and patterns (e.g. opiates, stimulants, poly-drug use, routes of ingestion such as injecting practices or smoking) and geography (e.g. urban and rural considerations). It may be more difficult to deliver drug and alcohol treatment services in rural areas than in urban areas. Commissioning of such services needs to take account of practical delivery issues to increase accessibility for drug and alcohol misusers needing these services, especially in rural areas.

It is expected that JCGs will co-ordinate the commissioning of drug treatment services on behalf of their DATs and the member organisations of the DAT.

Many joint commissioning groups are co-terminus with DAT boundaries but some are not; for example, some new primary care trust arrangements are not necessarily co-terminus. Clearly defined commissioning functions are important.

All commissioners working through their JCGs should ensure that an investment approach to drug treatment is taken in order to build the quality of drug misuse treatment services. This requires adequate investment in human resources to ensure a competent workforce and enable treatment services to meet recommended clinical guidelines (Department of Health 1999) and relevant quality and occupational standards (QuADS 1999; Prison Health Care Directorate 2000; SMAS 1999; Skills for Health, 2002).

4.4.2 Local commissioning partners

To ensure communication between mainstream health and social care services, drug and alcohol treatment commissioners need to work in close liaison with those who commission tier 1 and 4b services to ensure that drug and alcohol misusers have access to the wide range of generic services necessary to provide comprehensive and effective packages of care. Such services include housing and vocational, social, primary and specialist health care, and psychiatric services.

Drug treatment services cannot be commissioned in isolation. Drug treatment JCGs should work in liaison with a number of bodies responsible for the planning and commissioning of local services. Close liaison is required between DATs, other local partnerships, PCTs and strategic health authorities in planning and commissioning services.

It is expected that DATs and JCGs will work closely with criminal justice commissioners to maximise the interface between criminal justice drug treatment referral and provision and other drug treatment services. This work includes commissioning for arrest referral services, prison drug treatment, and drug treatment required in local DTTOs. The interface between drug action teams and local crime and disorder reduction partnerships, will increase over the next year (Home Office 2001).

Joint commissioning arrangements also need to be considered in respect of the statutory obligations on agencies providing services for people with severe and enduring mental health problems, specifically those with psychiatric co-morbidity (dual diagnosis). Opportunities should be maximised where services are provided jointly by mental health and specialist substance misuse services (Department of Health 2002b).

Commissioning and planning mechanisms for children's and adolescents' services (including substance misuse) should have clear links and interfaces with adult drug and (alcohol) treatment commissioning undertaken by JCGs and DATs. This should include commissioning drug (and alcohol) treatment service for those in transition from adolescence to adulthood (16 to 21 years). Commissioning mechanisms for children and young people's health and social care services should be the primary mechanism for commissioning drug and alcohol treatment for those under 16 years. Guidelines are expected in 2003 from the Home Office and Department of Health. Clear links to those commissioning children and families services is also expected, as many families of substance misusers may be 'in need' and some children of substance-misusing parents may require statutory child protection services.

4.4.3 Sub-regional and regional commissioning

Equitable access to drug treatment services in all DATs does not always equate with the availability of all of these services within the boundaries of all DATs. Many of these services must be available at local DAT levels, but others may be available at multi-DAT, regional and national levels. Table 1 (page 20) outlines drug treatment tiers by modality and commissioning level.

Some drug treatment services are best commissioned by two or more DATs. In these cases, DATs may establish a single joint commissioning group, or two or more joint commissioning groups (JCGs) may work together. Working in this way, JCGs may commission a range of services including: low-volume and high-cost services, for example, residential crisis intervention services, residential rehabilitation for mothers and children; and drug treatment services covering more than one DAT or local area, for example, services covering several local areas. Two or more JCGs can jointly develop and commission tiers 2 or 3 services, for example, gender or race specialist services can be developed to serve adjoining DATs.

Other ways of joint working between JCGs include jointly setting costing bands or reaching agreements on shared monitoring arrangements where they purchase services from the same provider.

The NTA will advise on regional and sub-regional commissioning and utilising the regional analysis of the DAT treatment plans.

Similar principles apply to alcohol treatment provision and commissioning.

