



Integrated Care for Drug Users

integration

Principles and practice

Effective Interventions Unit

Scottish Executive Effective Interventions Unit

Remit

The Unit was set up in June 2000 to:

- Identify what is effective – and cost effective – practice in prevention, treatment, rehabilitation and availability and in addressing the needs of both the individual and the community.
- Disseminate effective practice based on sound evidence and evaluation to policy makers, DATs and practitioners.
- Support DATs and agencies to deliver effective practice by developing good practice guidelines, evaluation tools, criteria for funding, models of service; and by contributing to the implementation of effective practice through the DAT corporate planning cycle.

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Effective Interventions Unit

INTEGRATED CARE FOR DRUG USERS: Principles and Practice

WHAT IS IN THIS DOCUMENT?

- The rationale for integrated care and its wider context.
- Definitions and concepts of integrated care and its key elements: accessibility, assessment, planning and delivery of care, information sharing, monitoring and evaluation.
- Evidence from research literature, focus groups and consultation on the key issues that influence effective practice in integrated care.
- Key principles and elements of effective practice drawn from the evidence.

WHAT IS THE AIM?

To provide information and support:

- to DATs and partner agencies in the planning, design and delivery of integrated care for drug users
- to service providers, managers and practitioners who are delivering services to people with drug misuse problems

WHO SHOULD USE IT?

Anyone involved in developing, designing, commissioning, implementing and evaluating services for drug users.

WHO PRODUCED THE DOCUMENT?

Andy Rome, Anita Morrison, Linsey Duff, Jane Martin and Patricia Russell gathered evidence and wrote the document. Scottish Drugs Forum conducted the service users' focus groups.

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FOREWORD

Across Scotland, there has been an increasing interest in recent years in the development of integrated care services for people with drug misuse problems. This has grown from a recognition that people with drug misuse problems will, in many cases, have a range of other difficulties in their lives. A range of treatment, care and support services, for example, housing, training and employment services, may be needed to help the individual to make progress towards recovery and to improve their relationships with their family, friends and community. In DAT areas, planning for integrated care is at various stages from early discussions to quite advanced planning while in a small number of areas a model of integrated care is in place.

The **Effective Interventions Unit (EIU)** undertook to examine the principles and practice of integrated care in our first Work Programme. We have collaborated with a wide range of agencies and organisations including health, Joint Future, social work and the voluntary sector through a Reference Group, Working Groups and consultation workshops. We have also sought the views of service users through focus groups conducted on our behalf by Scottish Drugs Forum. The other major part of the work was to review the relevant research literature and policy documents from the drug field and other sectors.

In the last 18 months, we have examined a number of aspects of integrated care. However, the concept of integrated care for drug users is still relatively new and, consequently, knowledge and expertise is developing all the time. We found, for example, in examining the planning and delivery of care, that there is a need for more evidence about the most effective approach to care co-ordination. The Models of Care initiative in England is exploring this issue through the Enhanced Treatment Outcome pilots and there will be lessons to be learned from those in due course.

The design of the document as a loose leaf binder will enable EIU to update existing chapters and to add new material as it becomes available. We hope it will also enable the document to be used in a practical way, allowing material to be extracted and copied for ease of use.

The role of the EIU is to provide the evidence, as far as it is available, to support the development of effective integrated care for drug users. The Executive has now set up an Implementation Group with wide representation to advise on implementation of integrated care for drug users based on that evidence.

THANK YOU

We should like to thank all those who contributed to the work on integrated care through membership of groups and attendance at workshops for their knowledge and expertise, ideas and comments. We should also like to thank those who participated in the Scottish Drugs Forum service users' focus groups.

ABOUT THIS DOCUMENT

What methods did EIU use?

We undertook a number of exercises to draw together this work on integrated care:

Reference Group

A Reference Group was established to draw on expertise from health, social care and the voluntary sector to support the EIU in the development of the integrated care work. This group met on six occasions during the course of the work. Membership of the Reference Group is set out in Appendix 1. The EIU is very grateful for their support and contributions.

Review of the research literature

EIU conducted a review of the relevant research and policy literature on integrated care systems, accessibility of drug services, assessment tools in the drugs field, the effectiveness of drug services and interventions and good practice in monitoring and evaluation. Some of this review work was conducted by members of the EIU Working Groups (see below). Key sources of health and social care research were searched including Medline, EMBase, PsychInfo, ASSIA, CINAHL, Social Sciences Information Gateway, Cochrane Library, Campbell Collaboration, Evidence Base 2000 and the NHS e-library.

Primary research studies

The EIU commissioned and conducted a number of research projects as part of the integrated care work. The Scottish Drugs Forum (SDF) were commissioned by EIU to conduct a series of focus groups with service users on both assessment and planning and delivery of care. Further SDF focus groups commissioned by the Scottish Executive with stimulant users provide information for the accessibility section. Andy Rome from the EIU conducted a study of the use of assessment tools in Scotland. Finally, studies commissioned as part of the Scottish Executive Drug Misuse Research Programme have also informed this work, including a systematic review of the international literature on the effectiveness of treatment.

EIU Working Groups

Through the Reference Group, three Working Groups were established by EIU to look at three components of the integrated care approach: accessibility of services, assessment practice and the planning and delivery of care. The membership of these groups is set out in Appendix 1. These groups met on at least three occasions and provided a wealth of practical experience and expert knowledge in each area. The EIU is grateful to participants for their support and contributions.

EIU Consultation Workshops

Five consultation workshops were organised across Scotland in March/April 2001. The views and experiences of practitioners, service providers and commissioners elicited at these seminars are presented throughout this document. In June 2002, a further 2 workshops were held with service providers to discuss the preliminary findings of specific elements of integrated care and identify further examples of innovative practice.

How is the evidence presented?

We have divided the evidence collected into five main 'types' and (where applicable) used these types throughout the document. Please note that there are some instances where sources, principally policy documents, are difficult to categorise. In these cases references alone have been provided. The types are as follows:

Type 1 Systematic reviews

These reviews systematically examine and appraise the level of evidence provided by well-designed primary research studies. These studies typically focus on one question and tend to look at the effectiveness of interventions.

Type 2 Narrative Reviews

Narrative reviews look across the information provided by a number of studies but do not systematically look at the level of evidence presented. These reviews commonly address a number of related questions or issues.

Type 3 Primary research studies

Primary research studies that are relevant to the work on accessibility, assessment and planning and deliver of care are included in this type. These include randomised controlled trials (RCTs), cohort studies, cross-sectional studies, service evaluations and qualitative research projects.

Type 4 User consultations

User consultations include the series of focus groups conducted by SDF on behalf of EIU and other user surveys that have been conducted in Scotland and across the UK. These generally include data on the users' views of different aspects of treatment and care.

Type 5 EIU Working Groups / Consultation Workshops

Data collected in the course of the EIU Working Groups and consultation workshops that are not included in the types above. These are mostly the views and experiences of service providers and commissioners.

Use of terms

We have tried to be consistent in the use of terms. In some of the research studies and other policy documents that we have reviewed terms are used interchangeably. For example, the terms ‘agencies’, ‘organisations’ and ‘services’. Throughout the document, we have used:

the term ‘**service provider**’ to describe any agency or organisation involved in directly providing treatment, care or support to service users.

the term ‘**agency**’ to describe any organisation involved in the planning and commissioning of services for drug users.

the term ‘**service user**’ to describe any individual who has (in the past) or currently uses a health or social care service.

n.b. in some, limited, instances and depending on the context, the term ‘agency’ also refers to a provider role

There is some variation in the terms used to describe individuals who may benefit from an integrated care approach. In some cases, this reflects the terminology used in the research literature and policy documents. This document is primarily concerned with those individuals who need services because their use of drugs is causing significant levels of harm to themselves, their families or their communities.

What is in this document?

Chapter 2 examines and discusses the **definitions and concepts** of integrated care for drug misusers. It also sets out the key principles that underpin an integrated care approach and the key elements of the integrated care process. This chapter also introduces Harry - the case study that runs throughout the document.

Chapter 3 discusses the importance of **accessibility** of drug services. The key service and individual service user characteristics that determine accessibility are presented. These are followed by key principles and elements of practice. An Annex which specifically examines the issue of waiting times for drug services is attached to the Chapter.

Chapter 4 examines and discusses the process of **assessment** and describes the key principles of evidence-based, effective assessment placing the service user at the centre of the process. It also describes the different levels of assessment, discusses self-reporting and sets out further information on assessment tools. The key results of a Scottish survey of assessment practice and a core assessment data set are provided in Annexes.

Chapter 5 examines the process of **planning and delivery** of care for the individual drug user and discusses care co-ordination. It also highlights issues to be addressed in the planning, design and delivery of services at a local level. It introduces the concept of an integrated care plan and offers an example in an associated Annex.

Chapter 6 examines the process of **information sharing**. It offers practical guidance to DATs and service providers on the exchange of personal client information across treatment, care and support services drawing on examples from health and social care. Key principles of information sharing are also set out.

Chapter 7 discusses **monitoring and evaluation** within the context of integrated care. It examines the type of monitoring and evaluation that could be conducted at strategic level and service level. This chapter also discusses the importance of building an evaluation culture within and across services.

Appendices at the end of the document provide additional supporting information. These include: research summaries, summaries of the findings from service users' focus groups, an outline of the training offered by Scottish Training on Drugs and Alcohol (STRADA) and an outline of the current criminal justice initiatives that apply to drug users.

How do I use this document?

This document is designed as a '**bench document**'. By this we mean you should be able to pick up and use each chapter as a standalone section, and pull out relevant sections to use or copy. We have tried to keep duplication to a minimum but, if the chapters are to be read in isolation, a certain amount of repetition is essential.



Chapter 1: Introduction

Introduction

- From shared care to integrated care
- Developing person-centred services

The Effective Interventions Unit (EIU) at the Scottish Executive was established in June 2000 to identify what is effective and cost-effective in the field of drug misuse prevention, treatment, rehabilitation and availability. The EIU also has a role in disseminating effective practice to policy makers, DATs and practitioners and supporting service providers to deliver effective practice. In autumn 2000, the EIU consulted on its first Work Programme. In the course of the consultation process, the development of **integrated care** services for drug users was highlighted as a priority.

During the 1990s, there had been an expansion of **shared care** arrangements across Scotland, mainly involving GPs and primary care staff, pharmacists and specialist drug services. However, Drug Action Teams (DATs), managers and practitioners were keen to involve a wider range of agencies and service providers from both the statutory and voluntary sectors to address the needs of individuals with drug problems. This would potentially include social and criminal justice services, housing and homeless services, employment, education and training services.

The EIU undertook to review research evidence and current practice with a view to identifying the principles and practice that would underpin the design and delivery of an effective integrated care approach, building on the current experience of shared care arrangements.

The purpose of this document is to set out for Drug Action Teams, service commissioners, managers and practitioners in the statutory and voluntary sectors

- the rationale for integrated care, its definitions and principles
- effective practice in planning, designing and delivering integrated services
- practical guides and tools (where possible)

Background and context: from Shared Care to Integrated Care

The development of shared care arrangements for the treatment, care and support of drug users in Scotland followed from the recommendations of the Ministerial Drugs Task force in 1994. They advocated a partnership approach between GPs and specialised central services. This was followed in 1997 by the Scottish Office report 'Planning and Provision of Drug Misuse Services' which provided guidance on effective planning and provision and reviewed the relationship between the guidance and the national objectives (Scottish Office 1997). This report was primarily aimed at the health service.

In more recent policy and practice initiatives there has been a move towards **broadening the number and range of agencies** involved in providing treatment, care and support to drug users. The Department of Health Guidelines: Drug Misuse and Dependence - Guidelines in Clinical Management (1999) promoted shared care as a 'model that can be applied to any close co-operative work between agencies or services which directly improves the treatment of the individual drug misuser'. The Guidelines emphasised the need for collaboration across a range of services including social services, voluntary sector and the criminal justice system.

Also in 1999, "Tackling Drugs in Scotland - Action in Partnership" identified the provision of effective shared care arrangements and integrated drug misuse services as a priority for action. On 1st December 2000, the Executive set out targets and standards for tackling drug misuse. This included a new national standard on shared care which requires every LHCC and Primary Care Trust to have a locally approved shared care (or equivalent) scheme by 2004. Information from the Corporate Action Plans indicates that all DATs have schemes in place or arrangements in hand to meet the target date.

In February 2001, the EIU produced **Initial Guidance on Shared Care arrangements** (EIU 2001). The focus of this Guidance was on shared care but it signalled the intention to do further work to examine the principles and key elements of integrated care services that would encompass the wider range of services that could be involved in the treatment, care and support of an individual. Following the publication of the guidance a series of consultation workshops was held around Scotland. The purpose was to consult with commissioners, managers and practitioners about the key elements of service identified in the Guidance and to seek views about the desirability and feasibility of promoting a more integrated approach to the treatment, care and support of drug users.

There was a **strong view** from a significant number of participants that the term 'shared care' described a service provided largely by the NHS and was not well understood or recognised within other agencies. As a result, a shared care service was regarded as primarily a 'medical' service. Another view from all the workshops was that the term 'shared care' had different meanings in different sectors. For both these reasons, the use of the term was potentially a barrier to providing a co-ordinated or integrated approach to the care of the individual whose needs could extend across benefits, housing, family problems and unemployment.

The general view was that the term '**integrated care**' was recognised and understood by a wider range of the agencies who should be involved with the treatment, care and support of drug users. It was seen as a more proactive term indicating action and enabling the participation of a range of services and the individual drug user and their family in the overall planning and delivery of care. The concept of integrated care as a way of supporting and promoting progress and recovery for drug users has been supported by our further consultations and review of the research evidence. It encapsulates a proactive approach to treatment, care and support; enables the participation of a range of services; and involves the individual and their family in the assessment and planning of care.

One of the overarching themes from the EIU consultation workshops and the research evidence is that the focus of integrated care should be on the individual, often described as a **person-centred service**. Much of the content of this document is about how to achieve a person-centred service: for example, by taking account of the views and wishes of the individual during the assessment process. However, while there was support for the objective of a service focused on the individual, the workshops also highlighted concerns about how to address organisational and institutional barriers. Within this document, we have tried to provide **practical information** about how to tackle some of the key issues that impact on the delivery of a person-centred service such as accessibility, information sharing and agencies working together.

The core of a person-centred service is that the individual will get the treatment, care and support that meets their needs. However, another concern was that this could lead to an expectation by drug users that their own wishes about treatment would automatically be met: for example, a higher dosage of methadone. In this document, we have placed the individual at the centre but within a context of an assessment and planning process that examines wider needs and circumstances and reflects them in an integrated care plan. Above all, the individual should be encouraged and supported to participate as fully as possible in discussions about their treatment, care and support at every stage.

Recent developments

In recent years, there has been a number of developments in policy and practice at national and local level that have an impact on the planning, design and delivery of services to people who have drug misuse problems. Overall, these complement and support the development of integrated care for drug users.

In particular, the provision of care to people with drug misuse problems takes place within the wider context of **Community Care** and involves a number of services within local authorities, NHS Boards and NHS Trusts. In 1998, the Scottish Office published 'Modernising Community Care - an Action Plan', which identified important aims for the future:

- better and faster results for people focusing on them and their needs
- more effective and efficient joint working based on partnership

The lack of mainstreaming of these initiatives led to the Scottish Executive's **Joint Future agenda**. It promotes a number of measures to improve joint working that local partners should adopt. The principles outlined in the Joint Future agenda apply equally to the management of drug misuse services and should underpin an integrated care approach for drug users. The Joint Future agenda will be a **key driver for change** in community care as a whole and drug misuse specifically. The key principles informing this document are closely aligned with those that underpin the Joint Future agenda. These principles are set out in Chapter 2: Integrated Care: Definitions and Concepts.

Next steps

While the scope of the work on integrated care has been wide, it so far does not cover all aspects of effective practice. There are some topics where it might be helpful to do some further, more detailed work. These include:

- integrated care pathways (planned for later in 2002)
- needs assessment (planned for early 2003)
- quality standards
- advocacy
- service response for those with co-morbid mental health problems

It is also the case that the development of integrated care for drug users will be a continuing process around Scotland with more lessons to be learned from monitoring and evaluation. We would welcome comments and ideas about the potential for further work on these or other related topics. You can contact EIU at the address at the front of the document. There will also be an opportunity to discuss a wide range of issues at the EIU dissemination seminars planned for November 2002.

Finally, The Executive has now set up an Implementation Group drawn from Health, Social Care, criminal justice and representatives of the voluntary sector to consider the principles and practice that we have identified. The Group's remit is to advise on implementation; to ensure that it is linked to other strategies and planning processes; and to advise on monitoring, evaluation and accountability. The Implementation Group will be chaired by the Executive's Director of Health Improvement.



Chapter 2: Integrated Care: Definitions and Concepts

Definitions and Concepts

- Definitions of integrated care and why it is important
- The agencies and service providers who should be involved
- How integrated care fits with Joint Future

This Chapter examines and discusses the definitions and concepts of **integrated care** for drug users. It draws on the available research evidence, the EIU consultation process, service users' views on various aspects of the treatment, care and support process, and current policy and practice guidance (in particular the Joint Future agenda).

It sets out:

- definitions of integrated care, its rationale and wider context
- key principles and elements of integrated care
- goals of integrated care
- the range of service providers likely to be involved with the individual

What is Integrated Care?

Integrated care for drug users is an approach that seeks to **combine and co-ordinate** all the services required to meet the assessed needs of the individual.

It requires:

- treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug users
- the service response to be needs-led and not limited by organisational or administrative practices
- collaborative working between agencies and service providers at each stage in the progress of the individual in treatment, care and support, through to rehabilitation and reintegration into the community

The rationale: Why is integrated care important?

