Consultation report
Models of care for the treatment of adult drug misusers
Update 2005
National Treatment Agency for Substance Misuse

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

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

The NTA is responsible for meeting the Department of Health’s (DH) targets to:

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

Reader information

<table>
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<tr>
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<th>A consultation report to update Models of care for the treatment of adult drug misusers (2002) which provided national guidance on the commissioning and provision of treatment for adult drug misusers. This document has been well received by the field but requires slight updating in light of the Audit Commission report Drug misuse 2004, NHS standards and the rapid expansion of drug treatment.</th>
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1 Introduction


This update is intended to build on the framework and concepts in Models of care 2002 rather than totally replace them. It requires drug treatment commissioners and providers to have implemented the key tenets previously described in Models of care 2002 including: the four-tiered model of commissioning, local screening and assessment systems, care planning and co-ordination of care at the heart of structured drug treatment, and the development of integrated care pathways.

In addition to the above, there is now a greater focus required from commissioners and providers of drug treatment on improving clients’ journeys and the effectiveness of drug treatment.

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

Whilst the NTA does not have statutory responsibility regarding drug treatment in prisons, NOMS has committed to ensure alignment of services and to implement Models of care in prisons.

Models of care: Update 2005 outlines:

- the policy context and rationale for updating Models of care 2002
- the key differences between Models of care 2002 and Models of care: Update 2005
- the context of improving treatment effectiveness and improving clients' journeys
- a reiteration of the four tiers
- updated information on assessment, care planning and integrated care pathways
- definitions of the full range of treatment interventions in the context of local treatment systems
- draft quality requirements, which are in line with the NHS policy and performance management structures
- key references.

This update should be viewed in the context of the NHS improvement plan: putting people at the heart of public services (2004) and the DH’s Standards for better health (2004). Models of care: Update 2005 supports development ‘standard D2’, described in Standards for better health (2004), which will be used as the basis of Healthcare Commission and NTA improvement reviews of drug treatment. Implementing Models of care: Update 2005 will contribute to the Government’s Public Service Agreement (PSA) target to:

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


The final version of Models of care: Update 2005 will be accompanied by a suite of documents, including:

- an evidence base review
- a summary for providers and commissioners
- a summary for service users and carers.
Separate guidance, *Models of care for the treatment of adult alcohol misusers*, is due for publication in autumn 2005 following an extensive consultation period. Whilst there are important differences from this document, the overall framework for commissioning treatment services, the division into tiers of provision, the description of levels of assessment that can be used and the focus on effective co-ordination of care through care planning are reiterated and remain consistent for both drug and alcohol treatment service provision. Development of integrated care pathways, high quality commissioning and service delivery in response to assessment of need and consideration of evidence for effective interventions, are also consistent between the two documents.
2 Overview and action required

The NTA is consulting on implementation of Models of care: Update 2005. See the separate consultation document for more details (available at www.nta.nhs.uk). This section will be expanded in the final published version of Models of care: Update 2005.

3 Policy and context

3.1 Good-quality drug treatment is effective

International and national evidence consistently shows that good quality drug treatment is highly effective in reducing illegal drug misuse, improving the health of drug misusers, reducing drug-related offending, reducing the risk of death due to overdose, reducing the risk of death due to infections (including blood-borne virus infections) and improving social functioning. (The Taskforce Review (Department of Health 1996)\(^5\), The National Treatment Outcome Research Study (1995-2000)\(^6\), the forthcoming review of the evidence base for drug treatment (NTA 2005)).

3.2 Significant improvement in access to and capacity in drug treatment since 2001

Funding for drug treatment has increased significantly since 2001 and will continue to receive substantial investment in future years. This has been matched by a rapid expansion in drug treatment in order to achieve the Government’s PSA target to double the number in effective, well-managed drug treatment by 2008. The drug treatment workforce has also grown significantly, from just over 6,000 practitioners and managers in 2002 to over 10,000 in March 2005.

The Audit Commission report Drug misuse 2004\(^7\) recognises the impressive progress in the drug treatment system since 2002, including the increased capacity of local drug treatment services, better working partnerships between local agencies, and more integrated services.

The wide variation in access to different types of treatment (as referred to in an earlier Audit Commission report Changing habits (2002)\(^8\)) has been largely tackled, with the implementation of Models of care 2002 leading to a good range of drug treatment services now available in most areas in England.

In 2002, the Audit Commission reported on a drug treatment being characterised by lengthy waiting times in most areas. In December 2001, the average national waiting time across all types of treatment was 9.1 weeks. This had been reduced to a national average of 2.3 weeks by June 2005 with lower waiting times for all clients in intensive Drugs Intervention Programme (DIP) areas (1.85 weeks in June 2005)\(^9\).

3.3 Drug treatment population trends

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

- In 2003/04, 125,545 individuals were reported to the NDTMS as receiving structured drug treatment. This figure has been revised from the figure published in September 2004 after resubmissions and corrections to the data received during 2004/05.
- Heroin was identified as the main problem drug for over two-thirds (67 per cent) of clients receiving drug treatment.
- Where heroin was a client’s main drug of misuse, 21 per cent reported crack or cocaine as the second drug of misuse.
- Of clients reporting crack or cocaine as their main drug of misuse, 13 per cent reported heroin as their second drug of misuse.
• Cannabis was reported as the main problem drug for clients under 18 (61 per cent); whilst the figure for adults was nine per cent. One fifth (20 per cent) of individuals under 18 reported heroin as the main problem drug, five per cent reported crack or cocaine.

• There are notable regional differences in the proportion of individuals receiving drug treatment with crack/cocaine recorded as the main problem drug. This ranges from under two per cent to up to of those treated in Yorkshire and Humber, to 23 per cent in London.

• The most common referral route into treatment was self-referral, representing over two-fifths (43 per cent) of all reported referral sources.

• Approximately 17 per cent of clients were referred into treatment via criminal justice agencies.

• Over half of all recorded drug treatment (54 per cent) was reported as being through specialist prescribing programmes, provided primarily by mental health trusts.

• About half (52 per cent) of all clients discharged from treatment remained in contact for 12 weeks or more following a triage assessment.

• A little under three-quarters (72 per cent) of clients presenting were male.

• Over two fifths (41 per cent) of closed Tier 4 treatment episodes resulted in a successful completion.

More information on the data analysis can be found in the report Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2003 to 31 March 2004 (DH, NTA, 2005).10

Evidence also indicates that alcohol misuse amongst those in drug treatment is common and poly-drug and alcohol use is common, if not the norm (Gossop 2005).11 The National Treatment Outcome Research Study (NTORS, 2000) found that drug treatment services were having little or no impact on drug service users’ drinking behaviour, despite half having identified alcohol problems. NTORS (1996) also commented on the “heavy burden” of health problems carried by drug users attending treatment, which adversely affected their physical and mental health and was accompanied by high rates of unemployment.

3.4 Harm reduction

Injecting behaviour Shooting up (2004)12, a recent report by the Health Protection Agency (HPA), reported an increase in the sharing of injecting equipment amongst injecting drug users. An increase in sharing injecting equipment has been reported from 1997 to 2003, with 33 per cent of an anonymous sample reporting that they had shared injecting equipment in the previous four weeks. Recent research (Rhodes: unpublished) into drug injecting trends amongst those using heroin and crack/cocaine suggests a growing nexus of risks of blood-borne virus (BBV) transmission, infections and venous damage.

Hepatitis C Shooting up (2004)12, also reported an increase in the prevalence of hepatitis C infection amongst injecting drug users both in treatment and out of treatment, from 36 per cent in 1998 to 41 per cent in 2003 (with only half of those hepatitis C seropositive being aware of this). Furthermore, an increase in the incidence of hepatitis C infection was reported amongst new injectors, indicating that transmission is increasing. There are marked regional variations in rates of hepatitis C infection amongst injecting drug users, with prevalence rates of over 50 per cent found in London and the North-West, and even higher prevalence have been seen in treatment populations Best et al. (1999)13 found an 86 per cent hepatitis C prevalence rate in one London drug treatment service.

Alcohol use and misuse is the single biggest contributory factor to those with hepatitis C infection developing fatal liver disease.

Hepatitis B In 2003 infection rates for hepatitis B virus of 22 per cent were found amongst injecting drug users in England. Infection rates amongst new injectors were low but had risen from five per cent in 1998 to nine per cent in 2003. Increasing hepatitis B vaccination rates were reported by samples of drug users, rising from 25 per cent in 1998 to 50 per cent in 2003. However, amongst those injecting less than three years, only 42 per cent had been vaccinated.
HIV Annual prevalence rates for HIV infection remain low and constant at about 2.9 per cent of injecting drug users in London and 0.5 per cent elsewhere in England. The prevalence amongst this group has not changed in recent years except in 2003 where, for those injecting for less than three years, a higher rate of 0.8 per cent has been found in England, which is the highest prevalence in this group since 1990.

Site infections Shooting up (2004) notes an increase in injecting site infections of various kinds, including tetanus and wound botulism. This indicates both poor hygiene whilst injecting and also some contaminated doses of drugs (particularly heroin).

Drug-related overdose deaths Although all indications are that these continue to fall, from 1,565 in 2000 to 1,300 in 2003 (ONS 2005), these deaths are still preventable and continued efforts should be made to reduce these deaths.