Table 1: Drug misuse treatment tiers and commissioning levels

Tier no	Tier title	Service modality	Commissioning level
1	**Non-substance misuse (SM) specific services**	For example: Personal/general medical services (primary care) Non-DM specific social services including children and family services; non-DM specific assessment and care management Housing and homelessness services Non-SM specific probation services Vaccination / communicable diseases Sexual health / health promotion Accident and emergency services General psychiatric services Vocational services	Local DAT*/ PCT/PCG
2	**Open access drug misuse services**	Drug-related advice and information Open access or drop-in services Motivational interviewing/ brief interventions Needle exchange (pharmacy/service/outreach) Outreach services (detached/domiciliary/peripatetic) Low-threshold prescribing Liaison with drug misuse services for acute medical and psychiatric sector DM specific assessment and care management	Local DAT/ PCT/PCG
3	**Structured community-based specialist drug misuse (DM) services**	Drug specialist care planning and co-ordination Structured care planned counselling and therapy options Structured day programmes (urban and semi-urban) Community-based detoxification services Community-based prescribing stabilisation and maintenance prescribing Community-based drug treatment for offenders on DTTOs Other structured community-based drug treatment services targeting specific groups Structured aftercare programmes Liaison with drug treatment services	Local DAT*/ multi-DAT
4a	**Residential substance misuse specific services**	Inpatient drug detoxification and stabilisation services Drug and alcohol residential rehabilitation services Residential drug and alcohol crisis centres Residential co-morbidity services Specialist drug and alcohol residential units targeting specific groups, e.g. mother and child units services	Multi-DAT/ regional/ national
4b	**Highly specialist non-substance misuse specific services**	For example: Young people's hospital and residential services providing drug and alcohol treatment services (16 to 21 years) Specialist liver disease units Forensic services Specialist psychiatric units including: personality disorder units; eating disorders units Terminal care services HIV specialist units	Regional/ national

*Joint commissioning groups (JCGs) or commissioning authorities (e.g. PCT, local authority) commission on behalf of DATs.

Commissioners of alcohol services are advised to ensure that alcohol misusers have access to a range of services in each tier as appropriate.

5 Integrated care pathways

5.1 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. So far, the drug and alcohol treatment system has been described in a structural way, with services grouped into four broad tiers. Any system of care, however, 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.

In many areas of health and social care, an integrated care pathway (ICP) approach is increasingly used as the preferred methodology to apply packages of care in a co-ordinated and integrated way. ICPs are known by various names, including 'critical care pathways', 'treatment protocols', 'anticipated recovery pathways', or 'treatment algorithms'. All of these are designed to standardise elements of care with professional consensus, and thus improve treatment efficiency, effectiveness and value for money. ICPs should be developed for drug and alcohol misusers for the following reasons:

- Drug and alcohol misusers often have multiple problems which 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 different tiers of service over time.
- ICPs ensure consistency and parity of approach nationally (i.e. a drug misuser accessing a particular treatment modality 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.

Commissioners should encourage the development of local ICPs for drug treatment modalities in line with *Models of care*, as described in the implementation plan.

5.2 Elements of integrated care pathways

Commissioners should ensure that each drug and alcohol treatment modality should have an ICP. ICPs should be agreed between and with between local providers and built into service specifications and service level agreements.

Integrated care pathways should have the following elements:

- a definition of the treatment modality provided
- aims and objectives of the treatment modality
- definition of the client group served
- eligibility criteria (including priority groups)
- exclusions criteria or contraindications
- referral pathway
- screening and assessment processes (see below)
- development of agreed treatment goals
- description of the treatment process or phases
- care co-ordination (see below)

- departure planning, aftercare and support
- onward referral pathways
- services with which the modality interfaces.

These elements are designed to provide clarity as to the type of client the drug and alcohol treatment modality caters for, what the client can expect the agency to provide, and the roles and responsibilities of the modality/programme within the integrated care system and towards the individual client.

The ICP approach allows commissioners to map the whole care system in a locality so that gaps and overlaps can be identified and rectified via the commissioning process. ICPs also provide a means of agreeing local referral and treatment or protocols to define where and when particular clients should be referred.

ICPs should be sufficiently comprehensive to allow effective drug and alcohol treatment planning, including all the necessary elements of care and support that an individual drug and alcohol misuser may need. This should include links and referral pathways between specialist drug treatment services and generic services in tiers 1 and 4b such as primary care, housing and vocational services. These services may be key to maximising improvements achieved through drug treatment and are formal links that may be vital for effective joint working and appropriate referral.

The ICPs for drug treatment described in *Models of care*: *part two* are illustrative rather than prescriptive. Local ICPs should be based and developed on these nationally defined ICPs that describe the structure and content of recognised drug treatment modalities. However, these can be adapted to local needs and drug treatment providers as appropriate.

Commissioners should consider developing local ICPs with agreed referral flow diagrams linked to a service directory for each drug treatment modality. Commissioners should ensure that the development of ICPs – and the clinical protocols that stem from them – is carried out in an inclusive way, with all relevant agencies and professionals reaching a consensus. Service users and carers should be involved in the development of ICPs to develop a more effective drug treatment system.

ICPs should not be applied in an overly rigid way. Departures from ICPs are sometimes required, based on individual need or local considerations such as delivery in rural areas. ICPs should guide, but not override, clinical decisions concerning individual drug and alcohol misusers, which should always be applied individually. However, departures should be justifiable.

ICPs should be developed to address pathways both within and between the four tiers. All drug and alcohol misusers receiving structured care should have a care plan which describes component ICPs. For example, a client may receive methadone maintenance and structured counselling simultaneously or consecutively as part of a co-ordinated plan of care.

It is advantageous for commissioners to encourage all services within the four tiers to have agreed protocols for referral pathways, eligibility criteria, and joint working arrangements, in order to deliver a seamless and co-ordinated programme of care. This may take time to develop, particularly between tiers 1 and 4b services and drug and alcohol specialist services.