The evidence shows that people who have drug misuse problems will, in many cases, have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behaviour and debt (Gossop) 1998, Type 3; McIntosh, 2001 Type 3; SDF 2002, Type 4). This means that a wide range of responses and support will often need to be deployed to address those problems.

Service users (and indeed providers) often feel that there is no communication between the various agencies leading to frustration and disappointment for them (SDF 2002, Type 4; EIU Consultations Seminars 2001, Type 5). Agencies and service providers may not deliver an effective service because they do not have access to all the relevant information about an individual nor the awareness of the roles of other agencies who could potentially be involved in their care.

Service users also commonly feel that support is weighted towards the beginning of the recovery process, jeopardising this process in the long-term (McIntosh 2001, Type 3). The EIU 'Moving On' report highlighted that clients who have moved on to employment needed on-going support to cope with the transition in their lives (EIU 2001, Type 2).

There is emerging evidence about the benefits for both individuals and service providers of working in an integrated way with other services. An integrated care approach founded on co-operation and collaboration between all relevant providers will have a number of benefits for **individual service users**. It should:

- promote early assessment and intervention for service users
- remove barriers to progressing towards stabilisation / rehabilitation
- provide more consistent, co-ordinated and comprehensive care
- ensure a more holistic and quicker response

The **benefits for those commissioning, managing and providing services** include the opportunity to:

- take a comprehensive view of the planning, commissioning and delivery of services
- develop “whole person” approaches to service delivery
- manage a broader range of services directly, in a way which is responsive to the individual’s needs
- break down cultural and other barriers, to develop a better understanding of others’ skills, and to develop a wider range of personal skills in dealing with clients
- develop a wider skill base among staff, to meet more effectively the needs of individuals
- recognise and utilise the strengths and areas of expertise of all parties involved
- make the best use of available resources by managing the care of more people in a co-ordinated and cost-effective way

Key Principles that underpin an Integrated Care approach

Principles of Joint Future

Chapter 1 highlighted the importance of the Joint Future agenda in informing the development of integrated care. The key principles underpinning the Joint Future agenda apply across the planning, design and management of integrated care. They are as follows:

- **Joint management** is the overall term that covers the elements needed to ensure a more co-ordinated and effective approach to services including planning, commissioning and operational management. The critical factor is that the relevant range of services is under single management. Joint management needs to happen at different levels including strategic and operational levels.
- **Joint resourcing** is the overall term that covers all aspects of resources brought together in a ‘pot’ to provide a single focus for the planning, commissioning and delivery of services. It encompasses staff, money, equipment (in its widest sense) and property and any other resources currently made available within each of the existing separate agencies to deliver services. To be effective, the ‘pot’ needs to be as comprehensive as possible. The budget can be aligned within existing powers or ‘pooled’ under the provisions of the Community Care and Health Act 2002. Useful guidance on pooling budgets is available at the Department of Health website on <http://www.doh.gov.uk/jointunit/guidance.htm>. Further practical advice on both joint resourcing and joint management is available at: <http://www.scotland.gov.uk/health/jointfutureunit/pracadvisedoc/jointresourcing.pdf>

- **Single shared assessment** aims to create a single point of entry to community care services with a view to better use of resources and more effective outcomes for people in need. The new assessment arrangements initiated under the Joint Future agenda will apply to all community care groups by April 2003. This should simplify and make more effective use of staff and information to produce better and faster results. For more information please see: <http://www.scotland.gov.uk/health/jointfutureunit/singshareass.asp>
- **Intensive Care Management** is a process to redesignate care management by concentrating on people with complex or frequently changing needs. Work on intensive care management is ongoing at the Joint Future Unit in the Scottish Executive. (The key point is to match the level of management and intervention with the level of need.)
- **Information Sharing** is being introduced as part of Joint Future. The key principle is that the information provided in confidence by service users to one agency should, in normal circumstances, only be disclosed to other agencies with the consent of the individual concerned. There must be clear and shared understanding of how information will be protected and used.

For further information about Joint Future, please see the Joint Future Unit website at <http://www.scotland.gov.uk/health/jointfutureunit/>.

There was particular support in the EIU consultation workshops for single shared assessment and joint management and resourcing of services. Many of the principles of the wider Joint Future agenda and integrated care for drug users are already being adopted across Scotland.

Further principles of integrated care for drug users

There are a number of **further underlying principles** that should form the foundation for the successful development of integrated care for drugs users. These are:

- needs assessment and review of services
- developing evidence-based practice
- monitoring and evaluating
- involving users
- involving communities

We also highlight further resources relevant to each principle.

Needs assessment and review of services

Conducting a local needs assessment helps to establish the extent and nature of the drug problem in the area, describe the socio-demographic profile of users and examine the common routes through which clients are referred. This helps to build a picture of an area's need and the appropriate service response. Service reviews allow periodic re-assessment of whether the current provision continues to meet the need identified. The importance of needs assessment and service review is highlighted in the key principles section of Chapter 3 on accessibility of services for drug users and the associated Annex 3B. **A guide on how to conduct needs assessment (specific to the Scottish context) will be produced by the EIU in early 2003.** Existing guides to conducting needs assessment in the substance misuse field include a World Health Organisation (WHO) document that includes workbooks and case examples. It can be downloaded at: http://www.who.int/substance_abuse/PDFfiles/needsassessment.pdf.

Developing evidence-based practice

With the development of the Modernising Government agenda, there is a concerted push towards ensuring that policy and practice in all fields of health and social care is informed by the evidence base. This means that the decisions of policy makers and the treatment, care and support choices of practitioners should be based upon the best available evidence.

In the drugs field, the EIU has a remit for identifying and disseminating effective practice in Scotland. Research is also commissioned by the UK government and is generally available at <http://www.drugs.gov.uk>. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) aims to provide objective, reliable and comparable information on drugs at a European level. More information can be downloaded at <http://www.emcdda.org/>. The United States also have a range of sources that draw together evidence on drug-related topics, most notably NIDA at <http://www.nida.nih.gov/>.

In the broader health and social care field, there are a number of other key sources. These include (for health) the Cochrane Library of systematic reviews <http://www.cochrane.org/>, and the NHS Centre for Reviews and Dissemination <http://www.york.ac.uk/inst/crd/welcome.htm> and (in social sciences) the Campbell Collaboration <http://www.campbellcollaboration.org/>. The NHS library also has various useful links <http://www.nelh.nhs.uk/>. Finally, the National Research Register (NRR) is also a useful source of information on current and complete research in the UK. It can be found at: <http://www.update-software.com/national/>.

Monitoring and evaluating

Systematic monitoring and evaluation of integrated care is crucial to establish how and why integrated care is or is not working, and to highlight areas for improvement. Good evaluation has the potential to improve services and maximise their co-ordination by identifying what works, what could be done better and what is ineffective. It helps to ensure that clients are receiving the best possible treatment, care and support. More information on monitoring and evaluation is presented in Chapter 7. The EIU have also produced a series of evaluation guides available at: <http://www.drugmisuse.isdscotland.org/goodpractice/effectiveunit.htm>

Involving users

Including users in the development, delivery and evaluation of integrated care helps to ensure that services are person centred and needs led. Service users' rights and views should be taken into account at all stages. This should help build an integrated care system that is accessible, appropriate and credible to service users. The Scottish Drugs Forum (SDF) has been at the forefront of developing user involvement strategies across Scotland in recent years. For further information contact SDF on 0141 221 1175 or see <http://www.sdf.org.uk/>.

Involving communities

Experience shows that community involvement or engagement can bring important benefits including the design of services better tailored to local need and more lasting and sustainable change. There are a number of different definitions of both 'community' and 'involvement', and a whole range of techniques that can be used to achieve involvement. The EIU has produced a **Guide to Effective Engagement** (EIU 2002) and a related guide to **evaluating** community engagement (EIU Evaluation Guide 10). Both these documents can be downloaded at <http://www.drugmisuse.isdscotland.org/goodpractice/effectiveunit.htm>. As with the work on user involvement, SDF now have a key role to play in developing community involvement and community engagement across Scotland.

Goals of Integrated Care

There are a number of different treatment philosophies and approaches in the drugs field, reflecting the different needs and priorities of both service users and providers. These approaches have their own intended outcomes. However, following the EIU consultation seminars, we felt it was important to set out broadly the **overarching aim and key goals of integrated care** while accounting for these different philosophies. Not all of the goals below will be relevant to every individual. For further information on goal setting for individuals, please see Chapter 5 on Planning and Delivery of Care.

The **overarching aim** of integrated care is to help drug users to overcome their drug problem and their associated health and social difficulties by providing effective, co-ordinated and timely treatment, care and support.

The goals of care are to:

Reduce illicit drug use by stabilising on a substitute medication or detoxifying (where appropriate), by reducing the range of different substances being used by the individual, by reducing the frequency of drug use and by minimising the risk of future relapse. The ultimate goal may be to help the individual to stabilise or to become drug free.

Reduce the risk of the spread of blood-borne viruses, in particular the risk of HIV, hepatitis B and C, and other blood-borne infections from injecting and sharing injecting equipment. This may be achieved through a reduction or cessation of sharing injecting equipment and injecting paraphernalia, a reduction or cessation of injecting and by the reduction or cessation of risky sexual practices.

Improve all aspects of health by assisting the individual to reach and maintain a state of good physical and psychological health. This will be partly achieved by the goals above, but drug users may also have a number of other physical health problems to address. Mental health problems are a serious problem amongst this population, particularly depression and anxiety.

Reduce involvement in criminal activity, in particular to reduce the need for criminal activity to support or finance drug use, including prostitution, theft and offences regarding the supply of drugs.

Improve personal, social and family functioning by assisting the individuals to maximise their ability to make clear and rational decisions and enable them to develop a level of social and family interaction with which they feel comfortable. This may include an improvement in family relationships and the development of new social networks.

Improve education and employment prospects by assisting the individual to access existing opportunities to increase their employability and providing support to them while they are undertaking education or training, or beginning voluntary or paid employment.

Improve stability of housing / accommodation by assisting the individual to access opportunities for housing, or improvements in housing and to provide support while they are undertaking any change in housing.

Which service providers are involved?

Throughout an individual's contact with treatment, care and support services they may require **different types of services** as their needs change. As their needs change, a wider, more diverse range of services should be employed to address the individual's goals and aspirations. These services should be regarded as being of equal importance within the context of developing a person-centred approach to service delivery.

From our consultations it is clear that these services span **both the statutory and voluntary sectors**. In some areas, voluntary agencies are commissioned by statutory agencies to provide services for drug users. In each area, service planners should ensure that a broad range of services can be utilised to help individuals move through care. These include:

- GPs and primary care teams
- Community-based specialist drug services
- Community and hospital pharmacies
- Scottish Prison Service (SPS)
- Providers of SPS transitional care arrangements
- Housing services
- Employment and Training providers
- Health specialties such as A&E departments, ante-natal and hepatology services
- Social Inclusion Partnership initiatives
- Social work community care, children and families services, criminal justice social work
- Criminal Justice services such as Drugs Courts, DTTOs and Arrest Referral Schemes
- Providers of residential detoxification or rehabilitation services
- Business communities including small business forums as well as national companies and public sector employers
- Government Departments and agencies - for example education, Employment Service, Scottish Enterprise, Job Centre Plus, Progress2Work
- After care services such as those provided through New Futures Projects

Annex (2A) sets out the possible services that might be provided by these agencies and organisations and their key roles.

Which partner agencies need to work together?

Planning and delivering an integrated care service for drug users will involve DATs and all associated agencies and organisations potentially involved in the care of drug users. It will require communication, co-ordination and co-operation. This involves recognising the role of each agency and developing effective partnership working. No single agency can tackle the diverse needs of the drug misusing population.

Partnership working is not new. Many organisations have been working in partnership for many years. However, it is not easy. It takes time, careful thought and effort to build effective partnerships. In many ways, ineffective partnerships are easier to characterise. They are often partnerships where: one agency dominates decision making and planning; there is little community and user involvement; aims and objectives cannot be clarified; and there is little accountability or trust. It is harder to characterise a successful partnership. However, the literature on good partnership working suggests that the **ingredients** of a successful partnership include having:

- clear identity and role for the partnership
- clear identity and role for each partner agency in the planning, design and delivery of services
- shared short and long term aims and objectives
- sufficient time and resource dedicated to partnership building
- adequate training for all members, including community and user representatives
- a supportive atmosphere where discussion and new ideas are welcome
- clear and supportive leadership
- an atmosphere where organisational and cultural barriers can be explored

There are a number of useful guides and evaluations of partnership working that can be downloaded or are available from the organisation that published them. For example, see:

- Working Together: Effective Partnership Working from the Ground. HM Treasury

<http://www.hm-treasury.gov.uk/mediastore/otherfiles/PSPP%20partnerships%20report.pdf>

- The NACRO Guide to effective partnership working at:

<http://www.nacro.org.uk/templates/publications/briefingItem.cfm/2001062503-csps.htm>

To achieve integrated care for drug users, partnerships will need to be established at **both strategic and operational level**. The DAT will have the lead responsibility for co-ordinating the planning and delivery of services in an area. The development of joint resourcing and joint management in local areas through Joint Future will provide both an impetus and supporting structures.

At strategic level, the DAT and partners should agree:

- the aims and objectives of an integrated service
- the range of services that could or should be engaged
- the commissioning and management arrangements, including joint resourcing
- the arrangements for sharing information
- the arrangements for multi-agency training to promote mutual understanding of roles
- monitoring and evaluation arrangements

At **operational level**, service providers should agree:

- common or core assessment procedures and datasets
- systems and protocols for sharing information
- systems and protocols for referral and joint working

Achieving integrated care will depend upon having effective mechanisms to communicate and exchange ideas **between** the strategic and operational levels. Strategy needs to be developed through dialogue with those people who understand how services are currently delivered and what is likely to undermine any process of change. Success will depend upon service providers having a sense of ownership and understanding of both the principles that underpin integrated care and the changes in practice required to deliver them.

THE KEY ELEMENTS OF INTEGRATED CARE

The Initial Guidance on Shared Care Arrangements (EIU 2001) identified the key elements of shared care as Accessibility, Assessment, Planning of care, Intervention, Monitoring and Evaluation. These six elements of service are central to the identification and measurement of good practice. From our review of the evidence we have further developed the aspects of service to consider within each element and added an element entitled 'information sharing'. Monitoring and information sharing are continuous activities.

The Key Elements of Care

Element of integrated care process	Aspects of service to consider
1. Accessibility	<ul style="list-style-type: none"> • Distance to travel • Hours of opening • Service information for users and other agencies • Women's issues • Ethnicity • Homelessness • Range of services for non-opiate users • Waiting times
2. Assessment	<ul style="list-style-type: none"> • Core Data Sets • Assessment protocols and tools • Models • Individual's view of their problem • Information sharing procedures including confidentiality
3. Planning and Delivery	<ul style="list-style-type: none"> • Liaison with other services • Service-user participation • Advocacy • Goal setting • Care planning • Co-ordinating and delivering care • Communication between services • Joint funding and resourcing
4. Information sharing	<ul style="list-style-type: none"> • Information sharing leaflet for clients / service users • Inter-agency information sharing protocol • Informed client consent to information sharing
5. Monitoring	<ul style="list-style-type: none"> • Collecting process data • Collecting cost data • Ensuring monitoring is integral to, and informs, service delivery
6. Evaluation	<ul style="list-style-type: none"> • Service level evaluations • Strategic level evaluation • Building an evaluation culture

Current models of integrated care

As outlined in Chapter 1, integrated care for drug users is being developed across Scotland and other parts of the UK. We have presented below the models used by Aberdeen City DAT, Forth Valley SAT and Greater Glasgow DAT. We asked representatives from the DATs to set out the strengths and weaknesses of their integrated care approach and to comment on the lessons they had learned. These models can be found in Annexes 2B, 2C and 2D. The EIU does not advocate any particular model (as these have yet to be fully evaluated) and the views expressed are those of the contributors. However, they offer valuable illustration and insights into the experience of developing integrated care. For further information please contact the relevant Action Team.

AND FINALLY..... Introducing Harry

As stated above, one of the key principles of integrated care is that it should be person-centred i.e. that agencies and service providers should work together to design, plan and deliver care to drug users that focuses on the assessed needs of individuals. To illustrate how the design and delivery of integrated care services might affect the individual, the following 3 Chapters on Accessibility, Assessment, and Planning and Delivery of Care will show how a service user – Harry – might find the different stages of treatment, care and support. The story of Harry is fictional.

INTRODUCING HARRY

Harry is 24 years old. He lives with his partner of 6 years who is not a drug user. They have two young children aged 3 and 5 years and his partner is concerned about the impact of his drug use on her and the children.

He has been using drugs since he was about sixteen but has never sought help before. Over the last couple of months drugs have become more available in his neighbourhood and are much cheaper than normal. Harry has been buying more than usual and has started injecting.

He has built up rent arrears and has recently lost the place he had on a training course. Any money coming into the house is being spent on drugs.

Harry wants to come off the drugs and is looking for help. He contacts his GP. He does not appear to be aware of other services in the area that could support him and address his needs.