A reinvigoration of harm reduction in all tiers of drug treatment: These trends will require an immediate response from both commissioners and providers to stem the increase of BBVs and drug-related deaths amongst the drug using population. Drug treatment clearly also needs to be able respond to the whole of an individuals pattern of substance misuse including stimulant misuse and alcohol use.

3.5 Variation in the quality and effectiveness of drug treatment

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

The Audit Commission report Drug Misuse 2004 noted that clients are often unsure about the goals of their treatment and are not fully involved as active partners in treatment: e.g. through lack of involvement in their care plans.

There is a wide variation in the quality of practice across the drug treatment field. Forthcoming audit and research findings from the NTA will illustrate a wide variation in prescribing practice, care planning, supervised consumption and needle exchange practice. One of the intentions of Models of care: Update 2005 is to promote more consistently high quality and more effective treatment practice.

The NTA and the Healthcare Commission have developed a system for the independent assessment of the quality of the substance misuse treatment services in each DAT area. This system will be used to facilitate improvements in key aspects of these services. The review process starts in autumn 2005, focusing on care planning and community prescribing interventions in 2005/06.

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

3.6 Improvements required in treatment effectiveness

Given the variable effectiveness of drug treatment services, this update places a greater focus on the need to improve the effectiveness of drug treatment systems – by improving interventions to reduce the risk of BBV infection and risk of overdose, to improve retention in drug treatment and to improve drug treatment delivery, completion and reintegration into communities.

This update is also set in the context of the NTA’s treatment effectiveness strategy, which identifies some of the critical success factors to improving drug treatment, and which bases a delivery plan for 2005-08 on them. The success factors fall into two main groups:
improving clients' journey through treatment
improving local drug treatment systems.

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

3.6.1 Improving clients' journeys through treatment

Waiting times: From April 2006, the expectation will be that service users voluntarily seeking treatment will be able to access treatment within three weeks, with faster access for priority groups. Partnerships will be expected to initiate local investigations if service users wait longer than six weeks.

Retention: Retention in structured drug treatment has been built into mainstream health performance management systems. Retention targets are now built into primary care trust and strategic health authority local delivery plans, and the Healthcare Commission star ratings of mental health trusts now include retention in treatment for 12 weeks. For more details see section 8.1.

3.6.2 Treatment delivery

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

3.6.3 Improving treatment completion and community integration

For clients who wish to be drug-free, treatment systems need to be better configured to create better exits from treatment (including housing, education and employment opportunities). In addition, for clients who wish to be maintained on substitute opiate medication, drug treatment systems should also be well integrated into other systems of care and social support to provide opportunities for them to receive social support, education and employment where possible.

3.6.4 Improving commissioning

Four critical success factors that are considered important in improving local commissioning partnerships are:

- local commissioning partnerships linking with relevant local strategic partnership groups
- better local needs assessments
- development of local workforce strategies
- local commissioners enabled to performance manage drug treatment systems with clear routes in, through and out of drug treatment.

3.6.5 Improving service provision

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

- ensuring providers have a competent workforce
- ensuring service providers can work with the diverse needs of their service users
- ensuring drug treatment is evidence-based and underpinned by good audit or clinical governance mechanisms
- drug treatment services are managed using close to “real-time” data provided from the NDTMS, and client satisfaction and client outcome data.
3.7 Changes to commissioning

3.7.1 Wider health policy context

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

Longer-term, commissioners will also have to be aware of, and be able to respond effectively to, changes to the social care system, as set out in the social care green paper, Independence, wellbeing and choice (DH, 2005).

3.7.2 Changes in partnerships

There have already been changes in the commissioning of drug treatment since 2002, and changes in the priority given to drug treatment in health and criminal justice sectors. Drug treatment has now been prioritised into mainstream health performance management systems. A range of new local strategic partnerships for the planning of services have been developed. Information systems have improved and resources for drug treatment are planned to continue to increase until 2008.

3.7.3 Commissioning criminal justice services

From April 2005, PCT commissioners are also responsible for the commissioning of the healthcare needs of local prison populations. The commissioning of drug treatment will be an important consideration for prisons. Responsibility for commissioning offending-related programmes aimed at behaviour change in offenders will fall to the new National Offender Management Service (NOMS). Health performance management systems and PCT commissioners will need to work in partnership with NOMS wherever possible, to commission drug treatment for offenders.

3.7.4 A step-change in commissioning is required

In most local areas commissioning drug treatment is a multi-million pound business. In recognition of the complexity of the task, a step-change is required in drug treatment systems management. Local drug treatment systems have done well to develop in line with Models of care 2002. Now Models of care: Update 2005 calls for a greater focus on services user journeys and “flow” through drug treatment systems, and improvement in delivery of effective pathways of care. This will require improved strategic partnerships between health and criminal justice, as well as improved partnerships with those responsible for housing, education and employment services in mainstream provision, in order to maximise treatment gains for drug service users and prevent relapse into illegal drug misuse.
4 Commissioning substance misuse services

4.1 A revised framework for drug treatment services

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

The four-tiered framework has been well received and previous consultation on *Models of care* 2002 indicates that the field would value the retention of this framework, with some minor amendments.

The *Models of care* 2002 framework has enabled a better description of provision of treatment, however the tiers were a conceptual framework that were not intended to be a rigid blueprint for provision. They have been interpreted rather rigidly at times, with some unintended consequences which need rectifying. It is important to note that the tiers refer to the level of the interventions provided and do not refer to the provider organisations (e.g. referring to a “Tier 3 agency” is not correct as such an agency will often need provide Tier 2 interventions alongside Tier 3 interventions).

4.2 Key differences between *Models of care* 2002 and *Models of care: Update 2005*

4.2.1 More focus on harm reduction with interventions integrated into all tiers

From previous consultation responses, feedback indicates that some harm reduction activities have been marginalised into being provided only by what have been called “Tier 2 services” (such as needle exchanges), at a time when there is evidence that rates of infection of BBVs are rising. *Models of care: Update 2005* advocates a far greater emphasis on the need to reduce drug-related harm including risks of BBV infection, overdose and other infections at all points in the treatment journey, alongside other interventions and across a range of tiers. Harm reduction interventions are required for drug users before, during, and after structured drug treatment.

The term ‘harm reduction’ can also cover a wide spectrum of interventions. *Models of care: Update 2005* advocates the commissioning and provision of a wide range of interventions to reduce the adverse effects of drug misuse on drug users with particular focus on reducing the risk of immediate death due to overdose and risks of morbidity and mortality due to BBVs and other infections. This may include responses at a commissioning and strategic planning level, and expansion and improvement in the provision of intervention to reduce drug-related harm. The latter may include increasing the availability of clean injecting equipment, interventions to encourage drug injectors not to share injecting equipment, to use ingestion methods as an alternative to injecting, and to attract drug users into oral substitute treatment when appropriate.

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

*Models of care: Update 2005* also advocates a harm reduction approach is adopted with local communities (e.g. minimising discarded used injecting equipment) and service users families and significant others (e.g. minimising risks to the children of drug misusing parents).
4.2.2 The four tiers revisited

In Models of care 2002, the four tiers were devised based upon a combination of setting, interventions and the agency responsible for providing the interventions. This has led to some confusion and rigid interpretation. In Models of care: Update 2005, the tiers describe drug interventions and the context for those interventions (e.g. within care-planned care, within residential settings).

4.2.2.1 Providers spanning tiers

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

4.2.2.2 More flexible opening times

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

4.2.2.3 Tier 1 drug interventions within generic services

The emphasis in Models of care: Update 2005 is that Tier 1 interventions are not the generic services themselves (e.g. housing, social services). Rather, Tier 1 consists of a range of interventions that can be provided by generic providers depending on their competence and partnership arrangements with specialised drug services. Given this change in emphasis, interventions that were previously described as “Tier 4b” (e.g. care provided in inpatient hepatology units for drug users suffering from problems caused by hepatitis C infection) in Models of care 2002 are re-designated to Tier 1.

4.2.2.4 Tier 2 drug interventions

Previous consultation responses have suggested the need for a wider recognition of the valuable role of open access Tier 2 drug interventions that may just stop short of being classified as structured drug treatment. In keeping with this, Models of care: Update 2005 advocates Tier 2 interventions should be strengthened. Within a local system Tier 2 interventions should include:

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

There is some perception that Tier 2 interventions have largely been focused on those who are still actively using illegal drugs. Models of care: Update 2005 calls explicitly for Tier 2 open access interventions also to be delivered to those who are drug-free (and wish to remain so). Tier 2 interventions can be a key delivery mechanism for the provision of aftercare. In this context aftercare is drug-related support following the completion of care-planned drug treatment. This could comprise support groups or individual support for those wishing to remain drug-free or access to user groups and advocacy mechanisms (such as Narcotics Anonymous or equivalent groups).

4.2.2.5 Community-based Tier 2 and 3 interventions

Some consultation responses called for the creation of “tier two and a half “, in recognition of work that practitioners undertake with clients that does not quite reach the threshold for care-planned care (e.g. two or three “sessions” of brief interventions). Rather than create a new tier, Models of
care: Update 2005 advocates a more careful consideration of what is being provided and a recognition that providers can and do provide a range of interventions spanning tiers 2 and 3.

The main difference between Tier 2 and 3 is the degree of structured care planning and reporting required, with more required at Tier 3, including the completion of National Drug Treatment Monitoring System (NDTMS) forms. However, it is recognised that in reality, the differences may be subtle. This may be further confused, as some of the actual interventions provided by agencies providing predominantly Tier 2 interventions may be the same in kind as those by agencies providing predominantly Tier 3 interventions (e.g. brief interventions for alcohol or cannabis use may be provided at both tiers). The degree of assessment, structuring of the plan of care and reporting requirements will help in categorisation to Tier 2 or 3.