Interfaces between the specific drug treatment ICPs and non-substance misuse specific services are important, not least because many service users have continuing care needs when an index treatment intervention has been completed. Therefore a particular inter-agency pathway for a service user may involve movement up and down the four treatment tiers as the needs of the service user change over time.

6 Commissioning levels of assessment within a tiered system

6.1 Commissioning local screening and assessment systems

Effective use of drug and alcohol treatment modalities and appropriate matching of drug and alcohol treatment type and intensity to presenting need, depends crucially on adequate assessment of the individual drug (and alcohol) misuser. This is particularly important in the context of a complex system of care and the development of integrated care pathways.

Effective assessment needs to be tailored in terms of comprehensiveness and complexity in such a way that it does not present a barrier to entry to, and engagement in, appropriate drug and alcohol treatment. When a drug and alcohol misuser presents in crisis with complex needs, it is particularly important to provide rapid access to urgent or emergency treatment. Assessment at all levels can provide opportunities for services to reduce harm (e.g. preventing drug-related overdose or needle sharing). In tiers 3 and 4, assessment should result in the formulation of a care plan with the client at the start of structured treatment.

Assessment should be needs-led. Furthermore, assessment should be an ongoing process rather than a one-off event, as an individual's needs are likely to evolve over time. Review and reassessment at regular intervals are necessary for good care planning and co-ordination.

The three levels of assessment required are:

- Level 1: Screening and referral assessment (tiers 1 and 4b)
- Level 2: Drug and alcohol misuse triage assessment (tiers 2, 3 and 4)
- Level 3: Comprehensive drug and alcohol misuse assessment (tiers 3 and 4a and some tier 2).

The levels of assessment reflect the different levels of complexity and expertise required to carry out the assessment at each stage. In this system there is a broad base of personnel to carry out less complex drug (and alcohol) misuse assessment, allowing more points of access to the drug and alcohol treatment system and less delay in treatment entry. However, the effectiveness of such a system depends on standardisation of approach. Specifically, commissioners should ensure the following elements are present in each locality:

- clear and standardised screening assessment processes used across all agencies
- clear criteria for referral and eligibility for entry to each part of the drug treatment system
- a local directory of services for drug and alcohol misusers
- clear criteria for priority treatment entry and emergency access
- adequate training of personnel carrying out screening assessment at each level
- adequate sharing of appropriate information between agencies in the drug treatment system
- a system of monitoring, auditing and reviewing of the screening and assessment system.

Drug treatment commissioners should ensure that local areas develop an agreed hierarchical assessment process with three levels of assessment. These three levels of assessment can be broadly mapped onto the service tiers already described in *Models of care*.

Different levels of assessment require different levels of competency of assessors. Commissioners and providers should ensure that local training in screening, triage and comprehensive assessment is available following the development of locally agreed processes, criteria, information-sharing protocols, and monitoring. Level 1 screening and assessment can be carried out by non-drug and

alcohol specialists (with training). More complex drug and alcohol assessment is a highly skilled activity and should only be carried out by professionals who have reached a required level of competence.

The purpose of sharing relevant information between agencies following assessment is to maximise the safety and effectiveness of drug (and alcohol) treatment interventions and to avoid repeated assessment of clients without action. Information sharing is also important in terms of management of risk. Commissioners should ensure that locally agreed policies on information sharing, including informed client consent, are developed. Information-sharing protocols should be sensitive to client confidentiality while facilitating referral to treatment options required by the client.

Assessment and subsequent care planning needs to be an inclusive process in which the client and the assessor work in partnership to identify need and plan care appropriately. The assessment should achieve sufficient agreement between client and assessor on the needs to be addressed by treatment and the most appropriate course of action. Without a sufficient level of consensus, future referral and effective engagement in treatment may be compromised, or at worst fail.

Issues of cultural diversity and the development of culturally competent services are essential ingredients of effective treatment systems. Evidence from other areas of health care, and mental health in particular, show a need for assessment procedures and instruments to take into account the cultural diversity of local populations.

During implementation, commissioners should ensure that each level of assessment:

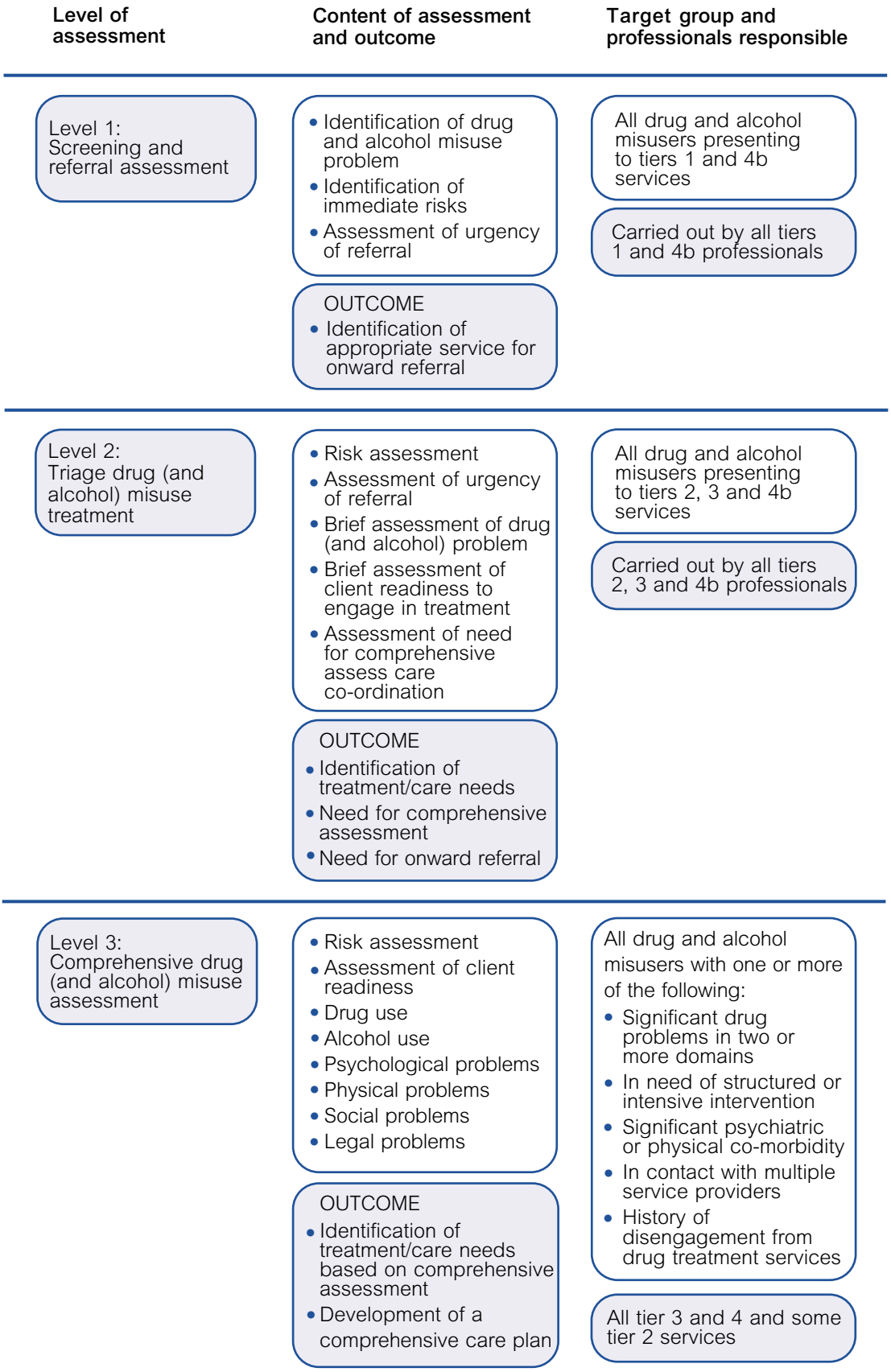
- is agreed locally and adapted to meet local needs and local service provision
- achieves referrals against agreed criteria
- is categorical, concise, comprehensive, and straightforward to apply
- can be audited against locally agreed standards.

Figure 1 overleaf illustrates levels of assessment, desired outcome and professionals responsible for each level.

Models of care: *part two* provides detailed descriptions of the three levels of screening, triage assessment and comprehensive assessment as applied to drug treatment, including staff competence requirements, risk assessment and assessing young drug misusers. It is recommended that those responsible for those developing these systems read *Models of care*: *part two* for greater detail.

In this system, assessment is seen as an ongoing process rather than a one-off event. Assessment should continue through the episode of contact with the drug and alcohol treatment system. Ongoing assessment should be linked to care planning and co-ordination and is essential to the effectiveness of integrated care pathways.

Figure 1 The assessment system



7 Commissioning care planning and care co-ordination

7.1 Principles of care planning and co-ordination

This section describes the role of care planing and care co-ordination as a key element of an integrated system of treatment for drug (and alcohol) misusers.

Drug treatment commissioners should ensure that improved systems of care planning and co-ordination are implemented in local areas.

Good systems of care planning and care co-ordination will ensure services are client-centred and not determined by the modalities provided by a particular agency. Such systems are intended to facilitate access to a programme of integrated and co-ordinated health and social care and to maximise client retention and minimise disengagement ('drop out') from the drug and alcohol treatment system.

All service users should have access to appropriate and effective assessment, care planning and care co-ordination. A range of professionals should be able to undertake care planning and care co-ordination. Broadening access to assessment, care planning and care co-ordination with clear local agreements on the criteria for access to different modalities of care will enable local drug and alcohol treatment systems to meet the needs of a greater number of drug and alcohol misusers more effectively.