Integrated Care Pathways

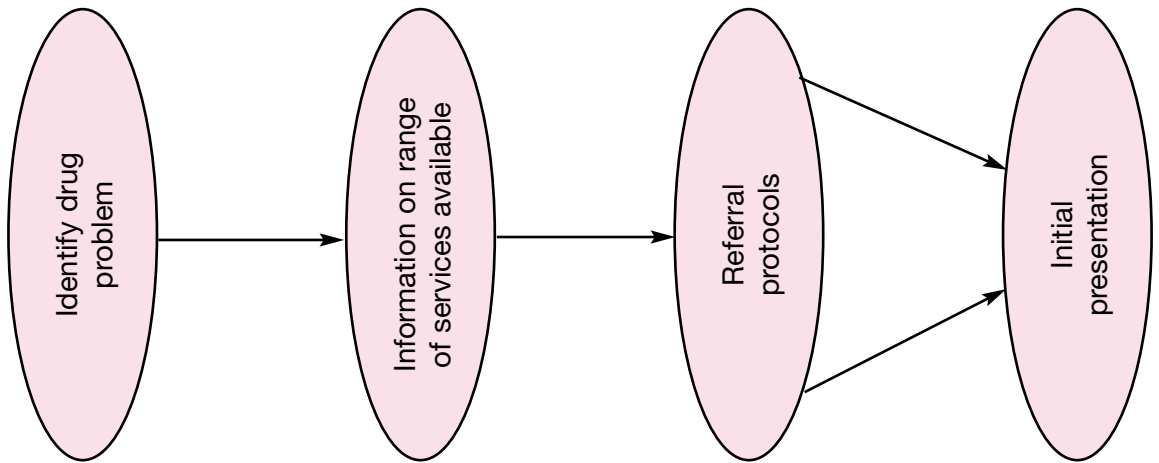
An Integrated Care Pathway (ICP) determines locally agreed, multi-disciplinary practice based on guidelines and evidence, where available, for a specific patient/client group. It forms all or part of the clinical record, documents care given and facilitates the evaluation of outcomes for continuous quality improvement. (National Pathways Association) <http://www.the-npa.org.uk>

The outline care pathway below sets out some of the processes and outcomes that should be considered when developing local ICPs. Chapters 3, 4 and 5 include illustrations of how these relate to the individual client, Harry.

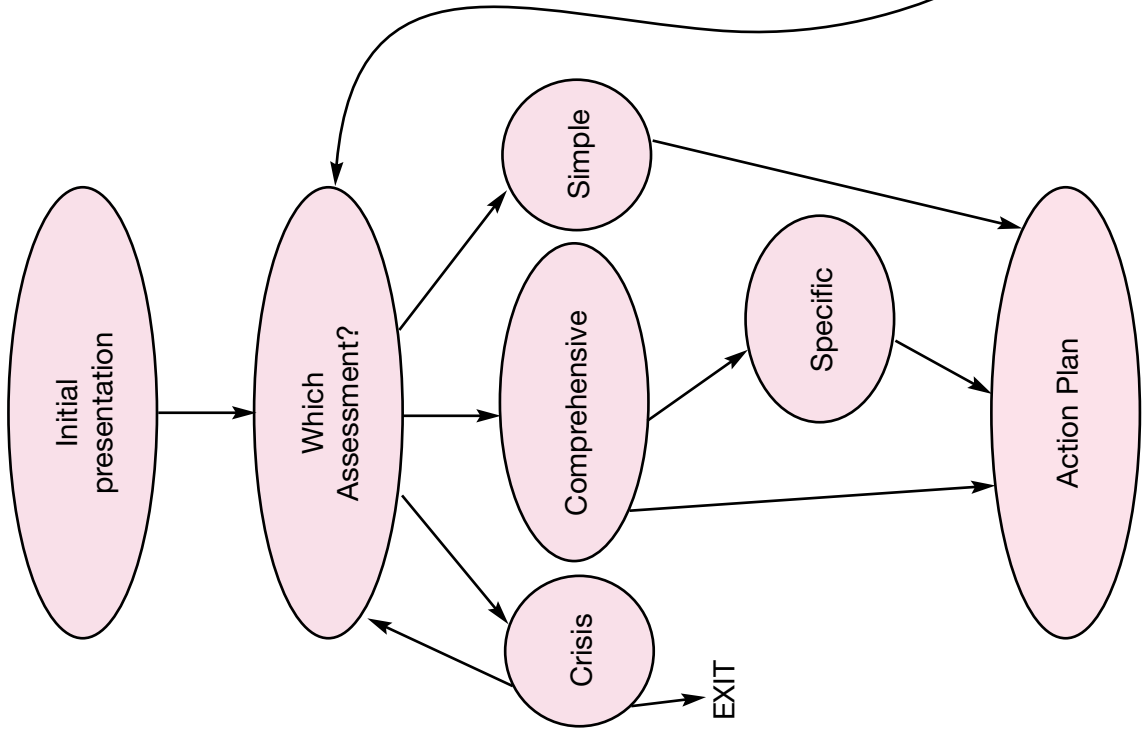
The EIU will shortly produce a guide to developing and implementing Integrated Care Pathways which will be published later in the year.

OUTLINE INTEGRATED CARE PATHWAY

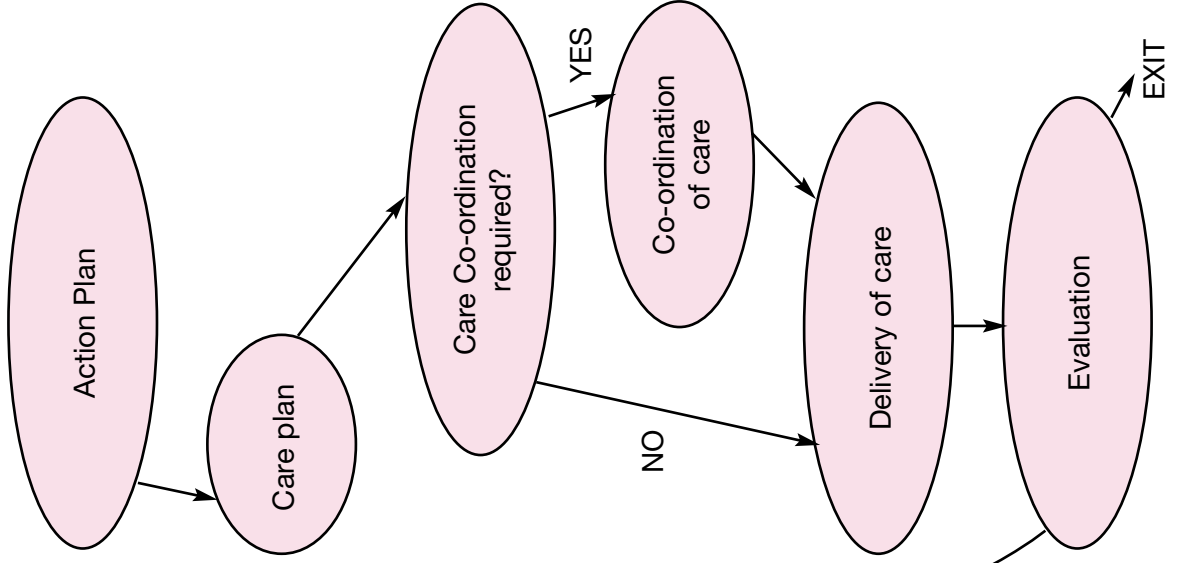
ACCESSIBILITY



ASSESSMENT



PLANNING AND DELIVERY



Outline of possible roles of service providers in integrated care.

Agencies	Possible roles
General practitioners / primary care team	<ul style="list-style-type: none"> • General medical services to all people with drug problems • Ongoing management of the care and treatment to the majority of individuals stabilised on substitute prescribing programmes and those maintaining abstinence
Community & hospital pharmacies	<ul style="list-style-type: none"> • Providing services related to needle exchange • Dispensing, and supervision, of methadone • Dispensing other medicines used in the treatment of drug use, e.g. lofexidine, naltrexone, buprenorphine • Advice and health education, including advice on secure handling and storage of medicines • Promotion of healthy lifestyles • Referral to appropriate agencies • Advising on safe sex and supplying condoms
Community based specialist drug services (statutory and voluntary)	<ul style="list-style-type: none"> • Overall treatment and care of people with drug problems • Assessment • Care planning • Substitute prescribing • Community / home detoxification • Social skills training • Counselling • Advice & information • Education • Monitoring & evaluation of planned care • Primary care liaison • Links to hospital & community services
Providers of residential detoxification or rehabilitation services	<ul style="list-style-type: none"> • Range of services for people with drug problems including detoxification and rehabilitation
Scottish Prison Service	<ul style="list-style-type: none"> • Providing range of treatment options within the prisons
Providers of SPS transitional care arrangements	<ul style="list-style-type: none"> • Providing appropriate transitional care arrangements between prisons and the community
Health specialties such as A&E departments, Ante-natal and hepatology services	<ul style="list-style-type: none"> • Specialist input to (and management of) pregnancy and specific, identified conditions such as Hepatitis C or mental health problems
Criminal Justice services such as Drugs Courts, DTTOs and Arrest Referral Schemes	<ul style="list-style-type: none"> • Referral to appropriate treatment, care and support services
Social work community care, children and families teams and criminal justice teams	<ul style="list-style-type: none"> • Range of services including comprehensive assessments, carer assessment, family support, child protection services
Housing services	<ul style="list-style-type: none"> • Providing service, advice and information including support in Homelessness
Employment, Education and Training providers	<ul style="list-style-type: none"> • Specific services to promote re-integration into employment and education • Further education colleges and the enterprise networks

After care services such as those provided through New Futures Projects	<ul style="list-style-type: none"> • Range of services and interventions to support stabilised and former users into employment, education and training.
Business organisations (including small business forums as well as national companies and public sector employers)	<ul style="list-style-type: none"> • Managerial experience, advice and support to new projects or provide opportunities for employment through a range of 'work taster schemes'
Wider community services	<ul style="list-style-type: none"> • Services to drug users could be seen as an extension to mainstream services, e.g. Police, Churches, Leisure Services
Other support organisations	<ul style="list-style-type: none"> • Specifically aimed to deal with drug use issues, for example, family support groups, drug awareness groups, recovery groups • Main remit targets other presenting issues but among whose clients there is an incidence of problem drug use, such as services to the homeless.

ABERDEEN CITY DAT INTEGRATED CARE MODEL

Background

In January 1999 a Project Development Manager was appointed and two working groups established, a Project Management Team and a Project Implementation Team, both of these groups had representatives of the main drug service providers within Aberdeen City each looking at management implications and operational implications respectively.

The project is an Aberdeen City DAT initiative. The project manager is hosted by NHS Grampian and the funding for the project has jointly come from DAT members NHS Grampian and Aberdeen City Council.

Horizontal and Vertical Integration

The IDS development has attempted to integrate the range of services involved in delivering drug treatment and care. What has also been of value has been establishing a mechanism for linking strategic management with operational management by having sub-groups of the DAT to take the development forward.

Phase 1: Integrated Infrastructure

The first phase of the IDS focussed on developing infrastructure changes that would allow organisations to work with clients together without changing the structure of the services. Some of the key features developed include:

- Agreed Model of Integration
- Common Assessment Form
- Review Form
- Case Closure Form
- Care Plan
- Referral Form
- Agreed Key-worker Job Description
- Agreed Referral Criteria between agencies
- Agreed Care Pathways
- Agreed methods of multi-agency Working
- Multi-agency Assessment Panel
- Common Policy on Confidentiality / Sharing Information
- Operational Handbook / Training and Guidance Notes

The project took an operational approach to development by attempting to develop integration through joint casework.

Some of the principles that we attempted to establish were that assessment was continuous and that assessment was a passport into the range of care required. By developing four care pathways that required different levels of information sharing, the issue of confidentiality could be managed to suit the client.

A key feature of the IDS at that stage was the development of "Assessment Panels". The term Assessment Panel is inaccurate and would have been better described as multi-agency case conferences. Ideally the Assessment Panels would have developed into managing their own budgets. The key principle of the facility was to have a regular "forum" where key worker could confidentially discuss cases and care plans on multi-disciplinary basis.

Phase 2: Structural Integration

As the first phase started to develop a number of issues arose which began to drive forward discussions about changing the way that services were delivered. A number of national and strategic guidelines were also beginning to shape service delivery - in particular the Scottish Executive's "A Joint Future".

Staff involved in working with the IDS felt that as services were still delivered by separate organisations there often was not a consensus about what the treatment and care objectives were. There still maintained a culture of individual organisations wanting faster referral rates into other organisations rather than actually delivering integrated care.

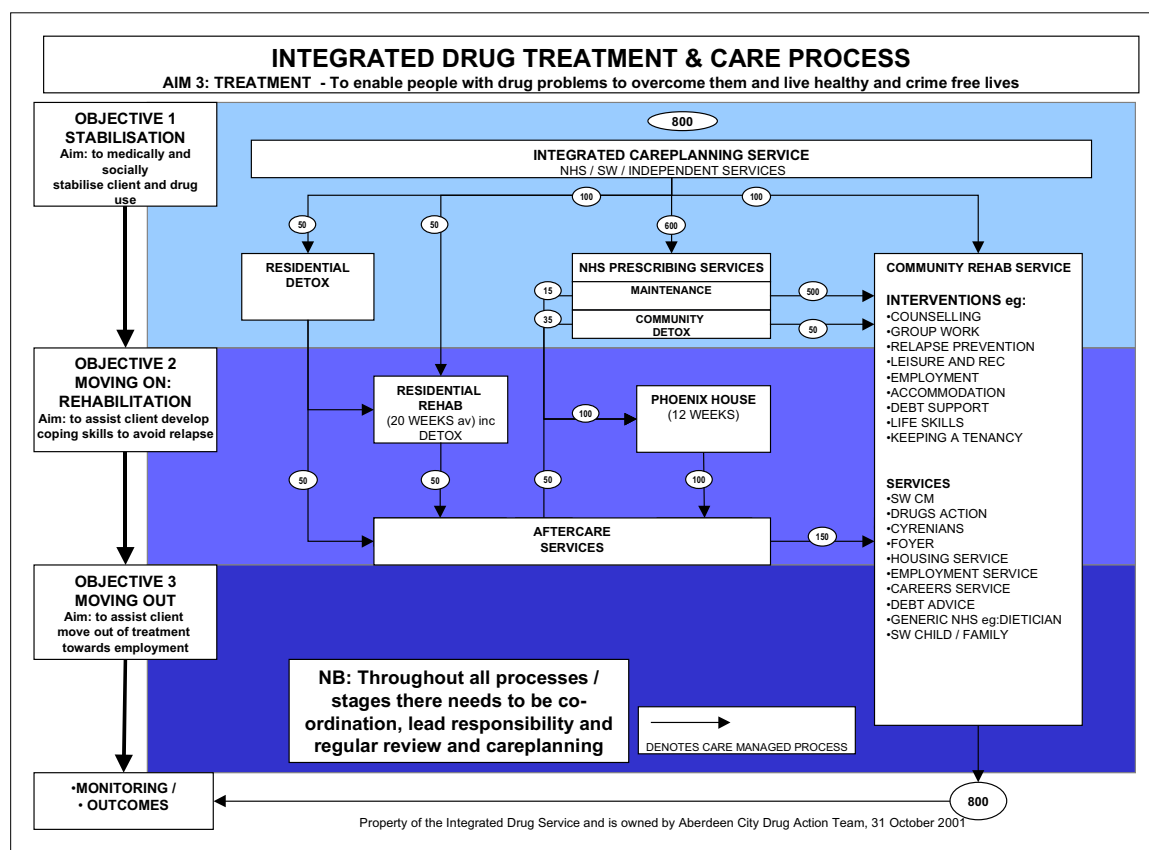
From these discussions initial plans were drawn up that started to build multi-agency "teams" around GP practices and other identifiable client groupings. However at this time there were no additional resources to take this further forward.

The background context to this is that the Shared Care Scheme, which had GPs at the front line of delivering treatment services, was becoming overloaded and GPs increasingly dissatisfied with the specialist level of treatment they were expected to deliver as waiting times to the specialist service grew.

During this time discussions took place about establishing a core set of treatment and care objectives. Services for drug users have traditionally been delivered on a "functional basis" with clients attending a range of professional services to gain support. The developments proposed a move from "functional" based service delivery to "process" based service delivery. At the core of this process are the care and treatment objectives of:

- Stabilisation
- Moving On: Rehabilitation
- Moving Out

The DAT agreed that from now on service outcomes, design and development would be centred on these objectives. The objectives were then incorporated into a "whole system" Treatment and Care Process. This is illustrated in the figure below.



Discussions are taking place to establish an Integrated Care Planning Service which will be delivered multi-disciplinary team of Nursing Staff, Specialist GPs, Care Management and Voluntary Sector Staff with a key objective of **stabilising** the client's lifestyle through medical and social interventions.

Discussions are also taking place to establish a Community Rehabilitation Service that will be delivered by a multi-disciplinary team made up from voluntary sector partners with specialisms in drugs, accommodation, training, employment and benefits advice. The key objective being to help clients **Move On** from their drug use and **Move Out** of services.

What we have learned / things that helped and hindered

- There are pros and cons to taking a bottom up approach to change management
- Having supportive GPs involved is helpful
- The publication of the Joint Future Report was helpful although time-scales and targets for substance use would have been especially beneficial
- EIU publications that highlight the requirement for integrated services are helpful
- Organisational managers took differing approaches to implementing and driving change within their organisations
- Competitive culture for resources within the voluntary sector can lead to fragmentation and resource led development
- The wide range of funding streams that do not require DAT approval fosters fragmented service development
- A specific commissioning and development budget for the IDS could have been helpful

- The sheer volume of client demand and staff caseload affects service development and change
- National initiatives that cut across national strategy and local initiatives generally are not helpful
- Organisations locked into legacy databases find it hard to implement new assessment forms/ developments
- Investment in IT and development of IT strategy locally and nationally
- Lack of resources: Aberdeen has the third highest drug prevalence in Scotland but receives the second lowest funding in Scotland per patient
- National standards against which to develop and measure integrated services would be helpful
- A national definition / model of “Community Rehabilitation” would be helpful

FORTH VALLEY INTEGRATED CARE SERVICES

Background and history

Services for dealing with substance users in Forth Valley were previously delivered in a relatively unco-ordinated fashion. The SAT was attended by numerous representatives from each commissioning authority. The group reflected the state of planning and inter-agency relationships at the time. The size and scope of its remit made effective action difficult. Like most such groups its membership was not consistent and the development of trust and an ability to work effectively together was slow. Despite these restrictions the SAT did successfully bid to the Scottish Executive for funds to support a pilot project of an alternative to custody scheme. A Forth Valley SAT Strategy was also produced & published before reorganisation of the SAT was undertaken, with a view to increasing its effectiveness & local impact, in 1999.