Tier 2 interventions do not ask for the same degree of commitment from the client. The level of assessment may be less (though there may be some). Interventions may not require the same degree of consent to a planned course of treatment and it often does not have the same level of duty of care for the practitioner (though still carries some). Thus there are different reporting requirements. Care plans should be used if appropriate but are not generally expected for Tier 2 interventions.

Tier 3 interventions comprise care-planned treatment, whereby an individual assessed has been found in need of structured treatment, and has a care plan which involves the client consenting to treatment. The client then receives drug treatment and other interventions (sequentially or concurrently) according to the care plan drawn up with the keyworker, together with scheduled keyworking sessions, and any co-ordination of care or case management required.

The most appropriate guide to decide whether interventions are Tier 2 or 3 is whether interventions are provided in the context of a care plan, following assessment. Models of care: Update 2005 contains a range of definitions to help clarify the process of decision making including care planning, keyworking, the treatment interventions and how they fit together.

4.2.2.6 The Drug Interventions Programme (DIP)

The Drug Interventions Programme provides Tier 2 assessment, referral and brief interventions to drug users within the criminal justice system and more structured Tier 3 interventions involving care planned work (or case management) via Criminal Justice Integrated Teams, and prescribing (either by employing clinicians or commissioning local prescribing services).

4.2.2.7 Drug Treatment based in prisons

CARAT services in prison provide both Tier 2 and 3 interventions. The majority of drug treatment programmes in prisons also provide Tier 3 interventions.

4.2.2.8 Primary care (including prison healthcare)

GPs and primary care services are clearly valuable in delivering a wide range of interventions, covering all four tiers, provided the GP or practitioners are competent to do so. The NTA has been working with the Royal College of GPs and with the Royal College of Psychiatrists, on a number of pieces of work that will feature in the final version of the Models of care: Update 2005 suite of documents. Issues that will be taken into account include:

- care planning in the context of primary care
- models of shared care
- the place of GP services in local drug treatment systems
- the required competencies of doctors in drug treatment, as covered in the report Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers (Royal Colleges of GPs and Psychiatrists).

4.2.2.9 All prescribing interventions are Tier 3

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

4.2.2.10 Tier 4: The need for expansion

Tier 4 interventions have not expanded at the same rate as Tier 2 and 3 drug treatment provision in the last few years. The coverage of Tier 4 interventions in England is still patchy and is sometimes (incorrectly) used as a last resort for drug misusers. Commissioning to expand Tier 4 is crucial to improve clients’ journeys, inpatient assessment and stabilisation for complex cases and to maximise treatment exits and access to abstinence-based aftercare. Tier 4 interventions are of increasing importance for a number of reasons:

- There is high level of expressed need for residential provision from service users and carers.
- Specialist inpatient interventions are necessary to provide the optimal local drug treatment system for clients with complex drug, alcohol and other health needs; those in crisis; those requiring medication stabilisation (e.g. on injectable or high dose opioids, or for effective detoxification).
- Inpatient detoxification followed by residential rehabilitation is the most effective way for drug misusers to become drug free, if they are motivated and this is the agreed objective (NTA, 2005)\(^\text{22}\).
- There is evidence to show that detoxification in specialist substance misuse facilities is more effective than in general hospital or psychiatric wards, which are associated with low success rates \(^\text{23}\).
- It is recognised that service users must have social support upon leaving rehabilitation units and secure adequate housing to maximise the benefits of treatment and to reduce risk of relapse and fatal overdose.

The commissioning of all Tier 4 interventions requires improvement. Some of the services providing these interventions have national catchment areas. Residential rehabilitation units (and some inpatient units) are particularly vulnerable if they are “spot purchased”. These interventions can be purchased through the use of community care funding, pooled treatment budget funding or mainstream health funding, or some combination of these. Providers report that the uncertainty in funding is increasingly difficult to manage, particularly for high cost and low volume services. New regional or sub-regional commissioning arrangements may be required, which requires partnership working with neighbouring strategic partnerships.

Therapeutic communities and some (residential) 12-step programmes fulfil the criteria for Tier 4 interventions in prisons.

4.3 The four tiers reiterated

The following reiteration of the tiers describes:

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

Commissioners need to ensure that all tiers of interventions are commissioned to form a local drug treatment system to meet local population needs. Local systems should allow for some flexibility in how interventions are provided, with the crucial factors being the pattern of local need and whether a service provider is competent to provide a particular drug treatment intervention.
## Tier 1 interventions: Drug-related information and advice, screening and referral by generic services

<table>
<thead>
<tr>
<th>Definition</th>
<th>Tier 1 interventions comprise drug-related information and advice, screening, assessment, and referral to specialised drug treatment</th>
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</table>
| Interventions | Commissioners need to ensure that a range of generic services provide as a minimum the following Tier 1 drug interventions:  
- drug treatment screening and assessment  
- referral to specialised drug treatment  
- drug advice and information  
- partnership or “shared care” working with specialised drug treatment services, to provide specific drug treatment interventions for drug misusers within the context of their generic services. Specific drug treatment liaison schemes may need to be commissioned to fully realise partnership work.  

Generic services should also provide their own services to drug misusers and some may be specifically designed for drug misusers (e.g. housing projects for those leaving rehabilitation). Commissioners should ensure that drug misusers are not marginalised from generic services by developing local strategic partnerships. |
| Settings | Tier 1 interventions are provided in the context of general health (e.g. liver units, antenatal wards, accident and emergency), social care, education or criminal justice settings. |
| Competency | Generic service staff rarely receive drug training. To enable generic services to provide Tier 1 drug interventions, commissioners may need to commission specific training or work with mainstream systems to integrate drug training into their vocational training. Competence will be required to screen, assess and refer into local specialised drug treatment systems in accordance with local protocols and to provide drug-related advice and information and to work in partnership with specialised drug treatment services. Commissioners may need to ensure competency-based training, information on local systems and drug liaison workers to support partnership projects.  
Of particular relevance are DANOS24 Standards (Drug and Alcohol National Occupational Standards): AA1 “Recognise indication of substance misuse and refer to specialists”; AB2 “Support individuals who are substance misusers”; AB5 “Assess and act on risk of danger to substance misusers”, and AF1 “Carry out screening and referral assessment” |
## Tier 2 interventions: Open access, non-care-planned drug-specific interventions

<table>
<thead>
<tr>
<th>Definition</th>
<th>Tier 2 interventions comprise drug-related information and advice, screening, assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.</th>
</tr>
</thead>
</table>
| Interventions | Tier 2 interventions which should be commissioned in each local area include:  
- screening, assessment and referral for structured drug treatment  
- drug interventions which attract and motivate drug misusers into local treatment systems, including engagement with priority groups such as pregnant women, offenders, stimulant users etc  
- interventions to reduce harm and risk due to BBV and other infections, including dedicated needle exchanges and the support and co-ordination of pharmacy based needle exchanges  
- interventions to minimise the risk of overdose and diversion of prescribed drugs  
- brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if it does not require structured treatment)  
- brief interventions for specific target groups including high-risk and other priority groups  
- aftercare support for those who have left care-planned structured treatment.  
- liaison and support for generic providers of Tier 1 interventions. |
| Settings | Tier 2 interventions may be delivered separately from Tier 3 but will often also be delivered in the same setting and by the same staff as Tier 3 interventions.  
Other typical settings to increase access are through outreach (general detached or street work; peripatetic work in generic services or domiciliary (home) visits) and in primary care settings.  
Pharmacy settings are important due to their unique role in pharmacy based needle exchange schemes and their role in supervised consumption of prescribed drugs.  
Criminal justice settings – including police and court settings for criminal justice referral, Drugs Intervention Programmes in community settings, as well as CARATs and prison healthcare provision within the prisons estate. |
| Competency | Tier 2 interventions require competent drug and alcohol specialist workers who should have basic competences in line with DANOS. Competency also depends on what cluster of services are provided. Normally front line staff would have competence in motivational techniques and drug and alcohol brief interventions. Those advising on injecting techniques should also ideally hold nursing or medical qualifications and be DANOS competent.  
Those providing extended pharmacy based services for drug misusers including interactive needle exchange and supervised consumption services would normally have drug specific competence, may have specific contractual arrangement with drug treatment commissioners and work in partnership with other community based drug services. |
**Tier 3 interventions: Structured, care-planned drug treatment**