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

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

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

7.2 Care planning and review

Commissioners should ensure that structured drug and alcohol treatment uses a care-planned approach with clients. The assessment of the drug and alcohol misuser should result in a written care plan. A care plan is a structured, often multidisciplinary, and task-oriented individual care pathway plan, which details the essential steps in the care of a drug and alcohol misuser and describes the drug and alcohol misuser's expected treatment and care course. The care plan involves the

translation of the needs, strength and risks identified by the assessment into a service response. It is used as a tool to monitor any changes in the situation of the drug and alcohol misuser and to keep other relevant professionals aware of these changes. The care plan must do the following:

- set the goals of treatment and milestones to be achieved (taking into account the views and treatment goals of the drug and alcohol misuser, and developed with their active participation)
- indicate the interventions planned and which agency and professional is responsible for carrying out the interventions
- make explicit reference to risk management and identify the risk management plan and contingency plans
- identify information sharing (what information will be given to other professionals/ agencies, and under which circumstances)
- identify the engagement plan to be adopted with drug and alcohol misusers who are difficult to engage in the treatment system
- identify the review date (the date of the next review meeting is set and recorded at each meeting)
- reflect the cultural and ethnic background of the drug and alcohol misuser, as well as their gender and sexuality.

A care plan should be reviewed and evaluated at regular intervals and at the request of a member of the care team, the service user or their carer. The date of the next review meeting is set and recorded at each meeting. In reviewing the care plan the following is assessed:

- the relevance of the care plan
- the effectiveness of care plans/outcomes
- any unmet needs
- client satisfaction with the care.

Drug and alcohol misusers with less complex needs who do not meet the criteria for standard care co-ordination (SCC) or enhanced care co-ordination will not need to be managed within the care co-ordination system. However, it would be good practice for all drug and alcohol misusers in tier 2 services to have, at a minimum, a written care plan and a named keyworker. Drug and alcohol misusers with less complex needs who do not meet the criteria for care co-ordination will:

- require support or intervention from one agency or discipline, or will require only low level support
- be relatively stable
- pose little danger to themselves or others
- be likely to maintain appropriate contact with services.

Care planning and care co-ordination should not represent a bureaucratic burden on providers and increase unnecessary paper work. However, it is essential to ensure that central records are maintained on all drug misusers, that care planning and review takes place regularly, and that notes are kept with dates recorded. Copies of care plans and reviews should be available for clients. The results of risk assessment and risk management plans must always be recorded.

7.3 Main elements of effective care co-ordination

7.3.1 Levels of care co-ordination

The level and intensity of care co-ordination will depend on the complexity of individual need. We recommend the following levels of care co-ordination:

- standard care co-ordination (equivalent to standard care programme approach [SCPA])
- enhanced care co-ordination (equivalent to enhanced care programme approach [ECPA]).

7.3.2 Client criteria or care co-ordination

The criteria for care co-ordination are identical to the criteria for comprehensive assessment, namely drug and alcohol misusers who present with one or more of the following:

- significant drug and alcohol misuse problems in two or more problem domains (see Assessment domains)
- a need for structured and/or intensive intervention
- significant psychiatric and/or physical co-morbidity
- significant risk of harm to self or others
- have contact with multiple service providers
- a pregnancy or children 'at risk'
- a history of disengagement from drug and alcohol treatment services.

In practice, many drug misusers who present to tier 3 and 4a services will automatically fall into this category. Some clients in tier 2 services will also require care co-ordination, but may need to be referred to an agency that is able to provide such a level of assessment and co-ordination of care.

When a drug and alcohol misuser with complex needs presents to a tier 2 service that cannot provide comprehensive assessment or care co-ordination, referral should be made to an appropriate agency, as suggested by the level 2 assessment. If an individual in this situation is unwilling to be referred, the agency should record the fact that referral had been discussed. If the tier 2 service has overriding concerns about the client that justify sharing information without consent (with reference to local guidelines), the relevant statutory agency should be contacted (e.g. social services, mental health team) and appropriate information shared to prompt assertive follow-up according to local protocols. In these circumstances, the tier 2 service is not responsible for a client's decision not to accept appropriate referral.

7.4 Standard care co-ordination

Standard care co-ordination (SCC) applies to those drug and alcohol misusers who meet the above criteria for care co-ordination but not the criteria for enhanced care co-ordination. Under SCC, the care co-ordinator is expected to carry out the roles and responsibilities described below. The responsibilities of the care co-ordinator and the function of SCC is co-terminus with standard care programme approach (SCPA).

Commissioners should ensure that all those who enter into drug and alcohol services receive a comprehensive, seamless approach to care and treatment. All drug and alcohol misusers in structured treatment should have a care plan and key workers. Care co-ordination should apply to all individuals with more complex needs.

Care co-ordination has the following main elements:

- systematic and ongoing assessment of the health and social care needs of those presenting to drug (and alcohol) services
- care planning which identifies health and social care needs and responds to these
- identification of a named care co-ordinator to organise care across health and social agencies and maintain contact with the drug and alcohol misuser
- regular reviews of the plan of care (care plan).

The principle of care co-ordination is not new to health and social care; however, the implementation of formal care co-ordination in drug treatment systems is. Drug treatment commissioners should phase-in requirements for this approach, recognising that providers require resources and capacity to do so.

The framework for care co-ordination described here is consistent with existing CPA

legislation and practice for drug and alcohol misusers with mental disorder. The framework is also consistent with care management arrangements under the Community Care Act.