The key problems:

Service delivery

- Delays & waiting lists for effective interventions
- A lack of a range of available interventions
- Poor co-ordination of existing resources & associated activity
- Collaborative working patchy with little organisational support

Strategy - SAT

- Large unwieldy committee with inconsistent membership and large remit
- Poor communication with local forums
- Little evidence of effectiveness - though some successes
- Perceived as distant and unaccountable by communities

Integrating Services to improve outcomes

Strategic change

It was recognised that the SAT needed to improve its effectiveness and local accountability. In 1999 the SAT partners embarked on a process of re-organisation. Each partner agreed to have one senior SAT representative. The SAT also recruited a local community representative for the first time. A process of team-building involving “away days” facilitated by consultants experienced in public sector organisational development and community engagement was undertaken. Subsequently a restatement of the Forum structure was made with the forum becoming the recognised route for dialogue between the communities and the SAT. The aim was to develop an effective “bottom-up” approach to planning and service delivery.

The Tiered Approach – Development of an Integrated System of Service Delivery

In 2000, Forth Valley SAT set up a multi-disciplinary group to consider the need for a new street-level treatment service. This group delivered an options paper which was consulted on widely through the SAT forums and at a multi-agency away day involving all local partners. This process identified the need to consider a way of organising services which would deliver a range of treatment options to drug users when they needed them, with minimal waiting times and improved accessibility. Services would be placed within a continuum of “Tiers” (Diagram 1). Tier 1 would be the direct access (street) level at which basic assessment would be undertaken. The person could then be managed within Tier 1 if their needs could be met there or would be referred on (using agreed criteria) to the most appropriate service for their needs.

Each Tier would deliver specific interventions which would imply the training & skill requirements of staff. Protocols using agreed criteria would facilitate the rapid movement of individuals through the system. 4 Tiers were agreed:

Tier 1 – direct access including self-referral; assessment using common shared assessment tool; access to harm reduction services; general counselling & support

Tier 2 – referral only; specialised assessment; specialised counselling interventions

Tier 3 – referral only; specialised medical interventions

Tier 4 – referral only; rehabilitation (community & residential); shared care

Delivery - New Services

The SAT partners used the Tiered system to inform their subsequent commissioning of new services. All new funds are agreed by SAT. Services commissioned have included:

Signpost Forth Valley

The first element of the Tiered approach was the delivery of a Tier 1 Service. Funding was through new local authority “Rehabilitation” funds which were pooled and administered through the Health Board.

Forth Dimension & 4D Structured Day Programme

A process of development involving New Futures funding and local partners led to the funding of a new model of community rehabilitation. New SAT funds for “Rehabilitation” were successfully bid for allowing the development of an attached structured day programme.

CADS Shared Care Service

New SAT “Treatment” funds were used to enhance the existing Shared Care model in Forth Valley.

CSCA becomes CSSAD

The Central Scotland Council on Alcohol altered its constitution to become the Counselling & Support Service for Alcohol & Drugs. This better reflects activity and places CSSAD in the Tiered system.

Delivery - Processes of Care & New Systems

Service providers have used the structure underpinning the tiered approach to examine the key elements required for effective service delivery and develop processes of care to deliver improved outcomes for drug users. This process has included:

Service providers group: All service providers (including generic providers) meet regularly to discuss issues of integration, problems around inter-agency interfaces etc.

Process of care group: All specialist providers are involved in the development of clear & agreed pathways of care which will support the development of protocols and agreements ensuring patients are being managed in the most appropriate service for their needs.

Shared common assessment tool & Service Directory: The SAT Co-ordinator led a multi-agency group (including GPs) which developed & agreed a new assessment tool and information pack containing up to date information on Forth Valley Services.

Information-sharing policy: A multi-agency group developed a Forth Valley information-Sharing Policy which has been examined & accepted by the local Caldicott Committee & other responsible parties in all partner agencies.

Key Positive influences for change & difficulties encountered

Positive influences

A number of important elements have facilitated the progress in Forth Valley:

- **SAT team development & stability:** the commitment to invest in development of the SAT as a unit has been crucial. This has resulted in an improved culture of trust among the partner organisations and has allowed a true partnership approach to evolve with a real focus on improving outcomes for drug users.
- **Strategic Commitment & agency accountability:** The resulting commitment to a corporate approach from all partners has enhanced the ability to “join up” resources & services.
- **Community engagement & communication:** The community has been positively engaged by recruiting a community representative onto the SAT and ensuring that all SAT decisions are informed by discussions at the forums.

Difficulties encountered

Despite the considerable progress there have been areas of difficulty, some of which are still being negotiated:

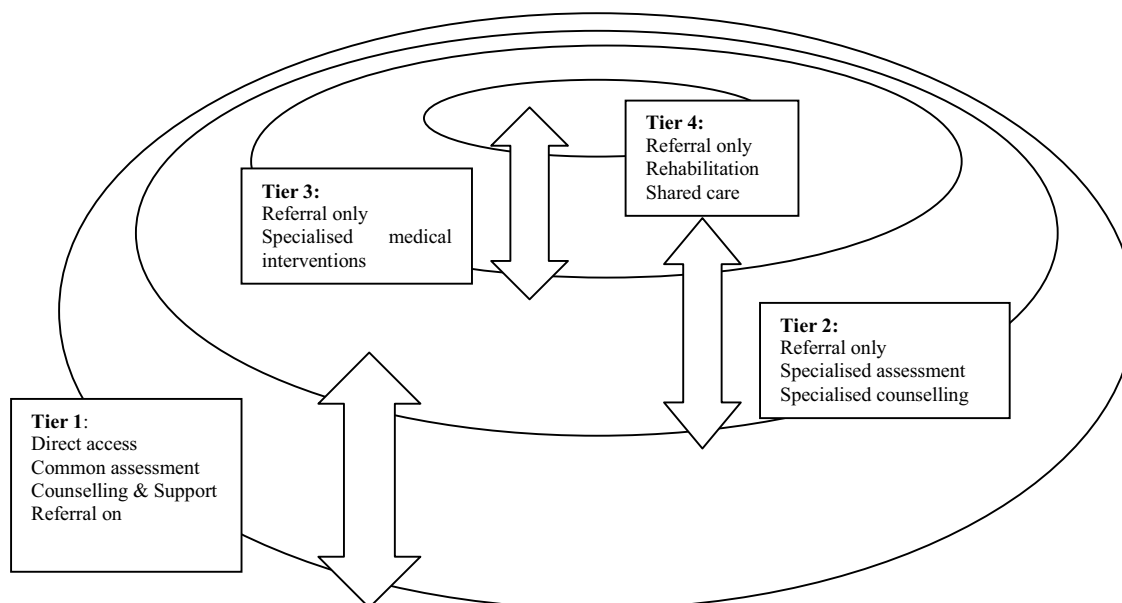
- **Commitment to & sustaining the joint SAT approach:** Initially (& still on occasion) it has proved difficult to keep all agencies committed to the joint approach. Pressures on the health system or political disagreements within local authorities can have the potential to divert resources from their agreed targets. Such issues must be honestly addressed at the SAT.
- **Culture:** As in most areas, FVSAT emerged from a local culture which included a lack of trust among agencies as well as a belief within the community that the SAT would not respond to their opinions regarding service delivery. These issues have been overcome by the SAT engaging in real community consultation (eg regarding the Tier 1 service which was ultimately awarded to a community consortium).

- **Communication problems – SAT & Community forums:** The forums required a lot of development work & support to empower them and ensure they functioned effectively. Previously they saw themselves simply as “pressure groups” and they required to make considerable culture change.
- **Information sharing – organisational “preciousness”:** The development of the information-sharing policy generated considerable resistance from some agencies. This may simply have reflected a fastidious approach to policy but can easily be related to agency preciousness.
- **Over-commitment of a small number of key agencies:** with such considerable development there has been a need for agencies to be involved in many meetings - which can over-stretch staff.
- **National funded projects:** Nationally committed funds can appear in an area with no attempt to relate these to local planning or systems of service delivery. The SPS throughcare service is one example which has not been helpful in Forth Valley.

Conclusions

In recent years the Forth Valley SAT has endeavoured to improve interagency working and planning to better engage their community and deliver services which are more likely to meet the needs of drug users.

The Tiered Approach



GLASGOW CITY COUNCIL, GREATER GLASGOW NHS BOARD AND PRIMARY CARE TRUST INTEGRATED ADDICTION SERVICES

Background

For the past twelve months Glasgow City Council Social Work Services and Greater Glasgow NHS Board and Primary Care Trust have been working to develop a model of integrated Addiction Services. This model has been developed through the secondment of two staff, one each from Social Work and Health who worked in conjunction with staff and managers across the current services.

This section describes the agreed framework for services and the specific proposals for community based services, which are currently subject to discussion with a range of stakeholders including staff trade unions. Two pilot services are due to commence from October 2002.

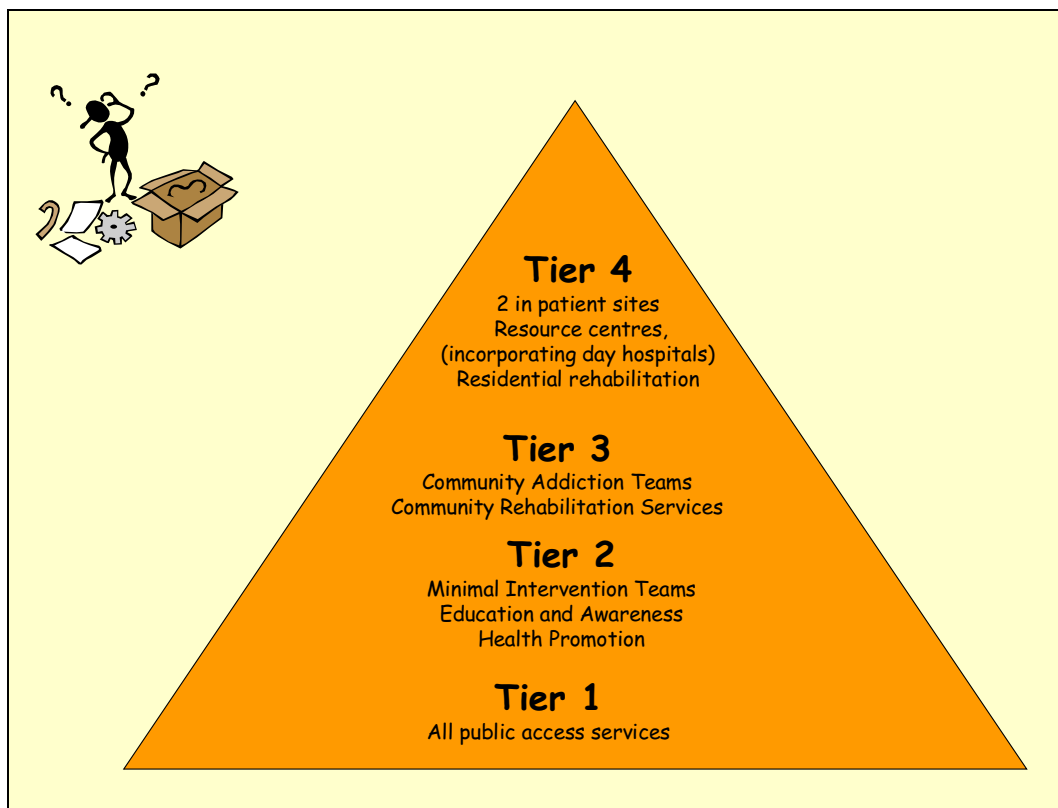
Further work is being undertaken in relation to developing a model for highly specialist treatment and care services within the Health Service and a review of services purchased from the independent sector is underway. Both these pieces of work are due to conclude later this year.

A Four Tier Model of Service Provision

The model proposed here was originally developed by the NHS Health Advisory Service in 1995 as a strategic model for Mental Health Services. It was later developed in 1996 in relation to drug and alcohol services in relation to young people.

The model describes four tiers within which it is possible to locate existing drug and alcohol provision within Glasgow. In using the model it has been our intention to provide potential for a re-shaping of existing services, within a tiered approach, in order to deliver the prospect of multi-professional Addiction Services.

As can be seen from the diagram below, the four tier approach moves from tier 1 'generic services', which in relation to addiction issues fulfill signposting functions, through to tier 2 which are described as 'generic with specialist functions', such as Social Work area services. It is in tier 3 and 4 where we identify the provision of specialist treatment and care services.



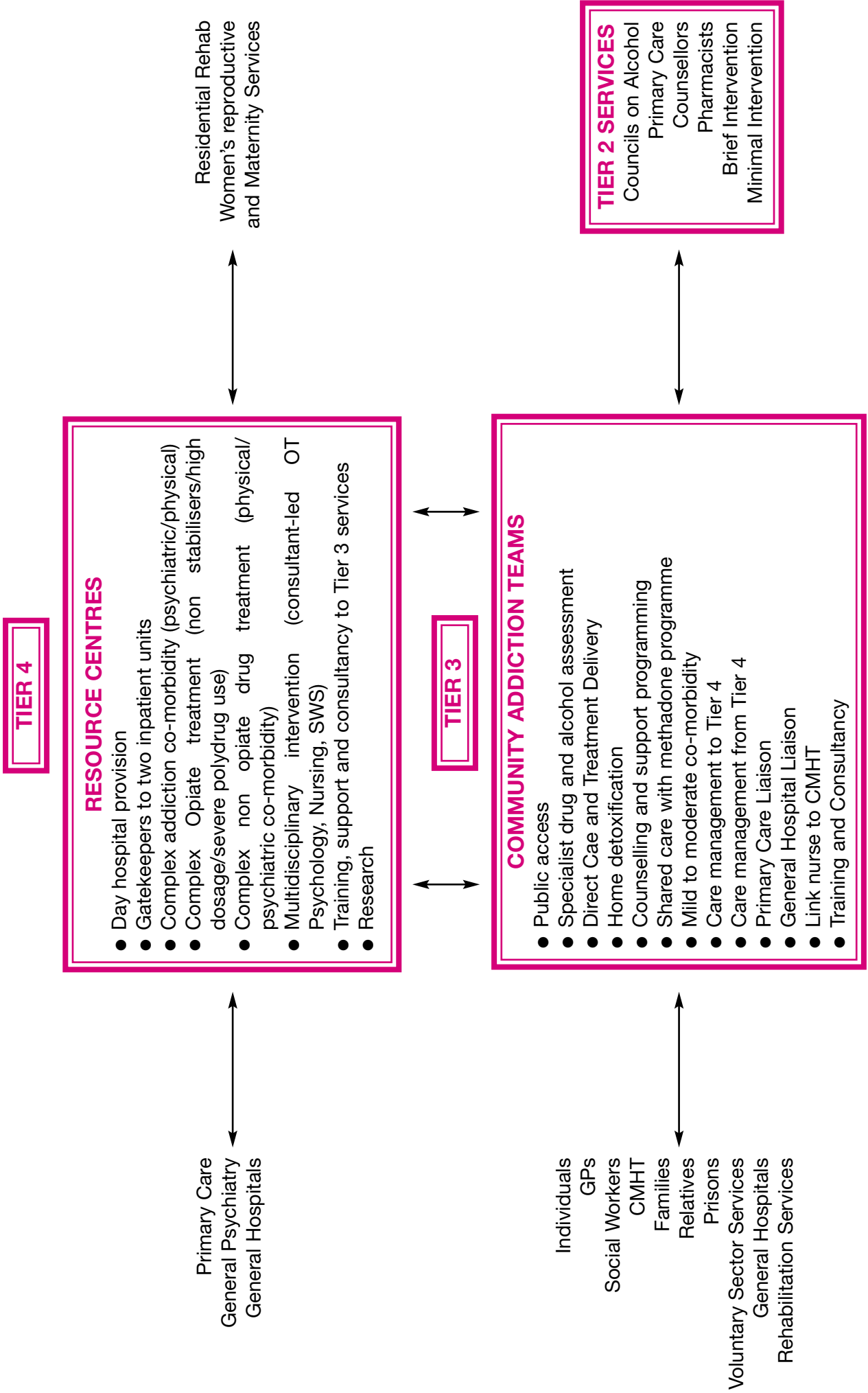
Community Addiction Teams

These teams will be located in nine areas of Glasgow and provide a direct access service across the whole city. They will combine current Social Work Addiction Services with existing and new nursing posts to form new integrated addiction teams under a joint team leadership and management arrangement.

The medical component of CATs will be provided through General Practitioners within the GP Shared Care Scheme for the methadone program. CATs will also have direct links to the highly specialist treatment and care services within Health and will ensure the effective care management of service users across the range of services provided and purchased from the independent sector.

The diagram below outlines the main functions of Community Addiction Teams and the interface between tier 3 and 4 services.

REFERRAL PATHWAYS – INTEGRATED HEALTH AND SOCIAL WORK SERVICES





Chapter 3: Accessibility

Accessibility

- **Definition of accessibility and why it is important**
- **Factors that influence accessibility**
- **Ways to manage waiting times**
- **Why needs assessment is important**

This Chapter examines and discusses the various factors that **influence accessibility to drug treatment, care and support services**, both in Scotland and elsewhere. These factors will affect (and even determine) the extent to which integrated care can be delivered in any area.

The key sources of evidence that have been drawn on for this Chapter are the research literature, service users' focus groups undertaken by the Scottish Drugs Forum (SDF), the EIU consultation workshops and the EIU Working Group on Accessibility. The Working Group undertook to review the issues that affect the accessibility of services (specifically in the Scottish context) and to identify key principles and elements of effective practice.

This Chapter sets out in more detail:

- the definition of accessibility, its rationale and wider context
- the evidence on factors that influence accessibility
- key principles and elements of effective practice

What is accessibility?