<table>
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<tbody>
<tr>
<td>Interventions</td>
<td>Tier 3 interventions that should be commissioned in each local area include:</td>
</tr>
<tr>
<td></td>
<td>- comprehensive drug misuse assessment</td>
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<tr>
<td></td>
<td>- care planning and review for all in structured treatment, often with regular keyworking sessions as standard practice</td>
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<td></td>
<td>- community care assessment and case management for drug misusers</td>
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<td></td>
<td>- care co-ordination for those with more complex needs</td>
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<td></td>
<td>- harm reduction activities as integral to care planned treatment</td>
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<td></td>
<td>- a range of prescribing interventions, in the context of a package of care, in line with the “Clinical Guidelines” (DH 1999) and other evidence-based clinical standards including: stabilisation and oral opioid maintenance prescribing; community based detoxification; injectable maintenance prescribing, and a range of prescribing interventions to prevent relapse and ameliorate drug-related and alcohol-related conditions</td>
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<tr>
<td></td>
<td>- a range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour, and also address co-existing conditions such as depression and anxiety</td>
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<td></td>
<td>- structured day programmes and care planned day care (e.g. interventions targeting specific groups)</td>
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<td></td>
<td>- liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health, hepatitis services)</td>
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<td></td>
<td>- liaison services for social care services (e.g. social services (child protection and community care teams), housing, homelessness)</td>
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<td></td>
<td>- a range of drug treatment interventions for drug misusing offenders including drug treatment elements in Drugs Intervention Programmes, Probation Orders with drug treatment components, and drug treatment provided within prison settings.</td>
</tr>
<tr>
<td>Settings</td>
<td>Tier 3 interventions are normally delivered in specialised drug treatment services with their own premises in the community or on hospital sites. Other delivery may be by outreach (peripatetic work in generic services or other agencies or domiciliary or home visits). Tier 3 interventions may be delivered alongside Tier 2 interventions.</td>
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<tr>
<td></td>
<td>Some of the Tier 3 work is based in primary care settings (shared care schemes and GP-led prescribing services), but drug specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care.</td>
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<tr>
<td></td>
<td>Drug treatment interventions for offenders may be delivered in prison settings by CARATs and some drug treatment programmes or within criminal justice teams (e.g. Drugs Intervention Programmes).</td>
</tr>
<tr>
<td>Competency</td>
<td>Tier 3 services require competent drug and alcohol specialised practitioners who should have competences in line with DANOS 22. The range of competences required will depend upon job specifications and remits.</td>
</tr>
<tr>
<td></td>
<td>Medical staff (usually addiction psychiatrists and GPs) will require different levels of competence depending on their role in drug treatment systems and the needs of the client, with each local system requiring a range of doctor competencies (from specialist to generalist) in line with joint guidance from the Royal Colleges of GPs and Psychiatrists (2005).</td>
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</table>
## Tier 4 interventions: Drug specialist inpatient treatment and residential rehabilitation

<table>
<thead>
<tr>
<th>Definition</th>
<th>Tier 4 interventions comprise residential specialised drug treatment which is care-planned and care co-ordinated to ensure continuity of care and aftercare.</th>
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</table>
| Interventions | Tier 4 interventions which should be commissioned to meet local area needs include:  
• inpatient specialist drug and alcohol detoxification and stabilisation services  
• a range of drug and alcohol residential rehabilitation units to suit the needs of different service users.  
• a range of drug “half way” houses or supportive accommodation for drug misusers  
• residential drug and alcohol crisis intervention units (in larger urban areas)  
• inpatient detoxification provision, directly attached to residential rehabilitation units for some  
• provision for special groups for which a need is identified (e.g. for drug using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness). These interventions may require joint initiatives between specialised drug services and other specialist inpatient units. |
| Settings | Ideal settings to provide inpatient drug detoxification and stabilisation are specialised bespoke inpatient or residential substance misuse units or wards.  
Inpatient provision in the context of general psychiatric wards may only be suitable for some patients with co-morbid severe and enduring mental illness, but many such patients will benefit from a dedicated addiction specialist inpatient unit.  
Those with complex drug and other needs requiring inpatient interventions may require hospitalisation for their other needs e.g. (pregnancy, liver problems, HIV-related problems) and this may be best provided for in the context of those hospital services (with specialised liaison support).  
Continuity of care is essential in preserving the gains achieved in residential treatments so there is a compelling argument for providing for suitable patients, inpatient detoxification beds attached to residential rehabilitation units (provided there are adequate medical supports). Other patients will need inpatient detoxification first in an addiction specialist inpatient unit (e.g. because of severity and complexity), but this still requires significant strengthening of the links with residential rehabilitation provision to ensure the seamless transition of clients between the two.  
Service users requiring residential rehabilitation or “half way houses” may wish to be located away from their area of residence and drug misusing networks. |
| Competency | Inpatient or residential interventions providing detoxification and pharmacological stabilisation would normally require medical staff with specialised substance misuse competency (rather than be provided by generalist GPs). The level of specialised medical staff competence required will depend on the types of service provided and the severity of the problems of the clients. Addiction specialist competencies will be needed for inpatient units for severe and complex problems, but suitably competent GPs can provide support to some units for patients with less complex needs.  
Staff in residential rehabilitation units that are registered care homes will need to meet relevant social care National Occupational Standards.  
Hospital based services will also be required to meet practitioner standards for independent or NHS hospitals.  
All staff working in all residential settings are advised to demonstrate competence against DANOS at both manager and practitioner levels. |
4.4 Treatment effectiveness: Improving clients' journeys

4.4.1 Evidence for treatment effectiveness

*Models of care: Update 2005* has a greater focus on improving clients' treatment journeys through systems. Drug treatment is not an event, but a process usually involving engagement with different drug treatment services, perhaps over many years. Each client drug treatment journey is different and depends on a range of factors including health status, relationships, nature of the drug problem and the quality of the drug treatment they receive. However, drug treatment use is often episodic, with service users "dipping" in and out of treatment over time. Evidence reviewed by the NTA research team suggests that an average time in treatment for someone with a heroin or crack cocaine dependence problem is five to seven years with some heroin users requiring indefinite maintenance on substitute opioids. Evidence also tells us that service users gain cumulative benefit from a series of treatment episodes. However, the biggest improvements in client outcomes are likely to be made in the first six years of treatment (DATOS)\(^{25}\).

Evidence suggests that optimised treatment usually involves retaining clients in drug treatment for a minimum of three months. This is the point at which treatment begins to have generalised long-term benefit. It is presumed this is by engaging the service user sufficiently in a therapeutic relationship to enable positive changes to occur. This approach requires a partnership between the treatment provider and the client or service user, with both working towards common explicit goals. This also requires a concerted effort on behalf of the treatment provider to enable all of the clients needs to be met, not just their drug treatment needs. This may include addressing alcohol misuse, health needs due to blood-borne virus infections such as hepatitis C, treatment for underlying anxiety or depression, building social support networks, and securing appropriate housing, education or employment. All of these may be crucial to prevent relapse back to illicit drug misuse.

While much of the focus of outcome research has been on identifying key individual characteristics that predict better treatment outcomes, such as higher levels of personal and social capital and lower levels of problem severity, increasing attention is being paid to service characteristics that can improve outcomes. The National Drug Evidence Centre research (2004)\(^{15}\) for the NTA showed that the best predictor of retention in community treatments in the north-west of England was related to service factors rather than client characteristics. Similarly, Meier (2005)\(^{26}\), has also reported that much of the variability in retention in residential rehabilitation services derives from factors about the service itself rather than the service user. This is consistent with empirical research conducted in the US, which shows that organisational development work can lead to significantly enhanced treatment outcomes across patient populations.

4.4.2 Component parts of the treatment journey

In addition to implementing the framework advocated in *Models of care 2002*, the NTA is committed to pushing for an improvement in drug treatment effectiveness. This new treatment effectiveness strategy, with a focus on improving clients' journeys through drug treatment is integrated in *Models of care: Update 2005*. The treatment journey is conceptualised into four overlapping segments, each with key objectives. These are illustrated in Figure 1 and comprise:

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

The treatment system needs to be able to engage people rapidly and retain them once they have entered treatment. Two issues important to improving treatment engagement are timely access to treatment, and a focus on supporting retention for at least three months in structured treatment for those adults with dependent drug misuse (particularly heroin, crack/cocaine, and polydrug and alcohol misusers). Each drug treatment system will be assessed on its ability to engage service users on these two issues.

During this engagement phase service users will need to be assessed to ensure treatment can be tailored to their needs and also they may benefit from motivational work to maximise engagement. Service users may benefit from induction into treatment so they are aware of the roles and responsibilities of both the service provider and the expectations on them. Following assessment, care plans will be agreed with the clients and structured treatment will begin.

4.4.2.2 Drug treatment delivery

Drug treatment providers need to deliver effective and evidence-based drug treatment interventions and need to work positively through the active fostering of positive therapeutic relationships with service users which encourages full participation by them delivering their care plans. Good quality drug treatment should improve an individual’s health, social functioning and reduce public health and offending risks they pose to others. With high levels of BBV infections in the drug treatment population and many drug misusers living in areas of social deprivation, this will be challenging for some treatment systems. A greater emphasis is required on improving service users’ physical and mental health, importantly including those with hepatitis C infection and misusing alcohol. Increases in the use of cocaine and crack cocaine by service users has the potential to make client outcomes worse unless addressed, particularly with injecting drug users.

The children and carers of service users should also be considered during care-planned treatment. The needs of the children of drug misusing parents also require greater attention (ACMD, 2004)\(^\text{27}\).

During this phase, other work, not just specialist drug treatment, should commence to meet the service users’ wider needs. This community reintegration could include: improving housing status, getting other healthcare needs met by other health specialists (e.g. liver disease, dentistry), and provision of assistance to enable service user back to work or education.

4.4.3 Improving community integration for maintenance and treatment completion

Few service users who enter drug treatment think that they will be in specialist drug treatment indefinitely. For those who wish to be drug free, commissioners and providers need to create better pathways and exits from specialist drug treatment including improved social support, housing, education and employment opportunities to maximise treatment gains.
Drug-related aftercare support, such as support groups or individualised sessions or alternatively from mutual aid groups run by Narcotics Anonymous (or equivalent), has been demonstrated to sustain abstinence.