Where treatment is being delivered within the framework of a drug treatment and testing order (DTTO), the care co-ordinator's remit to facilitate and encourage the drug misuser's consensual engagement in treatment needs to be balanced against the probation service obligation to enforce the order. DTTO National Standards (Probation Circular 25/2001) set out the expectations in terms of compliance with the treatment and testing elements of the order and dictates the amount of time the offender needs to be engaged in treatment on a weekly basis and the frequency of testing. It does not, however, specify the content of treatment programmes.

The care co-ordinator's role involves encouraging the drug and alcohol misuser to utilise appropriate help and assisting their access to and engagement in treatment, while accepting the individual drug and alcohol misuser's choice as to whether they accept treatment or not. Consequently, the care co-ordinator should not be held responsible for that individual's choice or their subsequent actions. However, if the drug and alcohol misuser is assessed as presenting significant risks to themselves or others, the care co-ordinator has the same duty as any other professional, namely to communicate this to the appropriate authorities in line with local protocols.

For drug misusers who are under statutory requirements to attend treatment (i.e. either subject to Mental Health Act CPA or a drug treatment and testing order), locally agreed guidelines should be followed if the drug and alcohol misuser fails to comply with treatment.

Commissioners should ensure that care co-ordinators are adequately supported in their role. Adequate support should be provided by the agency which employs care co-ordinator. Care co-ordinators should inform commissioning bodies of agencies that are unwilling to co-operate with care co-ordination arrangements, and appropriate remedial action should be taken by the commissioners. Commissioners should consider pooled budget funding for drug treatment being contingent on full co-operation with the care co-ordination system.

7.5 Enhanced care co-ordination

7.3.2 **Client criteria or care co-ordination**

Under enhanced care co-ordination and CPA, the expectation is that the client has severe mental health co-morbidity (e.g. schizophrenia, bipolar affective disorder, severe depression) and is thus subject to the national guidelines for enhanced CPA. In most cases, the client will be under the care of a community mental health team (CMHT), which will often be caring jointly with a drug and alcohol misuse service. Under these circumstances, the responsibility for follow-up is greater than under SCC if the client disengages from treatment due to his or her high level of vulnerability or risk. The CMHT should have responsibility for care co-ordination for clients on ECPA with the drug and alcohol treatment service being responsible for specific elements of the care plan. Joint working arrangements between specialist substance misuse services and mental health services needs to take account of the recent Department of Health guidance on dual diagnosis (Department of Health 2002b).

Enhanced CPA currently applies to those clients with severe mental health problems resulting in chronic disability or those clients who:

- need a high level of support generally from more than one professional or agency
- are subject to Section 117(2) of the Mental Health Act or Supervised Discharge under Section 25(a)
- are on the supervision register.

7.5.2 **Drug misusers on drug treatment and testing orders**

Under enhanced care co-ordination for criminal justice, the service user will be the subject of a sentence order as well as receiving care planned treatment. The care planning and

sentence planning processes will therefore require integration. The goals set in care and sentence plans will need to be regularly reviewed and monitored to ensure that treatment is effective in meeting its aims. Where treatment is not deemed to be effective it may require adjusting (Home Office and SCODA 2000).

Probation circular 25/2001 (Appendix A) makes it clear that DTTOs must be managed jointly by the probation service and the treatment provider and that, apart from in exceptional circumstances, neither party shall take major decisions in respect of any order without consulting the other. The need for effective partnership working is essential because, although the treatment provider will normally take the lead in terms of the care co-ordination role, this will need to take place within the statutory constraints and national standards framework that govern the enforcement of DTTOs.

7.6 Roles, responsibilities and competencies of care co-ordinators

New national occupational standards for drugs and alcohol (DANOS) include care planning and care co-ordination. National training modules for DANOS are under development for drug treatment providers and will be available from 2003.

Drug treatment commissioners should ensure that the new roles of care co-ordinators are implemented in local drug treatment systems. Care co-ordinators may be existing staff co-opted into these roles or new staff recruited and trained for the tasks. The development of these new roles within drug treatment systems will take planning and additional resources. *Models of care*: *part two* provides details of the roles, responsibilities and competencies required by care co-ordinators.

The regional pilots sites for *Models of care* may also inform the way in which local commissioners may implement the roles of care co-ordination. Two models are being piloted: one involving a discrete team of care co-ordinators, the other involving a virtual team of care co-ordinators with nominated and trained staff in each local drug treatment (tiers 2 and 3) service. The NTA will provide quarterly briefings on learning from the pilot sites.

7.7 Information sharing

Commissioners should support providers to ensure local protocols are agreed that balance the client's right to confidentiality with the safe and effective delivery of integrated care, which may require the sharing of essential information particularly around issues of risk. An important part of effective communication between agencies is the need for adequate and appropriate sharing of information about clients who are in contact with multiple agencies or whose care is transferred from one agency to another. It is the role of the care co-ordinator to ensure that relevant and appropriate information is passed between agencies with the client's written informed consent, within local guidelines.