A service is accessible when it is **available to all potential users** at a time and place suitable to meet their assessed needs and delivered in a user-friendly way. To make services accessible, it is essential to remove the barriers, real or perceived, that individuals experience. These barriers can lead to a lack of engagement and non-attendance. Key issues to be addressed include:

- equity of access for all potential users
- the location and opening hours of services
- the length of time to wait to be seen by a service or to get into treatment
- ensuring an initial (and subsequent) positive experience, as perceived by the user

Above all, a service is accessible when it is designed to meet the needs and aspirations of the individual. In other words, the organisational arrangements should be flexible enough to offer a service that is as **person-centred** as possible.

The Rationale: why is accessibility important?

Accessibility of services is important to ensure that users get access to the services and interventions most likely to help them, at times when they need them (EIU Working Group 2002, Type 5). This will help ensure that individual users:

- reduce harm to themselves and others
- reduce their drug use
- address other health and social problems
- have an opportunity to rebuild their lives

Ensuring access to effective services will also have an impact on the lives of those who care for drug users, those who are cared for by drug users and the wider community within which they live. Recent survey work on family support needs in Scotland shows that the mental and physical health of those caring for drug users can be seriously affected (EIU 2002, Type 3).

There is a growing evidence base on the range and combinations of interventions that can work with drug users (Simeons 2002, Type 1). Research shows that a **range of treatment interventions** (with a range of philosophies) may work, but the outcome depends on the individual getting the right treatment at the right time (Department of Health 2002). Ensuring access to a range of interventions and matching interventions to client needs can help promote the effectiveness of treatment (Gossop 1998, Type 3). This relies upon systematic and effective assessment procedures.

As outlined in Chapter 2, it is widely recognised that people who have a drug problem will have a range of other needs. These need to be resolved before that individual can make a full recovery. Interventions which help people to deal with **wider problems** in their lives and to move on after stabilisation or recovery also show promise and should also be accessible to all users. This highlights the importance of an **integrated approach** to the treatment, care and support of users.

The assessment process may identify needs for better and more stable housing, help with addressing difficult family relationships, help with addressing debt problems and the need to improve employment prospects. Conversely, a referral may be made to a drug service because there has been a problem in another area of the individual's life, for example, because a tenancy is under threat and a drug problem has been identified.

Overall, the available evidence suggests that (ideally) a **broad range of user-friendly interventions** that tackle the plethora of health and social needs of drug users should be accessible to those who need them at appropriate junctures. This includes being sensitive to the needs of individuals based on their socio-demographic characteristics. However, service users in Scotland and across the UK appear to have difficulties accessing co-ordinated drug treatment for a number of reasons including: the uneven availability of health and social care services and interventions, poor assessment procedures and lengthy waiting lists (EIU Working Group 2001, Type 5; Audit Commission 2002)

The Wider Context

Accessibility of services is a cause for concern across a number of settings, including primary care. For example, The Scottish Consumer Council Report 'Access to Primary Care Services in Scotland' (SCC 2001, Type 2) demonstrates that accessibility is a key issue for the patient population of Scotland. It stresses that, however effective a service may be, it is only of value if those who need it are easily able to access it. Access can be **limited in a number of ways**:

- where services are provided
- when services are provided
- how services are provided

Groups in the population who may potentially be disadvantaged in seeking access to primary care services include:

- homeless people
- travelling people
- people from minority ethnic groups
- disabled people
- those with mental health problems

Drug users are also a marginalised group and are **disproportionately represented** in some of the groups listed above. For example, there appear to be high rates of mental health problems in the drug treatment population. In a prevalence study of co-morbidity among substance misuse and adult mental health treatment populations in England, 40% of the drug treatment population were assessed as suffering from minor depression, 37% with a personality disorder, 27% with severe depression and 19% with severe anxiety (Weaver 2002, Type 3)

It is important that service providers consider the individual needs of service users. There are a number of legislative and good practice initiatives that help to ensure this. In Chapters 1 and 2 we have outlined the **Joint Future** agenda. This should be a key driver in promoting integrated care in the broader community care field and the drugs field specifically. However, there are other key legislative and practice initiatives.

For example, there are new **National Care Standards** in Scotland for care homes for people with drug and alcohol misuse problems (Scottish Executive 2001). Responsibility for these standards lies with the new **Scottish Commission for the Regulation of Care** (SCRC). These standards have been developed with the needs of the client in mind, and set out what they can expect from service providers in a residential setting. However, the standards also clearly articulate what is expected from providers of support and care services.

The National Care Standards in Scotland for care homes for people with drug and alcohol misuse problems are based on seven key principles:

- Dignity
- Privacy
- Choice
- Safety
- Realising Potential
- Equality
- Diversity

From April 2003, under the Government's **Supporting People initiative**, a new funding and policy framework for the provision of housing support services, will come into operation. Under this initiative local authorities will become responsible for the funding, planning and provision of housing support services in their area. The purpose is to make housing support services more accessible to everyone (regardless of tenure), to have services which are more attuned to people's needs and to enable direct payments to be made. The aim is also to improve the quality of services through the registration of providers of housing support services with the SCRC mentioned above. All new service users will be required to undergo an assessment of their housing support needs under the **single shared assessment procedure** outlined in Joint Future.

A further example is **disability legislation**. Service providers will need to comply with the Disability Discrimination Act 1995. The Act makes it unlawful for service providers to treat disabled people less favourably than they would treat other people, for a reason related to their disability, when offering or providing goods, facilities, or services. This clearly applies to health service providers, and extends not only to the physical, accessibility of premises, but also to how information is produced and how communication is made.

Similarly, the **Race Relations Act** 1976 (amended by the Race Relations Amendment Act 2000), makes it unlawful to discriminate against anyone on grounds of race, colour, nationality (including citizenship), or ethnic or national origin. The amended Act also imposes general duties on many public authorities to promote racial equality.

Finally, the **National Treatment Agency** (NTA) in England is set up as a special health authority to lead the development and monitoring of drug service standards. One of the key concerns for the NTA is the accessibility of drug services for individuals across all DATs in England. The NTA emphasise that a constellation of different services will be required in each area to manage and address the complex needs of drug users, and that these services will need to work in partnership to maximise the use of available resources. For further information about the NTA please see: www.nta.org.uk.

Factors that affect accessibility

We have identified a number of service and individual client characteristics that potentially have an impact on accessibility. These include the needs of specific groups of drug users whose circumstances require additional consideration if services are to be accessible to them:

Service characteristics

- the range of available treatment and care services
- client awareness and perception of services
- location of services / distance to travel
- opening times of services
- waiting times
- staff attitudes
- assessment procedures
- referral arrangements

Individual characteristics

- gender
- ethnicity
- rural and remote residents
- homelessness
- non-opiate users

Service Characteristics

1. The range of treatment and care services

As stated earlier, a fundamental feature of accessibility is the provision of an adequate range and capacity of treatment, care and support services to support the changing needs of the client. An effective range of services will be best designed and delivered when they meet **identified local needs**.

A recent survey of NHS treatment services across the UK showed that a wide range of harm reduction and abstinence oriented interventions is acceptable and available across the UK. However, their availability was limited by a combination of practical, economic, safety and theoretical considerations (Rosenberg 2002, Type 3). There is often a mismatch between what is appropriate and what is available.

A survey of NHS treatment services for opiate users carried out by Aberdeen University in 2001/2002 shows that the availability of different types of pharmacological treatments for drug users varies across Scotland (Cameron 2002, Type 3). This may, at least in part, reflect the different needs of local populations. Psychological approaches, psychosocial approaches and alternative therapies were also available in some areas, usually provided opportunistically by a member of the addictions team who was trained in a specific therapy. A summary of the results from this survey is available in Appendix 5.

Research shows that a **range of health and social interventions** may work but the outcome often depends on the individual getting **the right treatment at the right time**. Most drug users will require treatment, care and support from more than one type of service depending upon their drug of choice and their other health and social needs. For example, detoxification followed by relapse prevention, methadone maintenance accompanied by counselling, or symptomatic relief with cognitive behavioural therapy (CBT).

There is also good evidence for the **cost effectiveness** of treatment interventions. The National Treatment Outcome Study

An international systematic review examining the effectiveness of drug treatment suggests (Simoens 2002, Type 1):

- the effectiveness of methadone, buprenorphine and LAAM for community maintenance has been well established
- methadone, clonidine, lofexidine, and naltrexone can all be effective in the management of opiate withdrawal
- retention in treatment and length of treatment are associated with positive outcomes.
- programmes that include psychological and psychosocial interventions are most effective

A summary of the results is in Appendix 6.

(NTORs) in England estimates that for every £1 spent on treatment, there is a £3 saving on criminal justice costs (NTORS, Type 3). In particular, NTORs clearly demonstrates the high levels of criminal involvement by drug users before entering treatment. Further information and results from NTORs can be downloaded at www.ntors.org.uk. However, such economic analyses in the drugs field are often partial. They do not account for the increased quality of life for the users and their carers, nor the wider social benefits for the community. As well as 'cost effectiveness' the NTORS study has demonstrated a range of positive outcomes for drug users.

The Outcomes Pilot Study, conducted at five drug treatment services across Scotland in 1998/1999, demonstrated a range of positive outcomes for those retained in treatment after just three months (Galbraith 2001, Type 3). These included: a movement away from illicit to prescribed drug use, reduced injecting and sharing, improvements in physical and mental health, reduced criminal activity and improvements in relationships. The study also found:

- 60% of clients were no longer in contact with services three months after initial contact
- 84% of those who were no longer in contact were defaults (i.e. not turning up for appointments)
- 40% of all clients made only one contact with services, highlighting the importance of a positive first contact at drug services.

It is worth noting, however, that loss of contact after one visit may not necessarily be negative. A one-off contact be sufficient to resolve the client's problems. A follow-up to this study is now looking at reasons for presenting for treatment, expectations of agencies and motivations in relation to drug use in order to better understand reasons for retention in or drop out from treatment.

Research shows, however, that **more than one treatment episode** is frequently required. Services must be able to meet different types and levels of need that an individual may have as he/she progresses through treatment. This is an important consideration when planning and delivering services.

There are a **number of predictors** that highlight when long-term, or multiple, treatment episodes may be required (Brewer 1998, Type 1). Some of these predictors should be evident at the assessment stage and considered when planning treatment for an individual:

- high levels of pre-treatment drug use
- prior treatment for opiate addiction
- no prior abstinence from opiates
- abstinence or light use of alcohol
- depression
- high levels of stress
- unemployment or employment problems
- association with drug misusing peers
- short length of treatment
- leaving treatment prior to completion

As stated earlier, at initial assessment and when steps have been made towards recovery or stabilisation, a **whole range of other needs** may become apparent.

The range of services also needs to offer the possibility for individuals to move on to another, appropriate service when they have made progress. Further, the possibility of relapse is a concern. Users commonly feel that support is weighted towards the beginning of the recovery process, jeopardising this process in the long-term (McIntosh 2001, Type 3). The EIU Moving On review highlighted that clients who have moved on to employment needed on-going support to cope with the transition in their lives (EIU 2001, Type 2/3).

The Effective Interventions Unit 'Moving On' report (2001) highlights that employment and training can aid the **process of recovery** from substance misuse.

Qualitative research in Scotland (McIntosh 2001) emphasised the role that employment and other social activities can play in **helping fill the 'void'** left by drug use, and help break away from drug using peers.

Delivering this range of health and social interventions commonly requires **effective joint working** across agencies including specialist drug services, generic health, mental health, social work, criminal justice and housing services among others. There is evidence of good practice in partnership building across Scotland. For example, the New Futures Fund projects appear to have played a pivotal role in building partnerships between drug services and education, training and employment services (LRDP 2002, Type 3).

2. Client awareness and perceptions of services

One of the barriers to accessing services is **lack of knowledge** among potential clients of the services available to them and how to access them (EIU Working Group 2001, Type 5). Some drug users will have limited knowledge about the types and range of services available in their area. A number of drug users refer themselves to services and, if they have unrealistic or false expectations of what those services can provide for them, it could lead to a future reluctance to attend any service and potentially treatment failure.

Word of mouth appears to be an important way in which **opiate users** hear about services and make decisions about whether to approach them (EIU consultation workshops 2001, Type 5). However, qualitative research conducted with stimulant users in Scotland suggests that this may not be a key source of information for them (SDF 2002, Type 4). In general, primary **stimulant users** have a different profile. In particular, they are more likely to be employed and have social networks outwith other stimulant users.

Services need to consider **how best to target information** at the groups their service is designed for. In particular services need to be clear to their target audiences about key aspects of their provision. There are examples of how this has been achieved in Scotland. For example, in Argyll and Clyde a handbook has been prepared which includes details of the range of treatment, care and support services and prevention interventions in the area. It also includes information on the local drugs strategy and the list of priorities in the area. This is available at: www.show.scot.nhs.uk/achb/NHSA&C/adat/handbook%20sections.htm

Most of all, services need to be clear about **how the service can be accessed** (EIU Working Group 2001, Type 5). For example, they need to be clear about whether individuals can refer themselves to the service, or whether they need to access the service through someone else e.g. primary care.

The **perceptions** clients hold about services will also influence the extent to which they are accessed and when they are accessed. The credibility and knowledge of support agencies and their associated 'image' were highlighted as key factors in engaging with users in the EIU Moving On review and by the EIU Working Group (EIU 2001, Type 2/3; EIU Working Group 2001, Type 5).

3. Location of services

Research carried out to obtain the views of clients about the barriers to accessing services in England shows that the location of services is a **major barrier** (Audit Commission 2002). Public transport can be a real difficulty, particularly in more rural areas. Further, the cost of transport may exacerbate these difficulties. In the research conducted by the Audit Commission, one study area issued transport passes to their clients. The service users' focus groups suggested that once participants knew where the nearest specialist addiction service was located, they would approach this service first (SDF 2002, Type 4). However, this did pose problems in rural areas because services were sometimes difficult and expensive to get to.

In some areas **mobile services and outreach work** have been organised to tackle some of the difficulties posed by locating a service centrally. For example, there are a variety of ways in which needle exchange facilities are provided, including static services, mobile units and backpacking. This range of methods of distributing injecting equipment may reach injectors early in their injecting careers as well as users who would not normally access traditional needle exchange facilities.

A number of areas in Scotland offer outreach needle exchange services. Some of these services are targeted specifically at hard to reach drug users groups; for example drug users living in rural areas and homeless drug users.

The extent to which **out of area referrals** for residential rehabilitation are made is variable across Scotland (Cameron 2002, Type 3). This survey of NHS services for opiate users suggests that there are about 250 NHS out of area referrals for substance misuse each year in Scotland, mostly for residential detoxification. It should be noted that these figures also include alcohol misuse in some areas. Out of area referrals were commonly made when local services had been exhausted and the referral had the support of the clinician responsible for addictions. It is worth noting that the evidence base on the effectiveness of residential rehabilitation is not as strong as for community based interventions for opiate use (Simeons 2002, Type 1). Further research on the effectiveness of residential rehabilitation approaches is required.

4. Opening times of services

For many people it is difficult, if not impossible, to organise attendance at a service at a set time. **Individuals who have children** may have particular problems because of school hours or childcare responsibilities. Services need to be flexible in their opening times to allow these individuals to access services at times convenient to them.

It is also important to consider when **specific groups** of users can best attend. There is evidence to suggest that the majority of primary stimulant users are in employment and would find it hard to attend during normal office hours. This is also the case with steroid users. So, services to cater for these groups should be accessible out-with standard working hours.

Further, as an individual makes **progress towards recovery** it may be appropriate and useful for them to attend an employability project, attend training, undertake voluntary work or indeed enter employment. If individuals still require support from a treatment provider (e.g. for methadone) opening times need to be flexible enough to accommodate the needs of the client at that stage in their recovery.

Some services across Scotland offer evening sessions and a small number offer 24 hour access to maximise their contact with drug users. For example, a service for steroid users in Dundee operates in the evening to accommodate the majority of their clients who work during the day. The Glasgow Drug Crisis Centre offers a 24 hour drop-in service that includes a needle exchange, a one stop service and residential rehabilitation.

5. Waiting times

One of the keys to a successful outcome from treatment is a **prompt and appropriate response** when an individual seeks help. Lengthy waits are demotivating and discourage entry into treatment. (National Treatment Agency 2002, Type 3; EIU Working Group 2001, Type 5).

Waiting times for **access to drug services** is a problem across Scotland and the wider UK for both drug users and for service providers across health, social work and voluntary agencies. (EIU Working Group 2001 Type 5; SDF 2002, Type 4). Information from DAT Corporate Action Plans indicates that there are **wide variations** in waiting times for clients seeking help with drug problems, from a matter of days to several months. For drug users, long delays for and during assessment, delays following the initial assessment, and delays in referral cause frustration and may lead to reduced motivation. For services, lengthy waiting times have a demoralising effect on staff who can feel constantly under pressure. They may also feel that their performance is judged solely in this one area.

I was made to go for weeks...one day a week for assessment. You just became despondent. They were trying to see if you were motivated. But you saw people come and go in the time you were there and you were just like - when do I get my turn?... It was murder.

SDF Focus Group Respondent 2002

The length of waiting times can be due to a **number of factors**. Work on waiting times by the National Treatment Agency (NTA) and by the EIU Working Group in Scotland suggest that the following factors are the main causes of the problem with waiting times:

- availability of services does not meet demand
- capacity within and across services does not meet demand
- assessment procedures are numerous and variable, leading to delays
- treatment regimes are not flexible enough
- workforce constraints (in particular too few skilled staff)
- joint working arrangements could be better developed (referral / discharge procedures)
- criminal justice initiatives (e.g. DTTOs, drug courts) increase demand on services
- there is an increase in client demand at services with good outcome records

Sustaining the client's motivation to enter a service can be difficult when there is a waiting time. A number of interventions have been tried to **minimise drop-out** from waiting lists. However, evidence of their effectiveness is scarce. A randomised controlled trial to evaluate the effectiveness of a motivational intervention to reduce drop out from publicly funded treatment waiting lists in the United States did not enhance treatment entry, completion or outcome among treatment-seeking client (Donovan 2001, Type 3). The authors suggested that alternative strategies such as contingency management and case management may help. However, this is unlikely to be as effective as providing direct access to services.

