Models of Care for Drug Service Provision

Richard Bryant-Jefferies

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Foreword by

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Foreword

Models of Care, commissioned by the Department of Health, is the best attempt to date to bring some order to the fairly dishevelled and idiosyncratic profession of treating people with drug problems. For over 50 years, drug treatment has grown up in a relatively experimental and organic way across the United Kingdom. There was little agreement as to what was the right way to carry out treatment and there was equal dissension about what was the wrong way. The result was that where you lived dictated the care you would receive: the classic 'postcode lottery'.

Treatment was often 'service-centred', or 'treatment-centred', as opposed to 'client-centred', offering what the service had always offered instead of tailoring the care to address the needs of the client. Despite the findings of research and mounting evidence, treatment services chose to implement the findings of studies that complemented their own philosophy and practice while ignoring the others that contradicted their care. As a drug user, if you fitted into the rules, regulations and philosophy of the agency you stumbled into, you were in luck. If you did not, there was the door. It is no wonder that services around the country had an average drop-out rate of 50%.

The mission of Models of Care was to change all that. Commissioned by the Department of Health, Models of Care was written by a large team of practitioners and academics, of which I was one. It took over a year to pull all the evidence together from the UK and internationally about what constitutes good treatment and care for drug misuse. Written in four chapters, Models of Care defines the treatment that everyone in the UK should expect and be entitled to receive to work with and help them overcome a drug problem.

Models of Care has been accepted and generally embraced by the drug treatment world. It has provided additional legitimacy to their work and a framework to work within. The Department of Health has endorsed the work and given it the status of National Service Framework for drug treatment. It is now the role of the National Treatment Agency on Substance Misuse (NTA) to oversee the implementation of Models of Care across the country.

There has been an 18-month implementation timetable for services, during which time those with the responsibility to organise services, such as Drug Action Teams (DATs), have to comply with the structural and systems improvements called for in Models of Care. But it will be years before all the aspects of Models of Care are fully in place in every part of the country. Change is not easy

and, despite trying, Models of Care cannot provide answers to every situation. Local decisions still need to be made in implementing certain aspects of Models of Care.

Models of Care is a reference book. It is an encyclopaedia of what constitutes good care for drug treatment. But it is dry and difficult to digest. As one of the authors, I am at liberty to admit this fact.

That is what makes this book, *Models of Care for Drug Service Provision* by Richard Bryant-Jefferies, so fascinating and useful. It breathes life into a rather dull and abstract subject. Through the life of Mark, a fictitious drug user, and a range of professionals he comes into contact with over a three-month period, you get to experience drug treatment through the eyes of the service user.

It is not always a smooth ride in this process called treatment. It is full of bumps and U-turns along the way. The fictitious journey Mark takes rings true to my 20-plus years of working in this field and watching numerous clients, like Mark, start down this road.

Through all Mark's twists and turns, Models of Care is shown to be the route map that binds a lot of separate roads and paths into a system of care to help Mark, and people like Mark, come to terms with their drug use and take back control of their lives. Mark is no angel and, like most people, his problems are not always simple. Many steps along the road are painful and could so easily go wrong. There is a minefield of physical and emotional problems to manage and eventually overcome.

This new book is a wonderful reminder that we are dealing first and foremost with human beings who are complex, vulnerable and who also happen to have a drug problem. Our treatment professionals need to be well informed, up to date and responsive to the needs of clients like Mark. They also need to be understanding, tolerant and resourceful. Models of Care assists them by providing a framework within which to work and by helping to bind together the range of professionals and services into a system of care.

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March 2004

About the author

Richard Bryant-Jefferies qualified as a person-centred counsellor/therapist in 1994 and remains passionate about the application and effectiveness of this approach. Between early 1995 and mid-2003, Richard worked at a community drug and alcohol service in Surrey, though more recently he has taken up a position managing NHS substance misuse services in the Royal Borough of Kensington and Chelsea in London, within the Central and North West London Mental Health NHS Trust. He has experience of offering both counselling and supervision in NHS, GP and private settings, and has provided training through 'alcohol awareness and response' workshops.