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

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

This may require some drug treatment system or service redesign, including:

- more explicit commissioning of interventions that engage service users and build “therapeutic alliances” crucial to treatment retention and positive change in treatment
- investing in quality drug treatment delivery to maximise gains and service users’ improvement in treatment (whether achieving stability on maintenance treatment or achieving effective abstinence)
- enhancing routes to treatment completion or, for stable patients who no longer need specialist care, better routes to community maintenance in primary care settings
- commissioning a range of aftercare mechanisms for service users to follow structured treatment, as a development of Tier 2 interventions, and ensuring a range of other support mechanisms for ex-service users (e.g. drug-free support (such as Narcotics Anonymous or equivalents)). This aftercare support should include support for those maintained in primary care
- investing in strategic partnerships with housing, education and employment, together with bespoke initiatives for drug misusers aimed at reintegration.
5 Substance misuse assessment

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

5.1 Screening assessment

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

5.2 Triage assessment

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

5.3 Assessment in the Drugs Intervention Programme

Assessments of clients in the Drugs Intervention Programme (DIP) are to be carried out within the *Models of care* framework. The information that forms the basis of an assessment in the DIP is collected on the Drug Interventions Record (DIR). An effective DIR-based assessment addresses a range of the client’s needs and covers health and social issues as well as drug use.

In the context of the DIR, the assessment is the key step towards the development of an initial care plan and is also the first important stage in gathering together, in a consistent way, the information that will facilitate effective continuity of care for drug users within the criminal justice system.

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

5.4 Initial care plan

It has proven to be good practice, following triage-level assessment, to produce an initial care plan for clients (particularly for those who are identified as at high risk or likely to be hard to engage). This is to facilitate a focus on their engagement in the treatment system, to ensure their immediate
needs are met, and to ensure appropriate support whilst they wait to undergo comprehensive assessment.

The initial care plan is particularly relevant to clients in the DIP programme, all of whom will receive an initial care plan after triage-level assessment. Where a prisoner is in custody for a short period of time – up to 28 days – and there is insufficient time to progress to a comprehensive assessment and care plan, an initial care plan may be drawn up to ensure their immediate and throughcare needs are met.

5.5 Comprehensive assessment

Comprehensive assessment is targeted at drug misusers with more complex needs and those who will require structured drug treatment interventions. The assessment aims to determine the exact nature of the client’s drug and alcohol problems, and co-existing problems in the other domains of health (mental and physical), social functioning and offending. A full risk assessment will also be conducted. Comprehensive assessment may be conducted by more than one member of a multi-disciplinary team, because different competencies may be necessary to assess different areas of client need (e.g. a doctor needs to assess clients for prescribing interventions involving controlled drugs – a supplementary prescriber may also be involved; or a psychologist may need to carry out psychometric assessment). Comprehensive assessment can be seen as an ongoing process rather than a single event. Comprehensive assessment will be carried out when a client may:

- require structured and/or intensive intervention
- have significant psychiatric and/or physical co-morbidity
- have significant level of risk of harm to self or others
- be in contact with multiple service providers
- have a history of disengagement from drug treatment services
- be pregnant or have children ‘at risk’

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

5.6 Risk assessment

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

- risk of suicide/self-harm
- risks associated with substance use (such as overdose)
- risk of harm to others (including children)
- risk of harm from others (including domestic violence)
- risk of self-neglect.

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

The Drug and Alcohol National Occupational Standards (DANOS)\textsuperscript{22} outline the basic competencies for professionals to undertake different levels of drug and alcohol assessment. Comprehensive assessment is intended to be a multi-disciplinary process to ensure a holistic approach to client need. Where a medical intervention is required, such as substitute prescribing or a psychiatric evaluation, the assessment must be undertaken by an appropriately trained doctor.

For more information on assessment – see the Care planning toolkit.
6 Care planning

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

In *Models of care: Update 2005* there is a stronger focus on care planning as central to drug treatment and a defining characteristic of structured treatment. The Audit Commission report *Drug misuse 2004* outlines the good progress that has been made since 2002 to meet the recommendations of the 2002 report. However, one of the areas that *Drug misuse 2004* highlights as needing improvement is consistency in the quality of care planning. The report concludes that care planning is frequently *ad hoc* and should be a routine activity monitored by local drug partnerships in order to deliver the vision of integrated care envisaged in current national guidance. It also recommends that there should be performance indicators that focus on effective care planning and aftercare outcomes.

The NTA has put care planning as a key tenet in its treatment effectiveness strategy, recognising that good care planning, good co-ordination of care, and frequent reviews of care plans with service users, is the vehicle to deliver improvements to individuals’ health and social functioning and reduce the public health and crime risk they pose to others. The NTA business plan 2005/06 \(^{17}\) sets an objective that all individuals in treatment have an identifiable written care plan which tracks their progress, and is regularly reviewed with them, by 2008.

6.2 Care planning and co-ordination of care in *Models of care: Update 2005*

This section sets out key principles for care planning and co-ordination of care, and a summary of the process as it relates to a client’s treatment journey. Further details on the NTA’s recommendations for care planning are contained in the NTA *draft care planning toolkit* \(^{28}\), which is out for consultation alongside *Models of care: Update 2005*. The previous consultation confirmed that the vast majority of respondents wanted to see more emphasis on clients achieving treatment goals through the delivery of a care plan and the client treatment journey. Therefore, although the key principles of care planning and the co-ordination of care set out in *Models of care 2002* remain the same, there are some differences in focus, which are consistent with the overall greater focus on the client’s treatment journey. These are:

- the care planning process as the essential component of the client treatment journey
- the importance of all clients receiving regular keyworking as a crucial element of care planned treatment
- a greater focus on client participation in the care planning process, where they are involved in producing and agreeing their care plan. This is consistent with the consultation response where an overwhelming majority of respondents wanted to see more service user involvement in care planning and review.
- meeting client needs in the four key domains of – substance misuse, health (physical and mental), social functioning (including employment and education), and offending behaviour – will require providers to work together to meet these multiple needs. This will require greater co-ordination of elements of the care plan.
- the focus on the three main elements of the client treatment journey (and therefore an important focus of the care plans and the keyworking process) – engagement, delivery and treatment completion and maintenance

The previous levels of ‘standard’ and ‘enhanced’ care co-ordination are no longer referred to in *Models of care: Update 2005*, but there is a clear acknowledgement that clients have a range of needs, from simple to highly complex, and this must be reflected in the care plan and the intensity of care co-ordination. This enables services to reflect on case mix in a more flexible way taking into account the staff competencies, client characteristics and client needs, as well as the systems of multidisciplinary working that are in place.
6.3 Care planning

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

6.3.2 The care plan
A care plan is ideally a paper document that is available to the client and service providers. Care plans should document and enable routine review of client needs, subsequent goals and progress across four key domains:
- drug and alcohol misuse
- health (mental and physical)
- offending
- social functioning (including housing, employment and relationships).

A care plan should be brief and readily understood by all parties involved and should be a shared exercise between the client and service. It should explicitly identify the roles of specific individuals and services, and the client, in the delivery of the care plan. Care plans should be reviewed both routinely and opportunistically when a change in a client’s circumstances makes it necessary.

For more details on care planning, see the Draft care planning toolkit.

6.3.3 Care planning and the treatment journey
This section describes the client treatment journey represented in figure 2.

Clients may enter the treatment system through a wide range of service providers. These providers should provide screening to identify drug and alcohol problems. If the organisation is not a specialist drug service, it should provide onward referral.

Once the drug problem has been identified (and if necessary, referral has taken place) the client will receive a triage assessment to identify the nature and extent of a client’s drug use. The screening assessment may or may not be conducted at the same time, and by the same assessor as the triage assessment.

The issue of engaging and retaining a client in the early phases of treatment may be addressed after either (or both) screening and triage assessment. The need for a focus on continuing engagement may continue beyond the comprehensive assessment. Where interventions are required to engage the client these may include:
- psychosocial interventions (e.g. contingency contracting, motivational interventions)
- advice and information
- harm reduction interventions
- rapid access to prescribing
- other interventions focused on engagement
- interventions to help the client prepare for change
- interventions to address specific needs that may impact on a client remaining in treatment.

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

Clients in some service settings may not, at first, be considered to require comprehensive assessment, e.g. some DIP clients. These clients may not require Tier 3 or 4 interventions (such
as community prescribing or structured day programmes) and may not have complex needs. In this case they will receive interventions to address the needs identified. On review of the DIP care provision a client may be considered to need a comprehensive assessment. Alternatively the client may be discharged following review.

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

The comprehensive care plan will identify a range of interventions to meet client needs in the four domains. Regular keyworking should either deliver or co-ordinate provision of the treatment interventions outlined in the care plan. Once the interventions have started, treatment moves into the “delivery phase”, which includes regular review of the care plan.

The final stage in the treatment journey is the ‘treatment maintenance or treatment completion’ phase. Clients should be assisted to leave structured drug treatment when appropriate and to maintain the changes they have achieved. This may involve helping the client access a range of non-care-planned community based services, such as mutual aid groups (e.g. NA, AA), housing support, employment or training/education opportunities (if they are not already receiving these). Clients who are being discharged from treatment should then enter aftercare provision, aided by an aftercare plan. A proportion of opiate-using clients will remain on maintenance prescribing regimes in the community and remain in the treatment maintenance phase of structured treatment. These clients will continue to have a care plan and keyworker.