A client may refuse to give permission to share essential information. In exceptional cases, essential information should be shared where there are significant risks to the client or others in not sharing information, for example, in the case of child protection issues under Section 115 of the Crime and Disorder Act. A clear explanation must be given to the client about what information sharing means and how it affects confidentiality.

Mechanisms to safeguard confidential client information must be in place in line with data protection legislation. Information about these mechanisms must be available to clients in a written form.

7.8 Transferring care co-ordination

Commissioners should ensure local protocols are in place to ensure adequate transfer of care co-ordination where appropriate.

Sometimes it may be appropriate to transfer care co-ordination to a different agency. The general principle for transfer of care co-ordination is that care co-ordinators are allocated from tier 3 services, normally the highest community-based service with which the drug and alcohol misuser is involved.

Some drug and alcohol misusers will no longer require enhanced CPA (by virtue of recovery from mental health problems, or completion of a DTTO), but may continue to attend a tier 3 community drugs service. In these cases, care co-ordination can be transferred from the community mental health trust or probation service to the drug and alcohol service care co-ordinator, if appropriate and with joint agreement.

When a formal transfer of care co-ordination is carried out with agreement of the transferring and receiving agency, the name of the new care co-ordinator must be explicitly written in the care plan. The client and all relevant agencies involved in his or her care must be informed in writing. Referral of the drug and alcohol misuser to a new agency must lead to a care co-ordinator being allocated. Where a formal transfer of the drug and alcohol misuser has not occurred, the care co-ordination responsibility will remain that of the transferring agency.

8 Monitoring

8.1 Monitoring activity and outcome in substance misuse treatment

There is an increasing imperative to monitor the activity, cost and outcomes of drug and alcohol treatment services. This reflects a desire to gauge the return on local and national investment and to ensure that resources are directed to treatment that is effective.

Clinical governance frameworks in the NHS and Best Value frameworks in local authorities are also frameworks of accountability to ensure that organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. In drug and alcohol treatment services, QuADS standards on organisational management include specific standards on monitoring service activity and client outcome. Existing commissioning standards for those responsible for drug and alcohol treatment (SMAS 1999) includes explicit standards on contract monitoring and information gathering vis-à-vis local population needs. Commissioners have a critical role to play in developing local systems for monitoring activity and outcome.

8.2 Developing local systems for monitoring drug treatment activity and outcome

Commissioners are currently expected to routinely monitor drug treatment services in their locality through contract monitoring and participation in the National Drug Treatment Monitoring System (NDTMS). Some commissioners have been active in developing information-gathering initiatives for outcome monitoring, in addition to the routine monitoring of drug treatment services in their areas through contract monitoring.

All commissioners should move towards activity and outcome monitoring, although it is recognised that this will be an incremental process. Commissioners and DATs should develop, in the first instance, reliable activity reporting and move towards monitoring outcomes over time.

Commissioners and providers responsible for implementing these systems should also read *Models of care*: *part two*, which outlines suggested data reports from service providers based on the recommendations of the Task Force to Review Services for Drug Misusers (1996).

8.3 National drug treatment data sets

Some information on those presenting for drug treatment has been collected systematically for a number of years across England and includes data for the Regional Drug Misuse Database, now National Drug Treatment Monitoring System (NDTMS) and the DAT templates and treatment plans.

The NTA is currently developing an information strategy and minimum data set to support the implementation of *Models of care*. The data set will be published as an addendum to *Models of care*. The NTA data set will describe care received by the service user during each period of care and will be person-centred. It will also record outcome achieved through the treatment process. It is intended that the primary function of this data set is to determine whether desired outcomes are achieved by drug treatment services. It is also intended that the data set will provide managers, clinicians and other professionals with better-quality information for clinical audit, service planning, management and contract monitoring.

9 Summary of *Models of care*: *part two*

This executive summary should be read alongside *Models of care*: *part two*. Part two provides more detailed information and is 200 pages long. It contains additional details on the following topics.

9.1 Drug treatment modalities

Models of care: *part two* describes the main modalities of treatment that should be provided for drug misusers. In the case of tier 2 and 3 services, this will generally be provided in the locality where the client lives. However, it is acknowledged that in rural areas tier 3 services will be more difficult to provide locally. But consideration needs to be given to the provision of more individualised, structured, community-based programmes in rural areas.

Each modality is described in terms of a standard format. Each section has a definition of the treatment modality and its aims and objectives. The client group served is identified. There is a brief description of the evidence base for each modality. The location of and access to each drug treatment modality is described together with referral pathways, where appropriate. Assessment relevant to each modality is outlined. Consideration is also given in each section to service management, competencies of staff, standards, and performance management and outcome measurement.

In some cases illustrative care pathways have been described to provide examples of the way in which care pathways can be applied. The following drug treatment modalities are covered:

- advice and information
- needle exchange facilities
- care planned counselling
- structured day programmes
- community prescribing
- inpatient drug treatment
- residential rehabilitation services.