Richard had his first book on a counselling theme published in 2001, *Counselling the Person Beyond the Alcohol Problem* (Jessica Kingsley Publishers), providing theoretical yet practical insights into the application of the person-centred approach within the context of the 'cycle of change' model that has been widely adopted to describe the process of change in the field of addiction. Since then he has been writing for the *Living Therapy* series, producing an ongoing series of person-centred dialogues: *Problem Drinking*, *Time Limited Therapy in Primary Care*, *Counselling a Survivor of Child Sexual Abuse*, *Counselling a Recovering Drug User*, *Counselling Young People* and *Counselling for Progressive Disability*. The aim of the series is to bring the reader a direct experience of the counselling process, an exposure to the thoughts and feelings of both client and counsellor as they encounter each other on the therapeutic journey, and an insight into the value and importance of supervision.

Richard is keen to bring the experience of the therapeutic process, from the standpoint and application of the person-centred approach, to a wider audience. He is convinced that the principles and attitudinal values of this approach and the emphasis it places on the therapeutic relationship are key to helping people create greater authenticity both in themselves and in their lives, leading to a fuller and more satisfying human experience.

Acknowledgements

I would like to thank those who have contributed to this book: Jan Annan, who commented on the draft from her perspective as a member of the team that wrote *Models of Care*; and Dr William Shanahan, Consultant Psychiatrist, Kevin Simmons, Alison Smith, Francesca Trombaccia and Dennis Yandoli, Family Therapists, all working for the Substance Misuse Service within Central and North West London Mental Health NHS Trust. It has been important to widen the angle, so to speak, and to include perspectives from people working within other professions; professionals who have many years of experience of working within the substance misuse field and who know, from their own work with clients and with service development, what works and what does not, what is helpful and what hinders recovery.

I would also like to take this opportunity of acknowledging and thanking Movena Lucas who, by encouraging me to apply for my current job (which involved my preparing a presentation on Models of Care), triggered the chain of events that led to the writing of this book.

I am also grateful for the many discussions and conversations I have had with a variety of professionals regarding drug service provision over the years. My own experience of working in a community service – Acorn Community Drug and Alcohol Service in Surrey – has also been a factor in shaping my thoughts along with my current work as Sector Manager (Kensington and Chelsea), Substance Misuse Services, Central and North West London Mental Health NHS Trust.

We are indebted to the National Treatment Agency for allowing us to reproduce substantial portions of the Models of Care document in Chapter 1, all of which is in the public domain. This was essential to anchor the book to the current policies and strategies that aim to improve the quality of services and equity of access for all drug users.

Finally, to everyone at Radcliffe Publishing whose editorial skills have once again drawn together many threads to produce this book, and whose belief in the importance not only of the theme of this book, but also the style of presentation, has been so encouraging. Thank you once again.

Introduction

Drug problems affect us all, directly or indirectly. Perhaps a family member has or has had a drug problem. Maybe we have ourselves. Or it could be that we have been burgled by someone needing goods to sell on for a fix or two. But even if we have not been affected directly in this way, we are indirectly affected by the simple fact of our taxes being spent on drug treatment programmes, on the health and social care effects of drug use, and on criminal justice responses to illicit use. Drug use impacts on us all, to a greater or lesser extent.

Until the end of the last century, services were developed locally and there were huge amounts of competitive bidding for resources to develop services. Sometimes there was good co-operation between statutory and non-statutory services; in other areas bidding wars governed service provision. There might be little co-operation and communication between services. A culture of mistrust developed in some areas. Service provision varied from area to area. Good staff struggled to maintain quality service with increasing caseloads, and increasingly chaotic and demanding clients with new designer drugs being added to the already potent chemical cocktails from the past.

The National Treatment Agency (NTA) was established as 'a special health authority, created by the Government in 2001, with a remit to increase the availability, capacity and effectiveness of treatment for drug misuse in England' (NTA, 2002, p. 11) and has as its overall purpose the goal of 'doubling the number of people in effective, well-managed drug treatment from 100,000 in 1998 to 200,000 in 2008; and to increase the proportion of people completing or appropriately continuing treatment, year on year. This is in line with the UK drug strategy targets' (NTA, 2002, p. ii).

At the time of writing, drug and alcohol services are in the process of preparing for implementing the National Treatment Agency's 'Models of Care' system. This initiative will have a far-reaching effect on drug services throughout England. *Models of Care* has been published in two parts, both of which are available in hard copy (details at the back of this book) and online at www.nta.nhs.uk. The Models of Care system is composed of five elements: a four-tiered framework for drug and alcohol treatment services, integrated care pathways, assessment within a tiered system, care planning and care co-ordination, and monitoring. We will describe these in more detail in Chapter 1.