A study which examined the relationship between waiting times and outcomes of over 2000 clients in Warwickshire between 1983 and 1998 clearly demonstrated that those who completed treatment **waited less time** (on average) between assessment and admission than those who did not complete treatment (Georgakis 1999, Type 3).

The Warwickshire Study showed that those who completed treatment waited 15.6 days on average for treatment between assessment and admission compared to non-completers who averaged 19.4 days on the waiting list. (Georgakis 1999)

There are some management processes that (while put in place for good reason) may contribute to increased waiting times. For example, some substitute prescribing services require that the majority of their clients are on supervised consumption regimes. There can be requirements for weekly drug tests or regular meetings with key workers. For some clients and for a period of time, these conditions are entirely appropriate. However, **universal application** may be costly and will reduce the number of clients who can be treated by that service. Further, if regular reviews are not carried out, the continuation of the practice for individuals whose needs are largely met may prevent others from entering the service. This can lead to long waiting lists, increased waiting times and high priority clients struggling to get the support that they need. It may also have a negative impact on clients who are ready to move on to another stage in the rehabilitation process.

The NTA Guidelines 'Making the System Work' (NTA 2002) highlight that **working practices and joint working arrangements** are particularly important in tackling waiting lists. Some services in Scotland operate a duty system so clients do not have to wait for a first appointment. Other services have learnt through experience that referral to another provider may be more appropriate than further care in their service after stabilisation has occurred. Research conducted for the EIU Moving On report suggested that many treatment services were reluctant to 'let go' of their clients, even when they had been stabilised and were (at least in some cases) ready to progress to the next stage of rehabilitation (EIU 2001, Type 2/3).

There may also be problems with **managing non-attendance**. This will in turn increase the waiting times for others if the appointment cannot be allocated to another client. In some cases, the appointment systems are not designed to reflect the needs and lifestyle of the clients who have serious drug problems. To overcome this difficulty, some services operate on a drop-in or a one-stop model.

The EIU Working Groups and service users' focus groups highlight the problems associated with allocating priority to those on waiting lists. In particular, **drug users' perceptions** of what they need to do, or be assessed as, to be prioritised for treatment and care. There is a general consensus among users that you need to be referred through the criminal justice system, or be injecting to stand any chance of prioritisation.

A study was commissioned by NTA in 2002 to examine waiting time strategies in 4 DAT areas with zero to low waiting times. They shared a number of similarities:

- spread existing resources further
- use new approaches and interventions
- utilise new information systems and technology
- improve the integration of local services
- manage the movement of clients through the drug treatment system and minimize unnecessary delays
- keep services open for longer and later
- increase performance in the key areas of assessment, dosing, and care management procedures.

Annex 3A sets out a three-stage approach to addressing waiting times.

6. Staff

Staff will play a **crucial role** in attracting and retaining drug users in services. For drug users, staff members are the 'face' of the service. Staff members have a clear role in promoting the credibility and image of the service. Further, their attitude at first contact is likely to have a significant influence on whether the drug user will continue to attend (EIU Working Group, Type 5).

Currently there seems to be a national problem with recruiting and retaining staff in the substance misuse field in Scotland and the wider UK. A UK wide mapping exercise of the drug and alcohol sector conducted by Healthworks UK found that many staff working with users were well qualified, but their qualifications were not specific to the work they were undertaking (Healthworks 2001, Type 3). Recent developments in the criminal justice sector (e.g. DTTOs) offering offenders referral to treatment services have increased demand for services and, consequently, on staffing. The Executive is working with Drug Action Teams to identify and resolve staffing issues.

When qualified staff are in post, they need **support networks and supervision** to help them to reflect on their professional practice and provide support in dealing with difficult situations. Staff also need effective management support to help them manage their case loads and to access and undertake continuing professional development (EIU consultation workshops 2001, Type 5). Finally, administrative support is crucial to support the work of professional staff to ensure they are able to spend their time on the professional tasks they are qualified to practice.

Training is the key to ensuring that staff members have the opportunity to maintain and improve their skills and gain new competencies. In the context of integrated care services, there is a particular value in multi-agency training to promote and encourage mutual understanding of the role and working practices of other service providers. Access to appropriate services can be reduced because staff members do not know where to direct clients when they might benefit from another service or be ready to progress.

STRADA now provides training in a number of aspects of drug misuse and treatment for staff in a range of agencies. More detail is set out in Appendix 7.

7. Assessment

The assessment process is a **key factor** in making services accessible. Effective assessment practice can help ensure access to appropriate treatment within a time period that will allow the provider to capitalise on the individuals motivation. The judgement on what is the right treatment approach for an individual will be made largely as a result of the quality of information gained at the initial assessment. This is discussed further in Chapter 4. This Chapter provides information that supports the **design and delivery of effective assessment processes** including examples of assessment tools.

8. Referral arrangements

Strengthening referral and discharge arrangements is key to the provision of integrated care. Referrals to drug services are frequently made by a **wide range of agencies and by drug users themselves**. This reflects the diverse needs of the client group. Arrangements at a local level should ensure that referrals can be easily made by a wide range of care providers including health, housing, employment and criminal justice services.

In some cases, drug users simultaneously attend a number of services either through self-referral or through referral with no apparent co-ordination (Audit Commission 2002, EIU consultation workshops 2001, Type 5). Sometimes service providers will not know that the individual is being seen by other services in the area, or indeed within the same service. The result is **uncoordinated and potentially ineffective** treatment, care and support.

Another problem is reluctance by some service providers to refer their clients onwards. This was one of the **barriers** to helping recovering drug users to move on to training and employment provision identified in the EIU Review “Moving On” (EIU 2002, Type 2 and 4; EIU Working Group Type 5). It can arise from lack of knowledge and confidence among staff about the role of other providers and the services that they can offer.

There must be **effective and efficient referral arrangements** to ensure that individuals get access to services when they need them and their motivation is high. The referral arrangements also need to take into account the individual’s need for support to make the transition.

Individual Characteristics

1. Gender

Women make up one third (32%) of the drug treatment population in Scotland (Scottish Drugs Misuse Database 2000/01). Difficulties in accessing services may mean, however, that women are **under-represented** in treatment. The experience of drug addiction appears to be different for men and women. For example, women who have problems with drug use are more likely than men to have a substance misusing partner and to have experienced domestic violence (Gilbert 2000, Type 3; Powis 2000, Type 3). Other difficulties may include: a history of sexual abuse (Wallen 1992, Type 3); low self-esteem and poor emotional health (Swift 1996, Type 3; Gilchrist 2002, Type 3); and the greater stigma attached to drug use among women.

Strategies to improve accessibility of services must take into account the **particular experiences and circumstances of women**. Barriers to entering treatment may be real or they may be perceived. Services may be perceived as being male orientated (if more men than women attend), or women may simply be unaware of the services that exist. In response, active recruitment and outreach can encourage women into treatment. Even when women do engage with treatment services, they may not sustain attendance, thereby reducing the chance of a successful outcome. Further, the design and delivery of services needs to take account of women’s roles and responsibilities as mothers. While having children can be an important influence in the decision to seek treatment, child care or family commitments can act as a barrier to accessing services. A lack of **child care provision within services** can be a very real barrier to accessing treatment services. Providing child care facilities can increase attendance (Marsh 2000, Type 3). Whilst women are more likely to have child care responsibilities, it should be recognised that child care may also be an issue for male drug users.

For drug using mothers, the fear of their children being taken into care can present a psychological barrier to approaching services (Allen 1995, Type 3). Providing women with information can assist in overcoming their fears and drawing them into services. Explaining the confidentiality regulations of the agency and the reporting requirements for child abuse and neglect in a way that demonstrates that the worker has the women’s welfare in mind can assist in establishing trust (Kumpfer 1991, Type 3).

Aberlour Childcare Trust provides residential rehabilitation in Glasgow and Edinburgh for women who have a dependency on drugs or alcohol. Their services enable women and their children to stay together during the rehabilitation process.

Being away from their children as a condition of treatment may discourage women from entering residential services (Marsh 1985, Type 3). Allowing women to live with their children during residential drug treatment enhances retention in care, potentially improving the mother/child relationship and post-discharge treatment outcomes (Hughes 1995, Type 3).

An example of this is the Aberlour Childcare Trust residential rehabilitation facilities in Edinburgh and Glasgow. These projects also address the women's personal and social development and provide support to move on to training and employment.

For **women who are pregnant**, access to drug treatment and wider healthcare services, is particularly important. The Women's Reproductive Health Service (WRHS) at Glasgow's Princess Royal Maternity Hospital (formerly based at Glasgow Royal Maternity, Rottenrow) identified a range of barriers to the use of ante-natal services by pregnant drug users (Hepburn 1997, Type 3). Fear of encountering judgmental staff attitudes was often the primary reason for non-attendance. There were other barriers. Women found it difficult to get access to services because of referral procedures. Traditionally access to ante-natal care is by GP referral. There was no opportunity for self-referral. It was difficult to get to services because of distance and time constraints arising from their other responsibilities. Women were also concerned they might be made to have an HIV test and, if positive, be forced to have a termination.

Since 1990 the Women's Reproductive Health Service (WRHS) has provided a city-wide service for women with severe social problems, including drug use. The service's philosophy is one where drug use is recognised as a problem, but women are not condemned for using drugs. Before the service was established, few pregnant women reported drug use and when they did this was commonly late in pregnancy. Now their average booking gestation is the same as the hospital average. Also, the service works alongside social work services.

Women's relationships with their partners also have an impact on their likelihood of approaching services. Research shows that women who have drug problems are more likely to have a substance misusing partner (Lex 1991, Type 3; Powis 2000, Type 3; Pivnick 1994, Type 3). Drug using sexual partners can exert an important influence over women's drug misuse, with most female injectors having been given their first injection by a male sexual partner (Powis 1996, Type 3). As noted previously, they may also have experienced physical violence or sexual abuse. Having a partner who uses drugs decreases readiness to enter treatment (Riehmman 2000, Type 3). Similarly, there is research evidence that women who engage in treatment with, rather than without, their partner have better outcomes (Kim 1994, Type 3).

Base 75 in Glasgow is a drop-in centre for female street workers. They offer harm reduction and other services to women drug users involved in prostitution.

Turnaround project in Glasgow works with female drug users involved in the criminal justice system. Their main areas of work are: arrest referral/court support; prison drug work; and diversion from prosecution.

Some female drug users are involved in criminal activities. **Prostitution** and its associated dangers are of particular concern. This may be another barrier to accessing services. However, there have been some services specifically set up to address the health and social care needs of this group of women, such as Base 75 in Glasgow (see example).

Finally, for those working in drugs services and other agencies, improved inter-agency collaboration and a co-ordinated approach to service delivery should help assist in meeting the diverse and complex needs of women problem drug users (Becker 2002, Type 3).

2. Ethnicity

In 2000/01, only 27 people (0.3%) reported to the Scottish Drug Misuse Database were of ethnic origin other than White. The comparable figure for 1999/00 was 15 (0.2%). This is a lower proportion than the proportion of ethnic minorities in the total Scottish population. Surveillance and surveys suggest that drug use in the UK is more prevalent among white people overall. While this may be the case, there are likely to be substantial numbers of minority ethnic drug users, with geographical variations and differences in the type of drugs used.

Minority ethnic drug users have traditionally been reluctant to access existing services. Service providers must be more sensitive to the needs of minority ethnic groups. This involves providing materials and support in languages other than English, providing services to address the drug of use (e.g. not just opiates) and working with families with different cultural backgrounds and values.

ESHARA is a black and ethnic minorities drug project based at the Gorbals Addiction project in Glasgow. It offers counselling, detoxification, substitute prescribing and access to rehabilitation. The project aims to offer a culturally sensitive approach to dealing with minority ethnic drug users.

Different models of service have been developed and tried across the UK. Some of these are mainstream services with an attached worker to address the specific problems faced by minority ethnic users. In other areas (usually with a high prevalence of use among minority ethnic groups) dedicated services have been developed. Local needs assessment will help to guide decisions about the most appropriate service models.

A national scoping study of drug prevention and drug service delivery to minority ethnic communities conducted in 6 DAT areas in England in 2000/2001 (Sheikh 2001, Type 3) showed that ‘symbols of accessibility’ were important. This means showing explicitly that minority ethnic groups are welcomed by a service, e.g. posters, leaflets, cultural-specific newspapers and magazines (Sangster 2002, Type 3).

However, it was emphasised this was only one aspect of what was required to ensure access to culturally sensitive services. Others include a shift away from delivering services for opiate injectors to the development of services with a holistic, therapeutic and social focus, the importance of ‘cultural competence’ and gearing mainstream service towards meeting the needs of diverse minority ethnic groups. The full report is available from the Drug Prevention Advisory Service (DPAS Paper 16), or at:

www.drugs.gov.uk/ReportsandPublications/Communities/Blackminorityethniccommunities

3. Residents in rural and remote areas

Drug users who live in rural and remote areas encounter a **number of problems**, some of which are covered in the earlier section on the location of services. In recent years, the increasing problem of rural deprivation and the associated problems of drug use have been recognised (Scottish Executive 2001). Inadequate and expensive public transport, lack of training and employment opportunities and limited childcare provision are all features of rural deprivation. People with substance misuse problems were identified as one of the groups most affected by poverty and social exclusion in the 2001 report. In particular, there is a problem for people with substance misuse problems in reintegrating into the community.

There are a number of factors that affect accessibility for people in rural areas. The **range of accessible and available services** is often a problem. Very few rural areas seem to have carried out an adequate or accurate assessment to establish the real scale of the problem. National databases record activity of existing services that are largely urban based. Opiate use may not be the main problem. There is some anecdotal evidence that there is more opportunistic drug use (e.g. of manufactured substances such as amphetamines or readily “found” substances such as veterinary preparations).

There has also been an assumption in the past that people from rural areas would travel to the nearest town (as a ‘hub’). This may happen in ‘dormitory’ areas, but there is evidence that many people will not travel to get services (EIU Working Group 2001, Type 5). Sparse populations, long distances to travel and in some cases long standing rivalries between towns and villages mean that the characteristics of the services and who provides them may differ from those in urban centres.

There are frequently **problems maintaining anonymity** in small communities (EIU Working Group 2001, Type 5). There is little or no evidence to support the assertion that there is more mutual support and assistance within rural communities. The difficulties of disproportionately

low levels of confidentiality and high levels of stigma require that substantial efforts be made to engage with communities and improve understanding of the nature of drug problems and their impact.

Different service models can be used to tackle the problems specific to rural areas including home visits and mobile units. Outreach workers in particular can be used to good effect to provide services such as needle exchange, methadone maintenance and home detoxification. Alternatively, premises are found that can function as satellites to the central static sites that will inevitably be difficult for rural users to access. Research has shown that even city-based users were unlikely to travel more than a mile to access needle exchanges (Stimson 1988).

In one area of Scotland the home detoxification of opiate and amphetamine users has been very successfully combined with the already well proven home detoxification of people with alcohol problems. The service consists of short-term, high intensity support from Community Psychiatric Nurses with appropriate prescribing from the General Practitioner. Its success appears to be dependent on a high level of communication between themselves, the inpatient detoxification service and the various drug agencies as to what and when is the most appropriate form of after care and support.

4. Homelessness

In 2000/01, 2.7% of all 'new problem drug users' in contact with services reported to the Scottish Drug Misuse Database had a living situation described as of 'no fixed abode'. The comparable figure in 1999/00 was 3.1%. However, this excludes individuals who are living in insecure or temporary accommodation. Further, the homeless population are probably less likely than the drug using population as a whole to access services.

Homelessness and the problems associated with insecure accommodation appear to be very common among the drug using population. A review of the Rough Sleepers Initiative in Glasgow suggests that about half of rough sleepers between the age of 25-34 years and about one third of rough sleepers between the ages of 16-24 years were dependent on heroin (SWSI 2001). Similarly, a study of 200 drug users in Glasgow and Dundee demonstrated that approximately **one third** (32%) were currently homeless and **two-thirds** (68%) had experienced homelessness at some stage (Neale 1999, Type 3).

A report on street homelessness in Glasgow by the Homelessness Task Force emphasised the need to deal with drug problems and wider health and social problems alongside homelessness. The report identified the **barriers** faced by homeless people when seeking health care (Scottish Executive 2000):

- a poor reception and inadequate treatment at accident and emergency departments
- difficulty in registering and continuing to access general practitioners
- negative self image and lack of self esteem result in a lack of confidence to access services
- difficulty in tackling health problems when living in poor accommodation and with a lack of social support

Further work to review the causes and nature of homelessness in Scotland, to examine current practice in dealing with cases of homelessness and to make recommendations on how homelessness can best be prevented and tackled is underway. For further information please see their home page at <http://www.scotland.gov.uk/homelessness/>

These and other **barriers** are also highlighted by the Scottish Executive's Health and Homeless Guidance (2001). The purpose of this Guidance is to emphasise the importance of delivering on the target to end the need for people to sleep rough, and on the broader aim of delivering services to people whose life circumstances affect their access to care. A full copy of the guidance is at: <http://www.scotland.gov.uk/library3/health/hahg-00.asp>.