9.2 Special groups

Models of care: *part two* aims to identify special groups of drug misusers who are typically poorly served by drug misuse services. However, it is not always the case that these groups are poorly served; there are many examples of good practice and these are identified where appropriate. This chapter highlights the specific needs of these special groups and provides guidance on how services can be improved to meet these needs.

9.2.1 Stimulant misusers

Stimulant misusers (including cocaine, crack and amphetamine) have particular needs that are different from opioid misusers. The evidence base for the effectiveness of treatment interventions for stimulant users is less substantial than in the case of opioid users. But there is emerging evidence and practice examples as to how stimulant misusers should be catered for in drug services.

9.2.3 Women drug misusers

Women drug misusers face particular barriers to accessing appropriate treatment and tend to be under-represented in drug services, even taking account of the lower prevalence of drug misuse in women. Barriers to service utilisation include a range of social factors such as stigma, childcare responsibilities, and attitudes. *Models of care*: *part two* describes a range of ways in which agencies can maximise access for women, particularly pregnant women and women caring for children.

9.2.3 Black and minority ethnic drug misusers

Black and minority ethnic populations face barriers to treatment for a variety of reasons. The treatment needs of black and minority ethnic groups in some cases differs from those of other service users. Services therefore need to be sensitive to such needs, aware of legislation relating to race and racial discrimination, and employ ways of maximising treatment engagement and retention in these groups.

9.2.4 Young people

Specific issues pertain to the provision of treatment for young drug misusers under the age of 18. While it is beyond the scope of to provide a comprehensive framework for young people's drug treatment services, they are discussed in this section as drug services that are predominantly adult-oriented will come in contact with this group. Particular attention is drawn to the Children's Legal Centre and SCODA, 1999 policy guidelines and the Health Advisory Service 1996 and 2001 reports.

9.2.5 Substance-misusing parents and pregnant drug misusers

This section outlines issues of assessment and treatment of substance-misusing parents. Many adult clients in drug treatment are parents with responsibility for the care of children. Many, if not most, drug misusers are responsible and effective parents. However, there will be concerns about the ability of a proportion of clients to provide adequate care for their children. The welfare of the child is paramount and client confidentiality needs to be balanced against the needs of the children. Drug treatment services need to be aware of their responsibilities to both their clients and their clients' children. Pregnant drug misusers are also considered.

9.2.6 Alcohol misuse in drug misusers

Alcohol misuse in drug misusers is an often-neglected area in drug treatment services. However, there are particular risks attached to alcohol misuse particularly in the growing number of alcohol misusing clients who are hepatitis C positive. This section examines the issues around identification and treatment of drug misusers whose health is at risk through concurrent alcohol misuse.

9.3 Cross-cutting issues

9.3.1 Interface with the criminal justice system

Many drug misusers seeking treatment in health or social care agencies are also in contact with criminal justice agencies. This is particularly true in the case of clients involved with drug treatment in prisons, arrest referral schemes, and drug treatment and testing orders. This chapter considers interfaces with the criminal justice system to maximise retention and though-care and reduce drug-related harm such as overdose.

9.3.2 Reducing drug-related deaths

The recent ACMD report (ACMD, 1988) has recognised the important impact and potential preventability of drug-related deaths. This section examines some of the evidence concerning the epidemiology and provides guidance to reduce drug-related deaths, including overdose and blood-borne disease (hepatitis B and C and HIV). Blood-borne diseases present significant risk to the health of drug misusers through sharing of injecting equipment and sexual risk behaviours. Methods of reducing risk and preventing harm through routine health screening, hepatitis and HIV testing, and immunisation are presented. Guidance on standards, methodologies, and good practice around these issues is given.

9.3.3 Psychiatric co-morbidity

Psychiatric co-morbidity is a growing problem for both drug misuse services and mainstream psychiatric services. The epidemiological evidence for psychiatric co-morbidity and relevant treatment approaches is presented. Recent guidance from the Department of Health points to the need for greater joint working between community mental health teams and specialist substance misuse services in cases of co-morbidity, including a recognition that patients with psychiatric co-morbidity should be the primary responsibility of mainstream psychiatric services in liaison with drug services.

9.3.4 Outreach work

Outreach work as a method of delivery is outlined. Outreach work (detached, peripatetic and domiciliary work) lacks a substantive evidence base compared to some other interventions. It is, however, a significant part of the landscape of drug services. Management issues and interfaces between outreach services and more structured care are considered.

9.3.5 Users, carers and self-help groups

Self-help groups are an important mode of help for people with drug and alcohol problems, and have often provided the impetus for improvements in statutory service provision. They continue to provide an important alternative to professional care. The needs of carers are identified as well as specific interventions for carers that have proven beneficial. User involvement in drug treatment is crucial; greater user and carer involvement in planning and developing services will lead to more effective and acceptable services.

9.3.6 Complementary therapies

Complementary therapies are popular with service users and are increasingly employed in drug treatment services. These include acupuncture, reflexology, homeopathy and massage. While the evidence base at present does not provide strong support for such therapies, they may improve client satisfaction and treatment retention. More research is needed to evaluate such approaches.

Appendix one

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October 2002

Design: Moore-Wilson www.m-w.co.uk