Without doubt, the way Models of Care is implemented will vary greatly across the country, and the fact that each Drug Action Team (DAT) area has in effect

been left to formulate its own process means there is a lot of opportunity for services to collaborate on systems that will have relevance to a particular geographical area, offering scope for different areas of emphasis and service provision reflecting client need.

In writing this book I hope to contribute not only to the process of implementation, but also to stimulate thought and discussion around what it means to provide more 'client-' rather than 'treatment-centred' drug services. I believe we have to move away from any notion of 'one-size-fits-all' or, rather, one treatment response as being the answer to every drug user's difficulties. Models of Care should help ensure a range of treatment responses are available to all people regardless of where they live. Without doubt, assessment and care co-ordination are going to require appropriately trained individuals in order to ensure that the integrated set of care pathways that are formulated for a given service user will be genuinely tailored to meet that person's needs.

This book has been written to present a fictitious account of a client with a drug problem engaging with services as they might exist under the Models of Care system. It includes comment boxes on the process, on technical aspects of treatment and around issues that can arise in the treatment process. In places, these boxes also include references to the Models of Care system, highlighting what is being offered within the narrative and how it equates to levels of assessment or tiered treatment interventions. The book also includes three sections from leading professionals in the field, commenting on the account and on their professional view of Models of Care. I hope that the varied styles of the writers and the format in this book will serve to appeal widely, to all who will find themselves working either within, or in collaboration with, services within the Models of Care system.

Bringing together what is at times a technical and informative style with a more narrative 'story' has been a challenge. Telling a story in the context of a defined system of practice which has not yet actually been established is also an interesting process. Of course, there are many other treatment modalities that might have been included within the text of this book, and a range of other professionals that will be providing care pathways for clients with substance misuse problems. The text keeps to a health/medical and therapeutic emphasis in order to demonstrate their application. However, the range of professionals and services that might have been involved in the unfolding scenario could have been wider, and this will be reflected on further towards the end of the book.

A colloquial style is used within the narrative, seeking to reflect the language of the real world rather than that of the textbook. However, the language and style that individuals adopt will differ and so there is no intention here to represent a kind of stereotypical style of working or some kind of archetypal characterisation.

Models of Care for Drug Service Provision attempts to appeal to a wide audience, but perhaps those for whom it will have most appeal will be those who know little or nothing of drug service provision, those working within treatment modalities outside of those described in this book who want an insight into specific areas of Tier 3 treatment provision, and counsellors who wish to broaden their understanding of working with drug-using clients. For the specialist I hope that it will offer 'a good read', and an opportunity to reflect on their own practice and deepen

their understanding of how this fits into the Models of Care system. It will also have relevance for clients, and for relatives and carers of clients, who may wish to deepen their understanding of drug service provision. In using the narrative approach I have sought to bring the experience alive, to draw response and reaction from the reader.

Have I described an 'ideal client'? Perhaps. In reality there could be more problems arising and the process may well have been more drawn out. Many clients do not complete treatment, returning to old patterns of use sometimes, or moving out of area. Clients can take a lot longer to engage with, sometimes. Not everyone engages so quickly with the motivation that the client, Mark, achieves. So I hope this will be taken into account. Also, I am not trying to describe a 'right way' of working with clients, but 'a way' which I hope not only encourages greater understanding of Models of Care but also thoughts and reflection on what services are offering and how they can better collaborate in the interest of the client's health and well-being.

PART I

An explanation of Models of Care

CHAPTER 1

Introducing Models of Care

The following chapter is very much drawn from section 2 of the NTA's *Models of Care* publication (2002). Rather than attempt to rewrite what has already been said, and perhaps lose some of the definition in the process, it seemed more sensible to collate key ideas and present them in a somewhat compressed and hopefully readable form.

> The *Models of Care* document overall sets out a national framework for the commissioning of adult treatment for drug misuse (drug treatment) expected to be available in every part of England to meet the needs of diverse local populations. (NTA, 2002, p. 3)

This is a major step forward, establishing a national and co-ordinated approach to drug treatment.