For more detailed information on this process and how it works, see the Draft care planning toolkit.
Figure 2: Standard client treatment journey – with initial care plan option included
6.3.4 The keyworker and the care planning process

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

In the DIP, the keyworker role will be performed by a member of the criminal justice integrated team (CJIT), normally the case manager, who will take the responsibility for agreeing the care plan with the client, providing the motivational engagement, referring the client to other specialist treatment interventions, where appropriate, and co-ordinating links with other services (e.g. housing, employment etc). If a client is successfully referred to another specialist treatment service, that provider will usually take on the keyworking responsibilities. However the CJIT keyworker will retain a residual role and be ready to re-engage the client if they drop out of treatment or pick up responsibility for aftercare needs in negotiation with the treatment provider. This should be reflected in the care plan.

CARATs will take on the role of the key worker while the client is in custody, thereby ensuring continuity of care. CARATs will refer onto relevant CJITs on release.

6.3.5 Keyworking as part of the care planning process

Keyworking is a process undertaken by the keyworker to ensure the delivery and ongoing review of the care plan. This would normally involve regular meetings between the keyworker and the client where progress against the care plan would be discussed and goals revised as appropriate. The keyworker should have a therapeutic relationship with the client and would normally be a member of the multidisciplinary team responsible for delivering most of the client’s care. This includes case management arrangements within CJITs.

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

- information and advice on drug and alcohol misuse
- harm reduction work; and, motivational interventions
- other psychosocial and medical interventions may also be delivered during keywork sessions depending on the competency of the keyworker.

6.3.6 The three phases of keyworking

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

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

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

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

**Long-term treatment or treatment completion** The keyworker should ensure the care plan addresses actions to enable the client to move to long-term treatment when appropriate. This part of the care plan would usually involve maintenance on substitute medication. The keyworker
should also address action to support the client to leave treatment and maintain changes they have made while in treatment, or alternatively to arrange the transfer of a client to another service provider to continue treatment.

More detailed information on these phases is contained in the draft Care planning toolkit.

6.3.7 Care planning and co-ordination of care in the Drugs Intervention Programme (DIP)

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

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

It is important that at each stage of the care plan the keyworker considers whether other professionals are also involved with the individual and whether (within the legal framework) they should be liaising and exchanging information with other individuals or agencies.

6.3.8 Care planning in groups with externally co-ordinated care

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

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

Those who are under supervision or treatment orders from the criminal justice system will need careful integration of planning of their structured treatment to optimise outcomes (e.g. in the case of those on Drug Rehabilitation Requirements).

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

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

7.1 Commissioning integrated care pathways

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

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

- Drug and alcohol misusers often have multiple problems 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 services providing different tiers of intervention over time
- ICPs ensure consistency and parity of approach nationally (i.e. a drug misuser accessing a particular treatment intervention should receive the same response wherever they access care)
- ICPs ensure that access to care is not based on individual clinical decisions or historical arrangements.

Commissioners should encourage the development of local ICPs for drug treatment interventions in line with Models of care 2002 Part 2.

7.2 Elements of integrated care pathways

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

- a definition of the treatment intervention provided
- aims and objectives of the treatment intervention
- a definition of the client group served
- eligibility criteria (including priority groups)
- exclusions criteria or contraindications
- a referral pathway
- screening and assessment processes (see below)
- development of agreed treatment goals
- a description of the treatment process or phases
- co-ordination of care (see below)
- departure planning, aftercare and support
- onward referral pathways
- the range of services with which the intervention interfaces.

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

An ICP will not necessarily be the whole description of a person’s treatment journey. An individual ICP will be focused on one treatment intervention in a client’s care plan, within which a client may receive a range of interventions. Therefore it is important that the development of local ICPs takes into account the client treatment journey through care planned treatment.

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

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

8.1 Monitoring and performance management of drug treatment

8.1.1 Monitoring drug treatment data

Drug treatment is monitored through the national drug treatment monitoring system (NDTMS) and relates to the process of collecting, collating and analysing information from, and for those involved in, the drug treatment sector. There is an NDTMS centre to cover each region, with the actual services existing within various institutions such as Public Health Observatories, academic institutions and primary care mental health trusts. The purpose of the NDTMS centres is to obtain accurate, good quality, timely information for reporting drug treatment activity.

Through the NDTMS, the NTA monitors the performance of the drug treatment system at national and regional level, and reports on the number of people in contact with drug treatment services annually. It also reports on the percentage of discharged clients who remained in treatment for 12 weeks or more (known as the retention rate). Detailed analysis of the data collected on clients in treatment is published on the NTA website at www.nta.nhs.uk. From April 2006, NDTMS will measure the waiting times for drug treatment.

In addition to the NDTMS data on numbers in treatment and retention, every quarter, the NTA reports on waiting times for drug treatment and every six months reports on numbers in the drug treatment workforce. This data is also published on the NTA website.

With these monitoring requirements, it is important to minimise the burden of data collection on local service providers, therefore commissioners should agree the basic data to be collected with providers in their area.

8.1.2 Performance management of drug treatment

8.1.2.1 Local delivery plans

Targets on increasing numbers of people in drug treatment, and targets for retaining clients in treatment have to be set locally by each PCT, as part of the Local Delivery Plan (LDP) process. The LDP contains all the Government’s PSA targets on health, and is the key vehicle for a local area to set its priorities for improving health, developing services and involving local people in healthcare. The LDP also ensures that there are resources to meet all the key targets. The PCT targets on numbers in treatment and retention will be aggregated with other PCTs within a strategic health authority (SHA) area to form their overall LDP target on numbers in treatment and retention. The SHA will be performance managed on these targets by the Recovery Support Unit (at the Department of Health), and in turn the SHA will performance manage the PCT to ensure they meet the targets. The targets set must ensure year on year increases in numbers of drug users entering treatment and drug users retained in treatment for 12 weeks or more.

Details of local numbers in treatment and retention targets are available from the website of local SHAs and PCTs. Website and contact details for these can be found at the NHS website www.nhs.uk

8.1.2.2 Healthcare Commission star ratings

The number of people in drug treatment is a key target contributing to the Healthcare Commission’s star rating of PCTs, in line with the Public Service Agreement (PSA) target of doubling the numbers of people in drug treatment by 2008. Targets on 12-week retention in treatment now also contribute to the star ratings for mental health trusts through the balanced scorecard indicators, which provide an assessment across a broad range of health care areas.

The construction of these indicators, which detail the measurements and data required, is set out on the Healthcare Commission’s website at http://ratings.healthcarecommission.org.uk/indicators_2005.
8.1.2.3 NTA performance management

The above drug treatment monitoring data is used by the NTA regional teams in their performance management of local DAT partnerships to ensure they meet national and locally-set targets. The DAT partnership should set strategies through their treatment plan, for year-on-year increases in numbers of people entering treatment, clients being retained in treatment for 12 weeks or more, waiting times, workforce and other local targets. Draft treatment plans are submitted to NTA regional teams, who work with the DATs to upgrade and refine these plans in the light of resources available and local assessments of need. The plans agreed with each DAT are used by the NTA to help monitor the progress of drug treatment at a local and regional level. The NTA also works with strategic health authorities and other local and regional partners in performance managing DATs on targets on numbers in treatment and client retention.

The NTA makes the first part of each DAT treatment plan publicly available via its website www.nta.nhs.uk.
9 Quality criteria and improvement reviews

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

9.1 The Department of Health’s Standards for better health

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

There are two sets of standards, core standards and developmental standards, which cover seven domains – safety, clinical and cost-effectiveness, governance, patient focus, accessible and responsive care, care environment, and amenities and public health.

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


9.1.1 Standard D2: Patients receive effective treatment and care that:

- conforms to nationally agreed best practice, particularly as defined in the National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery
- takes into account their individual requirements and meets their physical, cultural, spiritual and psychological needs and preferences
- is well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations
- is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

9.2 NTA and Healthcare Commission criteria for review

The NTA is working in partnership with the Healthcare Commission to develop detailed criteria for reviewing drug and alcohol treatment services. These criteria will be developed during the process of each themed annual improvement review of drug treatment systems. Improvement reviews will review local providers and commissioning functions against these criteria and against the DH’s Standards for better health (2004).

The reviews for 2005/06 have already been piloted and developed in consultation with the drugs field. Detailed criteria have been developed for reviewing care planning and co-ordination and community prescribing, and were published in August 2005. They are available on the NTA website at www.nta.nhs.uk.

The themes for the next two years are:

- 2005/06: systems management (across the key elements of risk management, patient choice, diversity and effective partnerships) and harm reduction services
9.3 The NTA and Healthcare Commission improvement review process

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

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

More detailed information on the review process can be found on the NTA website at www.nta.nhs.uk, and the Healthcare Commission website at www.healthcarecommission.org.uk

9.4 National standards for professionals working in drug services

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

9.4.1 NHS knowledge and skills framework

The NHS Knowledge and Skills Framework (NHS KSF) defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff. The NHS KSF and its associated development review process lie at the heart of the career and pay progression strand of the NHS Agenda for change. Specific professional registration criteria and qualifications or accreditation programmes exist for groups such as nurses, general practitioners and addiction psychiatrists involved in substance misuse treatment, which relate to differing levels of competence (and involve accreditation by the Nursing and Midwifery Council, the General Medical Council and the Royal Colleges of General Practitioners and Psychiatrists) and most recently additional training and accreditation for supplementary nurse prescribers.