The guidance highlights the following:

- the criteria for accessing a service can be a barrier e.g. requirement to be drug or alcohol free
- unwillingness of some GPs to prescribe for homeless drug users due to fear of overdose and safe storage of substitute medication
- mobility of the homeless population means they may frequently move away from the area where they are registered with a GP

Overall, the research evidence points to the need for an **integrated strategy** of addressing the broader reasons for the homeless situation and drug use (though of course these can sometimes be difficult to disentangle). A study of good practice with homeless drug users suggests that there are a number of key elements that promote good practice (Kennedy 2001, Type 3). These include:

- devoting time and resources to ensuring easy access
- devoting time to establishing trust
- tailoring support to an individual's needs
- incorporating users views into service design and delivery

A number of service models have been developed to address the needs of homeless people, many of whom are drug users. These include one-stop services and outreach work. These services are commonly provided by a partnership of statutory and voluntary providers. Frequently these services offer a range of provision including: community care and supported housing assessments, housing advice, access to primary health care teams and drug and alcohol workers and advice on temporary accommodation.

The Access Point (TAP) in Edinburgh is a one-stop service providing housing, health and social work services for vulnerable homeless people. Some outreach work is also undertaken by the TAP team.

'Under One Roof' in London is a one stop-service run by a partnership of 30 statutory and voluntary agencies. The service delivers interventions to vulnerable young sleepers in two areas.

5. Non-opiate use

Research shows that the socio-demographic profiles of non-opiate users can be different from opiate users, and that a range of support and treatment must be available to address the diverse needs of this group. However, there is likely to be a substantial proportion of stimulant users who are also opiate users. A recent report from the Psychostimulants Working Group in Scotland established by the Scottish Advisory Committee on Drug Misuse (SACDM) in 2001 suggests that there are four main categories of stimulant users, each with their own set of needs (Scottish Executive 2002):

- youthful experimenters
- regular stimulant users
- problematic stimulant users
- opiate / stimulant co-users

It is clear from both the research literature and the service users' focus groups (SDF 2002, Type 4) that stimulant drug users perceive existing drug services to be the **domain of opiate users**. This affects the perceived accessibility of services for non-opiate users. In the case of opiate users who also use stimulants, this can mean that only their opiate use is being addressed by

services. It is clear that decisions on how to re-configure or redesign services to meet the need of stimulant drug users should be based on local needs assessments among non-opiate users and co-users.

Overall, there is limited evidence about the effectiveness of drug services designed to meet the needs of **non-opiate users**, and in particular stimulant users (crack, cocaine, amphetamine, ecstasy). However, a combination of pharmacological (in the main symptomatic relief) and psychological / psychosocial interventions is likely to be appropriate. In particular, evidence on the use of psychological and psychosocial interventions among stimulant users appears promising (Scottish Executive 2002). However, availability of these services and interventions for stimulant users is currently limited.

The full report of the PSWG can be downloaded at:

http://www.drugmisuse.isdscotland.org/publications/abstracts/sac_psycho_report.htm

Remember Harry?

The character of Harry was introduced in Chapter 2. The pathway overleaf shows what happens to Harry when he tries to access services for his problems with drug misuse, but is unaware of the services available locally.

Accessibility Pathway

This outline Integrated Care Pathway is designed to assist all agencies in developing a local multi-agency strategy to maximise the accessibility of services in their area.

Processes

Outcomes

Harry is trying to come off drugs, but is unaware what services are available to help him. He is also unemployed and has housing problems. He has a sympathetic GP.

A range of services is available. Information about local service providers is available.

Harry picks up a copy of the local directory of service providers for drug users from his local library.

What services/providers are best for me?

Some factors to consider

- Distance to travel
- Opening times
- Who the service is designed for
- Special arrangements

In consultation with his GP, Harry identifies the service(s) he wants and the service provider he feels would best meet his needs at this time.

Service providers should have clear referral protocols and procedures that are available to clients and other agencies.

Harry's GP makes arrangements for him to attend the selected specialist drug service.

Can I just go there or does my doctor have to refer me?

When will I be seen?
Who will I see?
What will happen?

Service providers should supply new clients with information about their first appointment, including the name of the person who will see them and what to expect from the first visit.

Harry attends his first appointment, after receiving information about when to attend, who he will see, what it will involve, and confirmation that he can take his partner along with him.



KEY PRINCIPLES AND ELEMENTS OF EFFECTIVE PRACTICE: ACCESSIBILITY

From our review of the evidence, we have identified the following key principles and elements of practice to help improve accessibility to integrated drug services. These are rarely one-off exercises, but rather they are cyclical, or become an integral part of service development and review. From our consultation work and EIU working groups, it is evident that some of these principles have been, or are being, applied in some areas of Scotland.

1. Establish the need for services in the area.

This is usually achieved by conducting a local needs assessment. The key principles and elements of needs assessment are set out in Annex 3B. Conducting a local needs assessment will help to establish the extent and nature of the drug problem in the area, to describe the socio-demographic profile of users and to examine the common referral routes. This will help build a picture of area population need. The results of the needs assessment should be written up and distributed to all key stakeholders. **A guide on how to conduct needs assessment (specific to the Scottish context) will be produced by the EIU early in 2003.**

2. Review the appropriateness, accessibility and capacity of the existing range of services.

This involves taking a systematic look at the current service profile including both specialist and generic services, and statutory and voluntary agencies. To conduct this review DATs will need to complete a number of activities including a mapping exercise of current provision, (in particular the characteristics and capacity of services) and identifying the relative roles and relationships between service providers. For more information, please see Annex 3B.

3. Establish whether the existing range of services meets the need identified in the assessment exercise.

It is important to examine whether the capacity of both specialist and generic services is sufficient. Further it will be important to assess whether the interventions and services delivered do indeed meet the needs of the local drug using population, and that they are accessible. This is sometimes called a 'gap' analysis. For more information, please see Annex 3B.

4. Ensure that the range and capacity of services and joint working is adequate.

If gaps in service provision are highlighted, DATs need to consider how these gaps can best be addressed. This may be achieved by developing more effective multi-agency working, making adjustments to service characteristics and developing new approaches (such as outreach) to meet the needs of the local drug using population, including the harder to reach groups. For more information, please see Annex 3B.

5. Establish clear arrangements for joint working between agencies to facilitate an integrated approach to providing health and social care services.

This includes working with other specialist services and generic services such as mental health, housing services, employment services and youth services. In rural areas, partnerships with generic services may be particularly important. This will be aided by:

- ✓ developing shared screening and assessment tools and procedures across partner agencies (also see Chapter 4)

- ✓ developing referral protocols and procedures for use by all staff.
- ✓ developing joint training for workers across partnership agencies, both at strategic and operational level.
- ✓ using other training approaches such as work-shadowing and mini-presentations about the services offered.

6. Develop more effective assessment processes.

Existing knowledge about the client should be used to avoid duplication of effort by agencies and service providers and frustration for the client. Key tasks are:

- ✓ development of single, core assessment information to be shared by relevant agencies to reduce the number of reassessments that are required.
- ✓ use of a consent statement that allows agencies to share information about the client across their partner agencies (see Chapter 6).

7. Produce and make widely available clear and concise information about services.

It is important for clients to know about the range of services in their area and how to access them. It is equally important that other service providers also know about the range of services available in order to ensure appropriate referrals.

- ✓ draw together information about services in your area for potential service users, service users, families of drug users and other service providers.
- ✓ identify the most appropriate techniques for making information available to both clients and service providers. The material should be designed and adapted for each of its target audiences and say clearly:
 - who the service is most suitable for (and who it is not suitable for)
 - what the service offers (and what it does not offer)
 - what clients can expect on arrival at the service
 - whether clients can bring someone with them
- ✓ Service users and service providers should be consulted on the design and content.

8. Provide a variety of access points and times.

It should be possible for service providers to take into account the previous progress of clients who have dropped out or relapsed and for clients to enter or re-enter treatment at an appropriate stage. Going back to the beginning of a care process can be demoralising and counter-productive for both staff and clients.

- ✓ arrangements should be in place to ensure that individuals do not go back to the beginning of the care process.
- ✓ assessment should build on existing information held on the client, rather than start from the beginning again.
- ✓ develop more flexible discharge arrangements.

9. Employ staff with appropriate skills, attitudes, training and qualifications.

It is clear that staff need (in most cases) to have well developed skills and competencies in their own areas of knowledge and expertise, but also to have knowledge of the range of provision available and how it can be accessed. Further:

- ✓ staff should be encouraged to build on existing training and qualifications (e.g. through STRADA training modules).
- ✓ staff members need to be trained in the assessment processes, referral mechanisms and joint working arrangements that characterise integrated care.

10. Clear information sharing protocols.

Clear information sharing protocols should be developed and explained to clients approaching service providers for help. This may be especially important for particular groups, for example female drug users with children who may have concerns regarding child protection issues. Chapter 6 on Information Sharing provides guidance on:

- ✓ inter-agency information sharing protocols.
- ✓ provision of information to clients/service users.
- ✓ informed client consent to the sharing of their personal information.

11. Involve family members.

It is good practice to involve family members and close friends in the care of the user. The research evidence points to the benefits of including significant others in treatment and care. Family members can also be pivotal in securing access to service for drug users.

- ✓ as part of the assessment process, it will be important to assess the level of potential support the individual is likely to receive from family members.
- ✓ it will also be important to assess the extent to which family members should be involved in delivering treatment, care and support to the individual.
- ✓ it will be important to be clear about where family members can get help and advice if they require it. There is a growing number of family support groups developing across Scotland.

12. Address negative community attitudes.

DATs and partner agencies should find ways to engage with communities and improve understanding of the nature of drug problems and their impact. This may ease the stigma associated with drug use, particularly in rural areas and help the development of services in the area. For further information see the EIU Guide to Community Engagement at http://www.drugmisuse.isdscotland.org/goodpractice/EIU_commeng.pdf. Further, the Scottish Drugs Forum have a remit for developing community engagement in the drugs field. For further information please contact them on 0141 221 1175 or go to <http://www.sdf.org.uk>.

- ✓ DATs should develop a community engagement strategy for their area. This involves being clear about the definition of 'community', the level of engagement they are aiming for and the techniques they may use to achieve this.
- ✓ the strategy should probably include plans to support user groups and family support groups in the area to help empower these individuals and help reduce community stigma.
- ✓ as with all strategies, this should be revisited and reviewed periodically.

13. Periodically undertake needs assessments and review the integrated care process and its effect on accessibility.

Regular reviews of these arrangements and procedures will help to identify if improvements can be made and to build on success. This will include:

- ✓ revisiting and updating the needs assessment exercise described earlier in this section and in Annex 3B.
- ✓ revisiting the analysis of current need compared to the profile of service provision.
- ✓ reviewing the effectiveness of joint working arrangements, assessment processes and referral procedures.

A THREE-STAGE APPROACH TO ADDRESSING WAITING TIMES

This Annex sets out a **three-stage approach to addressing waiting times**:

- **Minimising Waiting Times (Stage 1)** focuses on the development of systems to ensure that clients are directed to the most appropriate services as quickly and effectively as possible. It involves streamlining administrative systems to maximise the use of practitioners' time.
- **Managing Waiting Lists (Stage 2)** comes into effect when clients are having to wait for an unacceptable length of time for care and treatment. This stage requires that cases be prioritised and that steps are taken to ensure that the health and well-being of clients waiting for services is not put at risk.
- **Developing Contingency Plans (Stage 3)** would be initiated when the ability of the service provider(s) to see new referrals is compromised as a result of waiting times.

Included at each Stage are **key action points at client, agency/service provider and integrated services level**, adapted from the National Treatment Agency paper "Making the System Work" (NTA 2002).

This Annex also sets out information on the **monitoring of waiting times** and details of current **waiting times research**.

1. Minimising Waiting Times

Traditional approaches to improving access to services and reducing waiting times have focused on creating additional capacity within agencies. However, there is increasing awareness and acceptance of the role of service planners and referring partners in managing demand for services and improving the overall experience of the integrated care process.

From the information collected we have identified the following approaches to minimising waiting times:

- joint planning
- improving referral patterns
- appointments and bookings
- re-assessment
- triage and re-distribution
- communicating good practice
- managing resources to meet need

Joint planning

It is increasingly clear that effective management of capacity and demand must be carried out as a joint responsibility between services: for example, between primary and secondary care in health and across services such as health, social work and housing. As is often said "If we always do what we've always done we'll always get what we've always got" (NHS Modernisation Agency, Type 3). In order to reduce delays and improve access, systems need to be re-designed to improve waiting times.

In the health field, there is increasing awareness and acceptance of the role of primary care in managing demand for secondary care services. The work of the National Primary Care Development Team (NHS Modernisation Agency 2002, Type 3) goes one step further and introduces the concept of primary care managing a specified level of capacity of secondary care for their local population. This involves establishing a system of capacity and demand management which forms the central core of a range of activities that can be undertaken jointly between primary care and secondary care, to improve access to routine services.

Improve referral patterns

Statistics from the Scottish Drug Misuse Database, 2000/01, show the most common sources of referral to drug services to be GP and self (41% and 34% respectively).

The recent developments within the criminal justice system: Drug Treatment and Testing Orders, drug courts, arrest referral schemes and the Scottish Prison Service transitional care arrangements will have to be reflected in agreements at local level on the criteria and processes of referral. This should ensure:

- access to the right service
- core information for the assessment process

There are, at present, no specific questions on referrals from arrest referral schemes, DTTOs etc. on the Scottish Drug Misuse Database. It would, however, be possible to adapt the system to pick up this additional detail in future.

Service providers require a shared knowledge of where to refer someone on to, depending on their presenting need(s). Individuals wishing to refer themselves to a particular service will require up-to-date knowledge of what services exist in their locality and what the remit for a service is. This information will assist the individual to identify and approach the most appropriate service provider for them.

The referral process should promote accessibility to services at a time when they are needed. It depends on joined-up working between agencies. The process would be aided by:

- a directory of local services
- a referral form designed around the core data sets outlined in Chapter 4
- clear sign-posting information on services including 'Client Information Leaflets' and active outreach work

Appointments and bookings

Service providers and service users have stated that appointment systems are not always designed to reflect the needs and lifestyle of the clients who have serious drug misuse problems (EIU consultation workshops 2001, Type 5; SDF 2002, Type 4). There may also be problems with managing non-attendance in ways that increase the waiting times for others if the appointment cannot be allocated to another client. Service providers suggested that the provision of a number of community-based satellite points, with opening hours that reflect the needs of the client group rather than the needs of the service, would reduce non-attendance (EIU Consultation Workshops 2001, Type 5).

Auditing non-attendance patterns at service provider level can help to identify indicators associated with non-attendance. A study by North and East Devon Health Authority on patient, hospital, and general practitioner characteristics associated with non-attendance examined a cohort of 1972 referrals from 26 general practitioners, with complete follow-up (Hamilton 2000, Type 3). Five factors were found to be significantly associated with non-attendance: male sex; younger age; longer interval between referral and appointment; higher Jarman (Deprivation indicator) score and patients of high-referring GPs. Development of strategies to reduce non-attendance is possible using these results.

Re-assessment

The amount of time involved in re-collecting information when clients re-present at services could be reduced by ensuring that assessment processes allow for an update of information, to build on existing knowledge rather than a new assessment to be carried out (see Chapter 4 on Assessment for further information).

Triage and re-distribution

Following assessment it may be beneficial to consider how best the resources of an agency (or agencies) involved in an integrated care network can be employed in delivering the care required for the individual. Rather than “lining clients up” to see a particular person or service provider, the needs of the client may well be met through employing a triage and re-distribution system. Factors to consider in triage and re-distribution include:

- the demand for a service
- the number of service providers who could provide this service
- the current capacity of these service providers
- the preferences of the individual

Communicating good practice

There may be useful approaches to the management of waiting times in other parts of Scotland and from other sectors. In the NHS, later in the year, an on-line good practice guide will showcase examples of good practice (see ‘National Waiting Times Initiative’, in Section 4. ‘Monitoring Waiting Times’). “The database will enable the best possible use of capacity across the NHS in Scotland, help identify and shift bottlenecks and should even out the inconsistencies in waiting times across Scotland” (Mr Malcolm Chisholm MSP, Minister for Health & Community Care).

Managing resources to meet need

Chapter 5 on Planning and Delivery of Care highlights the need for integrated planning of care between service providers in order to ensure that services are in place when the individual needs them. This should ensure that clients waiting to move on to the next phase of their care are not delayed by administrative or resource difficulties. Often this situation has arisen in the past where there has been limited provision of substitute prescribing services outwith the specialist drug services. These service providers become log-jammed and unable to take new referrals.

DATs and partner agencies should develop local protocols aimed at ensuring a seamless transfer of care between service providers. At a service or locality level this will require agreement on:

- referral procedures of participating service providers
- discharge protocols, including those for non-attendance, which recognise the implications for other agencies
- joint transfer planning arrangements.

Key Action Points for Minimising Waiting Times - at Client, Agency/service provider and Integrated services level

Level	Action Point
Client	<p>Produce individual care plans with goals</p> <p>Service providers should:</p> <ul style="list-style-type: none"> • produce individual care plans for, and with, each client. Plans should include and be based on clear and achievable short, medium and longer term goals • review care plans in partnership with clients on a regular basis • develop joint care plans with shared care providers, where involved. All providers should agree and review the care plan with the client.
	<p>Develop discharge plans</p> <p>Providers should include a provisional discharge date in the initial care plan, which reflects the client's goals.</p>
	<p>Develop clear protocols for clients who have defaulted</p> <p>Service providers should:</p> <ul style="list-style-type: none"> • develop clear protocols for early discharge. These should contain possible interim steps to help clients resolve difficulties where possible, and be implemented fairly and consistently • involve any other agency, which is sharing the client's care, in the decision making process e.g. a specialist mental health service sharing the care of a client with dual diagnosis • liaise with the probation officer of clients on a DTTO • involve the key worker and at least one other colleague in making any decision to discharge a client early • allow clients the opportunity to present their case against early discharge • provide clients with information on the service's complaints procedure • provide clients with onward referral to advice, support and harm reduction services and advise clients about when and how they might seek readmission • tell all clients what the discharge protocol is when they are admitted and remind them of it, when and if necessary • carry out an audit of clients who are discharged early.