> The overriding concept behind Models of Care is that Drug Action Teams (DATs) should be seeking to develop an integrated drug treatment system in their area, not just a series of separate services. In the last few years, DAT members have received increasing funding to expand the capacity of the various modalities of treatment, but it is also felt that efforts must be made to combine these modalities into a seamless system of 'care pathways' for patients. The Models of Care approach describes how these processes of care would work, based on the menu of treatment services that have already been incorporated into DAT treatment plans, but now expressed in terms of 4 treatment 'tiers'. (NTA, 2002, p. 5)

Implementation targets

The NTA has set certain implementation targets before the DATs:

> To have agreed by *January 2003* the joint planning mechanism, and lead individual, that will be responsible in a DAT area for pursing the implementation of *Models of Care*. By *October 2003* to have completed an assessment of whether the assessment and referral mechanisms (and treatment providers) in your DAT area are operating according to the evidence-based patient placement

> criteria and treatment protocols outlined in the *Models of Care* document. The next step, due by *November 2003*, is to agree and publish a local referral, screening and triage system, supported by an information-sharing policy, making clear the referral points into the drug treatment system, who is responsible for conducting the various levels of assessment, how referrals are made into the main modalities of treatment, the protocols for information sharing and exchange, and the assessment forms and instruments that will be used. Finally, by *March 2004* locally defined care pathways, and a local system of care co-ordination should have been agreed and published. (NTA, 2002, p. 8)

A look at the NTA website will give you updates and information on the developments taking place around the country. Integrated care pathways are being generated, for instance, defining the responses to a diagnosed dual diagnosis, or to specific aspects of drug treatment needs, for instance, injectable prescribing.

Assessment forms are also being generated for use across DAT regions, ensuring that agencies are working to similar criteria and that information exchange can occur between agencies, and between tiers.

Four tiers

These are described as follows.

- Tier 1: Non-substance misuse specific services requiring interface with drug and alcohol treatment.
- Tier 2: Open access drug and alcohol treatment services.
- Tier 3: Structured community-based drug treatment services.
- Tier 4 services: Residential services for drug and alcohol misusers:
  - Tier 4a: Residential drug and alcohol misuse specific services
  - Tier 4b: Highly specialist non-substance misuse specific services.

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

Tier 1 services do not have a substance-specific role, but they provide an opportunity for screening drug misusers, engaging with them and initiating referral on to local drug and alcohol treatment services in Tiers 2 and 3. Tier 1 provision for drug and alcohol misusers may also include assessment, services to reduce drug-related harm, and liaison or joint working with Tiers 2 and 3 specialist drug and alcohol treatment services. Tier 1 services are crucial to providing services in conjunction with more specialised drug and alcohol services (e.g. general medical care for drug misusers in community-based or residential substance misuse treatment or housing support and aftercare for drug misusers leaving residential care or prison).

Tier 1 services are offered by a wide range of professionals, including primary care or general medical services, general social workers, teachers, community pharmacists, probation officers, housing officers and homeless persons' units. These professionals are not substance misuse specialists, but will have been trained to recognise and assess the presence of drug and alcohol misuse in order to refer people on to other agencies offering specific treatment responses.

The importance of training is emphasised in Models of Care, to ensure that professionals working in Tier 1 services can effectively identify and assess drug misuse. It is likely that there will be a need for developing liaison posts so that Tier 2 and 3 services can collaborate with Tier 1, for instance in areas where there are high levels of pregnancy and maternal health need, or a high transient homeless population attracted into the area by the presence of hostel accommodation.

Models of Care emphasises that:

> Drug misusers in all DATs in England must have access at local levels to the following Tier 1 services located within local general health and social care services:
>
> - a full range of healthcare (primary, secondary and tertiary), social care, housing, vocational and other services
> - drug and alcohol screening, assessment and referral mechanisms to drug treatment services from generic, health, social care, housing and criminal justice services
> - the management of drug misusers in generic health, social care and criminal justice settings (e.g. police custody)
> - health promotion advice and information
> - hepatitis B vaccination programmes for drug misusers and their families. (NTA, 2002, p. 17)

Tier 2: Open access drug and alcohol treatment services

Tier 2 services will offer a range of services for drug misusers, including needle exchange, drug (and alcohol) advice and information services, and general support, including harm reduction support, not delivered in the context of a care plan, and low-threshold prescribing programmes aimed at engaging opioid misusers with limited motivation, while offering an opportunity to undertake motivational work and reduce drug-related harm. Specialist substance misuse social workers can provide services within this tier, including the provision of access to social work advice, childcare/parenting assessment, and assessment of social care needs. Shared-care services with primary healthcare are also included in this tier, though this may vary depending upon the complexity of the clients' needs who are being supported through this approach.