9.4.2 Drugs and alcohol national occupational standards

Drugs and alcohol national occupational standards (DANOS) are the standards of performance required of individual practitioners and the knowledge and skills they require. A new qualification framework for DANOS is due in 2005 with training programmes expected to be developed in line with the new framework.

9.4.3 National minimum standards for care homes for younger adults

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

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

In 1999 the Substance Misuse Advisory Service (SMAS), on behalf of the Department of Health, developed the Commissioning standards for drug and alcohol treatment and care document as a tool for commissioners of drug treatment. The document provides guidance on the commissioning of comprehensive and evidence-based alcohol and drug treatment and care systems.

9.4.5 Quality in drugs and alcohol services (QuADS)

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

9.4.6 Other quality frameworks and standards

Other quality improvement frameworks, standards or accreditation systems are also be relevant to alcohol intervention and treatment systems. These may include clinical governance mechanisms in NHS providers, Investors in People, criminal justice accredited programmes, standards and registration for independent hospital provision, etc.

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

9.5 Quality requirements for drug treatment

The following section outlines the 15 key quality criteria for drug treatment. The quality criteria are divided into two sections: those for commissioners, and those for providers of drug treatment. The 15 broad quality criteria for drug treatment are:

9.5.1 Quality criteria for commissioners

9.5.1.1 QCC1: Strategic partnerships

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

9.5.1.2 QCC2: Local needs assessments

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

9.5.1.3 QCC 3: Drug treatment systems are developed in line with national frameworks

Local commissioners for drug treatment develop local drug treatment system plans annually in line with the Models of care: Update 2005, with focus on reducing harm to individuals and communities, improving clients’ journeys through treatment, predicting client flow through local systems and improving the effectiveness of local drug systems.
9.5.1.4 QCC 4: Local commissioning partnerships demonstrate good practice in managing public finance and contracts

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

9.5.1.5 QCC 5: Performance management of local drug treatment systems

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

9.5.1.6 QCC 6: Local commissioning functions are fit for purpose and competent

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

9.5.2 Quality criteria for providers

9.5.2.1 QCP 1: A person-centred service

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

9.5.2.2 QCP 2: Screening and assessment

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

9.5.2.3 QCP 3: Reducing harm to drug misusers

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

9.5.2.4 QCP 4: Reducing drug-related harm to others

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

9.5.2.5 QCP 5: Providing brief interventions

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

9.5.2.6 QCP 6: Improving engagement with structured drug treatment

Access to structured drug treatment should be within national waiting times for drug treatment and those accessing structured drug treatment should be retained for at least 12 weeks.
9.5.2.7  QCP 7: Structured treatment delivery: A care planning approach to deliver positive change in clients lives

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

9.5.2.8  QCP 8: Improving re-integration and treatment completion

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

9.5.2.9  QCP 9: Provision of aftercare and re-integration

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

10.1 Drug treatment interventions as part of a local treatment system

The following section outlines the key drug treatment interventions and how they fit into the local treatment system. In order to enable this, the NTA has clarified and defined the drug treatment interventions. These definitions are consistent with *Models of care 2002* but provide additional clarity and a summary of key issues. They are also updated to reflect new guidance materials e.g. DANOS; *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers* (2005)\(^3\). This section should be read in conjunction with the sections on care planning and the treatment journey, and integrated care pathways.

Specific interventions in local treatment systems should combine to form the client’s treatment journey, as set out in figure 2. The integrated care pathways for each intervention should be designed in a way that good links across a range of interventions can be made effectively to provide joined-up treatment for each client.

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

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

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

10.2 Substance misuse-related advice and information

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

- information about different drugs and their effects
- advice about stopping misuse of drugs and alcohol
- information on how to reduce the potential harm from drug misuse (e.g. safer injecting, reducing overdose risks, etc)
- how and where to access help for drug problems
- how and where to access help for other problems (e.g. housing, sexual health etc).

The information provided must be accessible and meaningful to the recipient (e.g. language, comprehension), and if possible, in a variety of media.

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

In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs (UKHRA, 2005).34

A “harm reduction approach” recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse, from reducing the sharing of injecting equipment, through to stopping injecting, substitution on opioid drugs for heroin misusers and abstinence from illegal drugs.

Most harm reduction interventions specifically aim to prevent blood-borne diseases (most particularly HIV and hepatitis infections) and other drug-related harm, including overdose and drug-related death. All drug treatment services, residential or community based, should provide a distinct harm reduction element to reduce the spread of BBVs and risk of drug-related deaths in the treatment they provide.

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

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

Harm reduction interventions such as needle exchange, advice and information on safer injecting, reducing injecting and preventing overdose should also be available as open-access services in each local area. Needle exchange services often have contact with drug misusers who are not in touch with structured drug treatment services.

Harm reduction interventions should be integrated into all drug treatment service specifications via contracts or service level agreements. Harm reduction interventions should also be integrated into structured drug treatment according to an individual client’s needs and should be incorporated into a care plan agreed with the client.

10.4 Community prescribing interventions: GP prescribing and specialist prescribing

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

- Stabilisation on substitute opioids, including dose titration
- Prescribing for a sustained period to substitute illicit drugs (e.g. methadone, buprenorphine) (maintenance prescribing)
- Prescribing for withdrawal from opioids with opioid or non-opioid medications (e.g. buprenorphine or lofexidine) (community detoxification)
- Prescribing to prevent relapse
- Stabilisation and withdrawal from sedatives, (e.g. benzodiazepines)
- Detoxification from alcohol where appropriate
- Treatment for stimulant users, which may include symptomatic prescribing.
Substitute prescribing alone does not constitute drug treatment (NTA Expert Prescribing group 2002). A community prescribing intervention should be provided within a care-planned package of care with an identified keyworker. It should be aimed at addressing the range of identified needs. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning. Interventions to tackle drug misuse problems may include:

- hepatitis B vaccination and HIV and hepatitis testing
- treating drug-related infections, e.g. abscesses
- harm reduction and health promotion interventions e.g. overdose prevention, sexual health advice, needle exchange
- provision of, or access to, psychosocial interventions and support, e.g. motivational interventions.

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

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

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

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

Commissioners should ensure local treatment systems have a complete spectrum of medical provision to meet the range of needs and numbers of substance misusers. This requires a variety of skills and competencies at various levels, from general medical skills to GPs offering less complex drug treatments under enhanced contracts, to specialist addictions skills and addiction psychiatry skills. This is a key message arising from the consensus document produced by the Royal College of General Practitioners and the Royal College of Psychiatrists *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers* (2005) as summarised in an NTA briefing note at www.nta.nhs.uk.

### 10.4.1 GP prescribing

GP prescribing is community prescribing for drug misuse which is carried out in a primary care setting through a primary care team, consisting of GPs and other primary care staff (depending on contractual arrangements).

GP prescribing should be provided within a care plan with regular keyworking. Different degrees of care planning may be appropriate in different primary care arrangements (NTA/RCGP 2004). The care plan should also address drug and alcohol misuse, health needs, offending behaviour and social functioning.

The client group has traditionally been drug users who are stable on substitute medication or whose problem level is mild to moderate. However, the exact nature of the clients treated and how the prescribing takes place will depend on the skills and competencies of the GP. The guidance document *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers* (2005) specifies four main job roles for GPs:

- **GPs providing core services:** A doctor providing general medical care only to substance misusers.
- **GPs providing enhanced services:** A doctor providing basic medical care plus care to substance misusers, in accordance with locally agreed shared care guidelines.
- **GPs with special clinical interest (GPwSI) providing enhanced services:** GPwSIs have received specific higher level training in the management of substance misusers in primary...
care, usually the GP Certificate in Management of Drug Use Part 2. GPwSIs delivering locally enhanced services or nationally enhanced services are able to work more autonomously and take responsibility for more complex cases in substance misuse than other GPs.

- **Substance misuse specialist (primary care):** A doctor with a general practice background and an extensive postgraduate training in substance misuse working as a specialist GP lead/director employed by a PCT or mental health trust.

The structures for providing GP prescribing services tend to operate within three broad levels:

- Shared care schemes, where GPs providing enhanced services are in a partnership with a local specialist drugs service. Shared care schemes should be delivered through nationally enhanced (NES) or locally enhanced (LES) service contracts.
- Drug services that can be primary care based or specialist based clinic type services, staffed by a GPwSI. These GPs often provide support to other GPs (GPs providing essential services and GPs providing enhanced services).
- Substance misuse specialist (primary care) service provision, which can be provided from primary care settings with a strong primary care ethos, or from other another service provider base, run by a substance misuse specialist (primary care) (e.g. a substance misuse specialist GP prescribing, as part of a mental health trust).

### 10.4.2 Specialist prescribing

Specialist prescribing is community prescribing for drug misuse in a specialist drug service setting, which normally comprises a multidisciplinary substance misuse team. Specialist prescribing interventions normally include comprehensive assessments of drug treatment need and the provision of a full range of prescribing treatments in the context of care planned drug treatment.

The specialist team should also provide, or provide access to, a range of other care planned healthcare interventions including psychosocial interventions, a wide range of harm-reduction interventions, BBV prevention and vaccination, and abstinence-oriented interventions.

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

The teams include specialist doctors who are usually consultant addiction psychiatrists who are doctors ‘with a Certificate of Completion of Training (CCT) in psychiatry, with endorsement in substance misuse working exclusively to provide a full range of services to substance misusers’.

Such teams sometimes have other specialists including:

- consultants in general psychiatry with a special interest in addiction
- consultants in general psychiatry
- other doctors on the specialist register (associate specialists)
- senior clinical medical officers (see Roles and responsibilities)
- doctors in training.

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

### 10.5 Structured day programmes

The term “structured day programmes” replaces the old term “structured day care” and will be the intervention name used for NDTMS monitoring from April 2006. Introduction of an additional category of “other structured treatment” can be used for less extensive or less structured “day care” provided in the context of a structured care plan (see the relevant section below for further discussion).

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

SDPs usually offer programmes of defined activities for a fixed period of time. Clients will usually attend the programme according to specified attendance criteria, and follow a set timetable that will include group work, psychosocial interventions, educational and life skills activities. Some clients may be attending the SDP as a follow-on or precursor to other treatment types, or may be attending as part of a criminal justice programme supervised by the probation service, or community rehabilitation.

**Setting:** SDPs are normally community based services, set in centres that have been specifically designated for the programme (purpose-built or converted) and have rooms designated for specific parts of the programme (e.g. group work, life skills etc). They may be attached to other drug treatment services if they are part of a larger treatment agency.

### 10.6 Structured psychosocial interventions

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

Structured psychosocial interventions are clearly defined psychosocial interventions, delivered as part of a client’s care plan, which assist the client to make changes in their drug and alcohol using behaviour. These interventions are normally time limited and should be delivered by competent practitioners. Competent practitioners will have adequate training, regular clinical supervision to ensure adherence to the treatment model and be able to demonstrate positive client outcomes.

Structured psychosocial interventions should be identified within a care plan. These interventions can be delivered in individual or group settings, and by any practitioners who have appropriate training and supervision. A number of these interventions can be developed and delivered through use of protocols to improve consistency and ease of delivery.

Evidence-based psychosocial interventions include:

- cognitive behaviour therapy (CBT)
- coping skills training
- relapse prevention therapy
- motivational interventions
- contingency management
- community reinforcement approaches
- some family approaches.

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

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

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

2. The difference between psychosocial interventions for problem substance misuse and formal psychological therapies targeting a client’s co-morbid mental health problems is that the latter interventions are specialist psychological treatments (such as cognitive behaviour therapy for depression or anxiety, cognitive-analytic therapy, dialectical behaviour therapy, or schema-focused therapy for personality disorders) aimed primarily at the non-drug psychological problem. Such interventions should only be delivered by specialist practitioners such as clinical/counselling psychologists, suitably trained psychiatric staff or other specialist therapists with relevant training, qualification and supervision in the therapy model being offered. This would be delivered as part of the care plan but would not constitute a ‘structured psychosocial intervention’ for problem drug use itself.

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

Setting: a range of community and residential services. Some structured psychosocial interventions may be delivered as part of the process of engaging and preparing clients for change, and/or during the “delivery” phase of the client’s treatment journey and hence may be delivered in different setting for an individual at different stages of the treatment journey.

10.7 Other structured treatment

“Other structured treatment” describes a package of interventions set out in a client’s care plan which includes regular planned therapeutic sessions with the keyworker as a minimum. The care plan should address drug and alcohol misuse, health needs, offending behaviour and social functioning. “Other structured treatment” describes structured therapeutic activity not covered under the alternative specific intervention categories set out in Models of care: Update 2005.

The creation of this “other” category of intervention reflects the evidence base that those receiving drug treatment consisting of individually tailored packages of care in the context of a therapeutic relationship is beneficial. This intervention may be particularly relevant for non-opiate drug misusers and clients who are receiving criminal justice treatment interventions.

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

Most clients receiving “other structured treatment” will receive a range of interventions to meet needs identified in their care plan. These will involve a range of interventions to address their drug misuse and support to address needs in other domains. Examples of these may include:

- A crack user who is receiving regular keyworking and attending “day care” sessions to address a range of social and health-related needs
- An opiate user who has been through community detoxification, and is receiving ongoing support to maintain abstinence as part of the care plan (prior to referral on or provision of aftercare arrangements), and is also receiving harm reduction interventions and help to deal with her health needs
- An uncomplicated problem cannabis user who is receiving a short period of care-planned regular brief interventions to deal with his cannabis use
- A client who is receiving keyworking sessions to address social needs and offending behaviour from a Criminal Justice Integrated Team but is not assessed as needing “structured psychosocial interventions” for the problem drug use itself.

“Other structured treatment” can describe regular sessions with a keyworker, that are delivered in order to keep a client engaged in the treatment system while they are waiting to start receiving another care-planned intervention (e.g. GP prescribing), if the structured interventions are outlined in an initial care plan following a comprehensive assessment.

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

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

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

This requires the delivery of a package of structured intervention that is beyond that required for Tier 2, but which does not meet the specific criteria for the other categories of structured interventions described above.

**Settings:** Other structured treatment could take place in a wide variety of different treatment settings, including settings that may normally be known for delivering Tier 2 interventions. Clients receiving other structured treatment may often be part of a Drugs Intervention Programme (DIP).

### 10.8 Inpatient drug treatment

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

- Medically supervised assessment
- Stabilisation on substitute medication
- Detoxification from illegal and substitute drugs
- Specialist inpatient treatments for stimulant users
- Emergency medical care for drug users in crisis.

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

Care planned inpatient treatment programmes may also include a range of additional provisions such as relapse prevention work, educational work, and preparation for referral to residential rehabilitation or community treatment, aftercare or other support required by the client. This is an
important component in enabling adequate assessment of complex needs and in supporting progression to abstinence.

**Setting:** the three main settings for inpatient treatment are:

- general hospital psychiatric units
- specialist drug misuse inpatient units in hospitals
- residential rehabilitation units (as a precursor to the rehabilitation programme).

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

### 10.9 Residential rehabilitation

Drug residential rehabilitation programmes provide a range of interventions to address drug and alcohol misuse including abstinence-orientated drug interventions within the context of residential accommodation.

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

There are a wide range of residential rehabilitation interventions, which include:

- Drug and alcohol residential rehabilitation units to suit the needs of different service users. These units follow one of three broad approaches: therapeutic communities, 12-step programmes and faith-based (usually Christian) programmes
- Residential drug and alcohol crisis intervention units (in larger urban areas)
- Inpatient detoxification directly attached to residential rehabilitation units
- Residential treatment for specific client groups (e.g. for drug-using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness). Interventions may require joint initiatives between specialised drug services (Tier 3 or 4 – depending on local arrangements) and other specialist inpatient units
- “Second stage” accommodation where a client moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a care plan and receive keyworker and a range of drug and non-drug related support
- Other supported accommodation where clients stay while receiving therapeutic drug-related and non-drug related interventions at a nearby site.

Residential rehabilitation programmes normally combine a mixture of group work, psychosocial interventions and practical and vocational activities. This definition can include specialist residential programmes for particular client groups (e.g. parent and child programmes).

Clients usually begin residential rehabilitation after completing inpatient detoxification. Sometimes the detoxification will take place on the same site as the rehabilitation programme, to enhance continuity of care.

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

### 10.10 Aftercare

Aftercare is a package of support that is put in place for clients when they leave structured treatment (after the end of their care plan), or for offenders when they leave or complete community sentences or are released from prison (remand or sentenced). The aim of aftercare is to sustain treatment gains and further develop community reintegration. Aftercare may include drug-related
interventions, open access relapse prevention or harm reduction. It may also include non-drug-related support such as housing, access to education, generic health and social care.

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

As long as a client has an active care plan they are considered to be “in treatment”. When their care plan comes to an end they may continue to receive a range of services that they were receiving as part of the care plan, and in this context, these will be deemed to be aftercare. These can be drug-related support or non-drug-related support.

In the context of aftercare, drug-related support could include open-access relapse prevention, mutual support groups (e.g. AA/NA or equivalent), advice and harm reduction support. In addition a range of open-access and low-threshold interventions should be available to provide specific interventions to people who have completed treatment, but who may want or need to have occasional non-care planned support. The non-drug-related support can cover a range of issues such as housing, supported accommodation, education and training, support to gain employment and childcare.

If links to all appropriate support services are not already in place during a client’s care planned treatment, drug treatment agencies should assist the client to make these links before their treatment comes to an end. During the completion or exit phase of treatment, an aftercare plan should be drawn up and agreed with the client, and the service must work to ensure that all support not already in place, is in place in time for the client leaving treatment. The aftercare plan should include measures that cover possible relapse and to ensure swift access back to treatment if required.
11 References


9. Full details of waiting times are available on the NTA website at www.nta.nhs.uk


Further detailed statistics on drug misusers in treatment, England 2003/04 are published by the NTA at www.nta.nhs.uk


16. Review of CARAT services, 2005-05 (unpublished report available on request from the National Offender Management Service Drug Strategy Unit – noms@homeoffice.gsi.gov.uk)


Further information on practice-based commissioning is available at http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/PracticeBasedCommissioning/fs/en


A summary of the findings from the first stage of consultation, carried out during Nov/Dec 2004. Available at www.nta.nhs.uk


25. A summary of DATOS research is available at www.datos.org


32. SCODA, Alcohol Concern (1999) *Quality in Drugs and Alcohol Services (QuADS)*. London: SCODA, Alcohol Concern


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