A key element in defining the services within this tier is their low threshold of access, and the limited requirements on clients to receive services. Access will be

by self-referral as well as via other agencies: Tier 1 who have identified a problem requiring Tier 2 intervention or triage assessment that may be carried out by local Tier 2 services, or higher Tier 3 or 4 services when a client has been assessed as requiring the kind of community support and intervention of a Tier 2 service as part of a care planned and care co-ordinated response.

The aim of the treatment in Tier 2 is to engage drug and alcohol misusers in drug treatment and reduce drug-related harm. Tier 2 services do not necessarily require a high level of commitment to structured programmes or a complex or lengthy assessment process. Models of Care points out that Tier 2 services require competent drug and alcohol specialist workers, and that the tiers do not imply lower skills within lower tiers.

> Drug misusers in all DATs in England must have access to the following Tier 2 open-access specialist drug interventions within their local area:
>
> - drug- and alcohol-related advice, information and referral services for misusers (and their families), including easy access or drop-in facilities
> - services to reduce risks caused by injecting drug misuse, including needle exchange facilities (in drug treatment services and pharmacy-based schemes)
> - other services that minimise the spread of blood-borne diseases to drug misusers, including service-based and outreach facilities
> - services that minimise the risk of overdose and other drug- and alcohol-related harm
> - outreach services (detached; peripatetic and domiciliary) targeting high-risk and local priority groups
> - specialist drug and alcohol screening and assessment, care planning and management
> - criminal justice screening, assessment and referral services (e.g. arrest referral, CARATS [Counselling, Assessment, Referral, Advice and Throughcare Services])
> - motivational and brief interventions for drug and alcohol service users
> - community-based low-threshold prescribing services.
>
> (NTA, 2002, pp. 17–18)

Tier 3: Structured community-based drug treatment services

Tier 3 structured services include psychotherapeutic interventions and structured counselling, as well as motivational interventions, methadone maintenance programmes, community detoxification, and day care provided either as a drug- and alcohol-free programme or as an adjunct to methadone treatment. Community-based aftercare programmes for drug and alcohol misusers leaving residential rehabilitation or prison are also included in Tier 3 services. Such services are likely to be required to work closely with other specialist services to meet the needs of specific client groups. For example, where the drug users have a

psychiatric co-morbidity there will be a need for substance misuse and mental health services to work closely together.

Tier 3 services require that the drug and alcohol misusers receive a comprehensive assessment and have a care plan which is agreed with the client, generally including a structured programme of care which places certain requirements on attendance and behaviour, and commitment from both parties: the service provider and the client. Models of Care stresses the importance of a care co-ordinator for those clients 'whose needs cross several domains . . . responsible for co-ordination of that individual's care on behalf of all the agencies and services involved' (NTA, 2002, p. 18). Any changes to a care plan must follow consultation with the drug and alcohol misuser.

> Drug misusers in all DATs in England must have access to the following Tier 3 structured drug treatment services normally provided within their local area and occasionally by neighbouring DAT or regionally located facilities:
>
> - specific community care assessment and care management
> - new care co-ordination services for drug misusers with complex needs (provided by suitably trained practitioners)
> - specialist structured community-based detoxification services
> - a range of specialist structured community-based stabilisation and maintenance prescribing services
> - shared-care prescribing and support treatment via primary care
> - a range of structured, care planned counselling and therapies
> - community-based Drug Treatment and Testing Order drug treatment
> - structured day programmes (in urban and semi-urban areas)
> - other structured community-based drug misuse services targeting specific groups (e.g. stimulant misusers, young people in transition to adulthood, black and minority ethnic groups, women drug misusers, drug misusing offenders, those with HIV and AIDS, drug misusers with psychiatric problems)
> - liaison drug misuse services for acute medical and psychiatric sectors (e.g. pregnancy, mental health)
> - liaison drug misuse services for local social services and social care sectors (e.g. child protection, housing and homelessness, family services)
> - throughcare and aftercare programmes or support. (NTA, 2002, p. 19)

Tier 4 services: Residential services for drug and alcohol misusers

Tier 4a: Residential drug and alcohol misuse specific services

Tier 4a services are aimed at individuals with a high level of presenting need. Services in this tier include: inpatient drug and alcohol detoxification or stabilisation services; drug and alcohol residential rehabilitation units; and residential