Level	Action Point
Agency/ Service Provider	<p>Streamline re-assessments</p> <p>Providers should ensure that when a client is re-referred or returns to a service with a view to re-admission, the re-assessment process builds on existing knowledge about the client and does not duplicate information which is already available</p>
	<p>Keep case review focused</p> <p>Providers should:</p> <ul style="list-style-type: none"> • routinely incorporate case reviews into care planning and care management • meet requests for case reviews as quickly as possible - particularly from GPs involved in shared care • focus case reviews on the issue in hand and not involve unnecessary further detailed re-assessment
	<p>Conduct an appointments audit</p> <p>Service providers should:</p> <ul style="list-style-type: none"> • conduct an appointments audit to identify patterns in unattended appointments and to gather client's suggestions on how systems might be improved. The audit should identify how often and why clinical sessions or booked appointments are cancelled by services • review and redesign the appointment system, if required • operate a range of appointment options, if possible. This could include partial and double booking to minimise time loss; drop-in and 'turn-up by' dates for stable clients; evening and weekend sessions for people in work; and appointments at peripatetic sites for clients who have to travel long distances, or who find travel difficult • develop guidelines on what to do when a client fails to attend. Where possible, this should proactively seek to determine why the client did not attend. This, and the client's level of risk, should determine the course of action to be taken
	<p>Manage workforce constraints</p> <p>Service providers, in consultation with joint commissioners, should:</p> <ul style="list-style-type: none"> • assess the administrative workload of practitioners and clinical staff and, where necessary, appoint additional administrative cover. Practitioners and clinicians should not spend time on administrative tasks • ensure that service managers do not carry a clinical caseload. Clinical time lost as a result is likely to be offset by a more efficiently managed service • consider the benefits of new initiatives such as the role of nurse consultants and patient groups directives

Level	Action Point
Integrated Services	<p>Develop evidence-based practice</p> <p>Providers should:</p> <ul style="list-style-type: none"> • develop mechanisms for remaining up-to-date with new and emerging evidence and approved standards of practice - clinical and managerial • provide staff with access to relevant professional journals. Services could consider developing a local ‘journal club’, possibly in partnership with a relevant research organisation • develop internal systems for monitoring practice against approved standards • implement strategies to raise practice standards to approved levels where indicated
	<p>Establish and maintain clinical governance systems</p> <p>NHS service providers should:</p> <ul style="list-style-type: none"> • have in place a governance system for ensuring standards are set and met. This should promote accountable and responsible practice and support continuing quality improvement • ensure that their clinical governance systems interface with those of other health and social care organisations, including Community Mental Health and Primary Care Trusts
	<p>Map local services</p> <p>Whilst DATs, in accordance with existing guidance, should already be aware of the range of local services, this might be complemented by comprehensively mapping the full range, scope, role and client groups served by all local providers</p>
	<p>Provide information on available services to reduce inappropriate Referrals</p> <p>In accordance with existing guidance, providers should ensure that clear, up-to-date information about services:</p> <ul style="list-style-type: none"> • is widely available • is produced in the first languages of key local communities • is delivered through a range of techniques, including help lines (with 24 hour recordings), the internet and printed materials • is designed and adapted for professional and service user audiences. Service users should be consulted on design and content • provides advice on estimated waiting times but encourages clients to attend so that they start to link into the drug treatment system

Level	Action Point
	<p>Develop local common assessment criteria</p> <p>Assessment should serve a clear and common purpose. Providers should:</p> <ul style="list-style-type: none"> • develop common screening and assessment criteria and aim to harmonise their assessment protocols • reach common agreement on the key elements of screening and assessment • implement triage assessment. By receiving referrals from generic providers, standardised triage assessment should ensure only appropriate onward referral to specialist services
	<p>Work with general hospitals to develop local protocol</p> <p>[Action on Waiting Groups¹] and local general hospitals should work together to develop a local protocol for managing drug users admitted to general medical and surgical wards which:</p> <ul style="list-style-type: none"> • reduces the risk of avoidable self-discharge due to ineffective drug treatment prescribing • ensures planned discharge so that specialist drug treatment is maintained
	<p>Develop shared care arrangements with GPs</p> <p>DATs should:</p> <ul style="list-style-type: none"> • work in partnership with LHCCs, and lead the development of shared care arrangements within their localities. This should include responsibility for funding the provision of shared care and ensuring its underpinning in accordance with approved standards
	<p>Develop integrated care for through and aftercare</p> <ul style="list-style-type: none"> • DATs should reflect the importance of through and aftercare services in commissioning plans • Drug treatment specialists should regard generic providers as members of the extended treatment and care team

Source: adapted from the National Treatment Agency (NTA) paper “Making the System Work” (NTA 2002)

¹There is no equivalent in Scotland at present

2. Managing Waiting Lists

Once a client is placed on a waiting list the service provider has a duty of care to ensure that they will receive treatment (Council of Europe 1999).

Allocating priority

For services where there are waiting lists, there may be a case for allocating priority. The EIU Working Groups and the service users' focus groups highlighted the problems associated with allocating priority to those on waiting lists, in particular users' perceptions of what they need to do, or be assessed as doing, to be prioritised for treatment and care. There is a general consensus among service users that you need to be referred through the criminal justice system, or be injecting to stand any chance of prioritisation.

A tool for prioritising waiting lists

If it proves necessary or desirable to allocate priority, agencies should develop clear criteria for allocating such priority and make those criteria known to other partner agencies. Partner agencies should also agree a local protocol for assessing risk where priority is being allocated.

West Sussex Addiction Services have developed a Behavioural Risk Assessment Tool on part of the Enhanced Treatment Outcomes (E.T.O.) Pilots (see Chapter 5). This tool and the guidance notes attached help to ensure that risk is identified in a consistent and measurable way. A copy of this tool is attached at the end of this section.

Client perception

Clients should be actively involved in decisions about their own treatment, care and support. This means that, when they are added to a waiting list, they should be told:

- whether any priority ratings have been applied, and the implications that these have for waiting times guarantees
- how long the waiting list is and what the expected waiting time is likely to be
- what happens if they cannot attend for an offered appointment and they let the service provider know in advance
- what happens if they do not attend an appointment without letting the service provider know in advance
- what happens if they attend for an appointment but are unable to fully participate due to problems with withdrawal or over-sedation

Individuals, in discussion with their keyworker or care co-ordinator, should be able to make informed choices about where they are referred for treatment. There are a number of factors which should be taken into account, including the preferences of the individual, the size of waiting lists for services and the likely waiting times for treatment (accepting that waiting times will be largely determined by priority cases).

The development of such policies may be helped by national standards of what is an acceptable length of wait for each service. Although these policies would then need to be locally determined, depending on the service and the circumstances, as a minimum they should:

- provide for effective risk management by reviewing clinical priorities for clients on the list
- include ways of keeping patients and referrers informed of the current waiting times for specific agencies and services
- if possible, identify alternative treatment options, including the use of different locations and service providers

Maintaining contact

Agencies and service providers will need to ensure that they have strategies in place that will monitor the situation of each person waiting for treatment. The key objectives of this function are:

- monitor the risk of harm from self or other person
- prevent loss of motivation and where possible enhance motivation as a precursor to entering treatment
- ensure the retention of the individual on the waiting list
- provide alternatives as needs change

Key features of a well managed list:

- clear managerial ownership and control
- senior practitioner and managerial leadership
- clear lines of accountability for the management of the list, and clarity in the roles and responsibilities of everyone involved
- integrated IT systems so all waiting lists within a DAT area can be accessed, interpreted and audited consistently
- consistent application of definitions for national reporting and comparisons to ensure equity for all clients
- early warning system in place to identify unacceptably long waiting lists or times
- data protection of clients' information guaranteed
- information provided to clients on position on list and expected waiting time
- information for the public on waiting lists and waiting times

Key Action Points for Managing Waiting Lists - at Client, Agency/service provider and Integrated services level

Level	Action Point
Client	<p>Enhance motivation of clients on waiting lists</p> <p>Providers should work with clients who are waiting for treatment in order to enhance motivation, prevent loss of motivation due to waiting, and improve retention and the effectiveness of treatment</p>
Agency/ Service Provider	<p>Maintain contact with clients on waiting lists</p> <p>Service providers should maintain contact with clients on waiting lists in order to:</p> <ul style="list-style-type: none"> • identify changing need • continue to assess and provide interim support and advice to enable clients to reduce drug related risks whilst waiting for treatment • actively follow-up clients on long waiting lists who have not been in contact for up to two months <p>Providers should not use waiting times to test a client's motivation. It is the responsibility of service providers to help clients remain motivated whilst waiting for treatment</p>
Integrated Services	<p>Establish clear criteria for prioritising clients</p> <p>DATs should:</p> <ul style="list-style-type: none"> • establish clear local criteria for prioritising clients who need treatment. Criteria should be based on a locally agreed protocol for assessing risk to reduce harm, both to self and others. Protocols should state: • the possible outcomes of risk which the protocol aims to reduce or avoid (e.g. overdose, acquisition or transmission of blood borne infections) • who is a priority (e.g. pregnant women and their using partners, prisoners due for release) • which behaviours are priorities (e.g. chaotic drug use, criminal activity) • circumstances that are priorities (e.g. soon to be discharged from hospital) • advise generic services who refer to drug services of the criteria for prioritising clients for assessment

Source: adapted from the National Treatment Agency (NTA) paper "Making the System Work" (NTA 2002)

3. Developing Contingency Plans

The report on waiting times in Scotland by the Auditor General (Audit Scotland 2002) states that it is not acceptable to simply leave a list to grow ever larger; management action is required to ensure that clients do not suffer as a result. Problems such as this need to be actively monitored, and all service providers need to ensure that they have early warning systems and contingency plans in place to identify and manage potential waiting list problems.

Anticipating new demands

Increasing the resource capacity of service providers as a means of reducing waiting times may not necessarily provide the 'breathing space' that workers and service planners may be seeking.

For example, expansion of methadone maintenance treatment (MMT) at Ontario's Centre for Addiction and Mental Health did not result in a drop in demand for the clinic-based MMT treatment programme. In fact the patient population was able to continue to grow. There was a broadening of the patient profile in the programme including patients who were better educated, more likely to be employed and less likely to be currently injecting (although with a significant history of past injection drug use). The expansion in treatment availability did not impact negatively on the existing programme, but rather enabled access for a group of higher functioning opioid dependent patients who were previously being deterred from treatment entry by the large waiting lists and the need for priority access for pregnant and HIV positive heroin users (Brands 2000, Type 3).

Examples of where such new demands and expectations may come from include:

- new developments in criminal justice services, such as DTTOs and arrest referral schemes
- an increase in the prevalence of drug misuse locally
- changes in patterns of drug using behaviour, for example greater use of stimulants such as cocaine
- difficulties in recruiting and retaining suitably qualified staff
- changes within other service providers

Monitoring demand activity

Potential sources of information for monitoring demand activity include: service provider's own process information; the views of service users; data from partner agencies; statistics from the Scottish Drug Misuse Database on numbers of new individuals in contact with services; and national prevalence information.

The monitoring of waiting times is discussed in more detail below.

Key Action Points for Developing Contingency Plans – at Agency/service provider and Integrated services level

Level	Action Point
Agency/ Service Provider	<p>Consider subcontracting elements of service Service providers, in consultation with joint commissioners, should:</p> <ul style="list-style-type: none"> consider subcontracting elements of their service, if they are experiencing staff shortages or space constraints. For example, a community service with a prescribing function could sub-contract a partner service to run its waiting times support group. By working with its partners and using funds creatively, services should consider extending outwards rather than expanding inwards consider joint appointments or inter-service arrangements for seconding staff when shortfalls arise due to staff sickness or annual leave. By reimbursing locum costs, GP specialists could be recruited to provide temporary clinical cover review the caseload and casemix of their staff. Regular team meetings should ensure that a service's total workload is evenly distributed, care plans regularly reviewed, and plans in place to enable appropriate and timely discharge
Integrated Services	<p>Develop a local contingency plan [Action on Waiting Groups²] should:</p> <ul style="list-style-type: none"> develop a local contingency plan to manage sudden change in the nature and size of demand for specialist drug treatment services consider scope, and develop protocols for interim services, including prescribing services provided by GPs or local independent contractors involve primary care and Accident and Emergency services in developing contingency plans <p>DATs should:</p> <ul style="list-style-type: none"> monitor local trends aim to gain prior knowledge of plans to disrupt local drug markets <p>Forecast demand and supply</p> <p>In accordance with existing guidance, DATs should develop their abilities to forecast new demand as part of the needs assessment process. This information should be considered against current waiting times and existing capacity, in order to identify the possible impact of new demand on the drug treatment system and inform investment decisions</p>

Source: adapted from the National Treatment Agency (NTA) paper "Making the System Work" (NTA 2002)

²There is no equivalent in Scotland at present

4. Monitoring Waiting Times

Consistency in data recording

Consistency in the recording of waiting times information at a local level is required if waiting lists are to be successfully managed. Data received from Drug Action Team Corporate Action Plans suggest that a number of different recording procedures are in place across service providers, statutory and voluntary, both within local areas and across Scotland. Audit Scotland's review of drug services also found different practices operating in the recording of waiting lists.

Monitoring systems

It has been suggested that waiting times for first treatment episodes should only be measured once comprehensive assessment has been completed and a referral for treatment made. While that information may be helpful to the planning and delivery of services, it is a reality that a person's perceived need for treatment prompts referral and that, for this reason, **waiting times should be measured from the date of first referral (or self referral) to the date an individual begins a programme of treatment and care.**

Whilst information systems need not necessarily be the same across agencies and service providers, the data collected, the way it is validated and the way it is interpreted needs to be consistent. A core data set should include at least the following items:

- client details (age, gender etc)
- priority of client
- date of referral
- date of first contact
- date of assessment (if different to first contact)
- date the programme of treatment commenced. In a sophisticated system it may be possible to include the dates that subsequent programmes commenced (e.g. aftercare, rehabilitation)
- date of discharge/referral to other service
- information on 'did not attend' rates

To ensure consistent returns agreed definitions of "waiting time" should be used e.g. maximum length of wait, average length of wait or number of people waiting. A standardised approach to prioritisation and an understanding of the impact of this approach should also be agreed.

Information sharing

Waiting lists contain confidential client-based information and so should be subject to high levels of security access. Only those with a demonstrable need to access the waiting list should be able to do so. Audit Scotland found that not all computerised systems had password protection or an audit reporting facility.

Case study: Good practice in developing waiting list procedures and monitoring waiting lists and times in primary care trusts

Renfrewshire & Inverclyde Primary Care Trust uses a procedure manual, which is given to all those involved in waiting list management. This is also available electronically.

Lanarkshire Primary Care Trust has implemented a comprehensive and effective monitoring system across all its services to manage the time that patients wait according to clinical need. A template has been developed to help clinical teams structure clinical information, helping it ensure consistency in data collection and simplifying reporting mechanisms.

Greater Glasgow Primary Care Trust has developed a comprehensive waiting times reporting mechanism with a standardised approach to all the services it provides.

National Waiting Times Initiative

National work to tackle waiting times in the NHS is currently underway through the National Waiting Times Unit. There are targets in place for inpatient/day case treatment and for the clinical priorities of cancer and heart disease. These national initiatives are being supplemented with local waiting times targets, set by NHS Boards, which reflect local priorities, and which should be identified in Local Health Plans.

A national Waiting Times Database is due to come on-line at the end of 2002. This will contain useful approaches to the management of waiting times in all sectors. It will showcase examples of good practice, some of which may be applicable in a drugs services setting.

There is no waiting time initiative currently operating for drug misuse treatment services. However, ISD Scotland, on behalf of the Executive, has recently gathered detailed information across Scotland on waiting times for drug services to see how this might be improved and monitored in the future. Following analysis of this information it is intended that work be taken forward with the Waiting Times Unit to look at options for the routine monitoring of waiting times, including what national standards might sensibly be set. The options will include the following:

- continue to collect waiting times information through the annual DAT planning arrangements
- monitor waiting times directly from treatment services on a more frequent basis, possibly through surveys on a quarterly basis
- introduce a patient based monitoring system, possibly expanding the existing Scottish Drug Misuse Database dataset

Decisions on how the work will be taken forward will be made later in the year, in consultation with DATs and local agencies.

5. Current Research on Waiting Times - Drug Misuse Research Initiative

The Drug Misuse Research Initiative (DMRI) is a £2.4 million programme of research over the years 2000-2003. It is located within the Department of Health Policy Research Programme and currently comprises 13 studies in the areas of drug treatment and prevention. This includes two studies focusing on waiting times.

Waiting for Drug Treatment - Effects on Up-take and Immediate Outcome (OWL)

This project is headed by Dr Michael Donmall, Director of the Drug Misuse Research Unit, University of Manchester. The project aims to describe the current status of waiting lists and times for drug treatment across England, to study the effects of waiting on treatment uptake and retention, and to investigate the effects of waiting on those seeking treatment. The investigation will have relevance for all those engaged in drug misuse and waiting for care.

The study has three components:

- a national survey of the dynamics and management of waiting lists
- a prospective study of the effects of waiting time on treatment uptake and retention
- an investigation of user perspectives

By identifying critical factors influencing waiting times and their effect, this study will inform policy makers and practitioners, and provide evidence for improved management of problem drug takers at the critical stage of engagement with services.

The project commenced in September 2000 and initial findings from the study will be published around November 2002.

Randomised Clinical Trial of the Effects of Time on a Waiting List on Clinical Outcomes in Opiate Addicts awaiting Out-Patient Treatment

This project is headed by Professor John Strang of the National Addiction Centre.

The project aims to assess:

- if time spent in waiting for treatment initiation is associated with an increased risk of treatment drop-out
- if time spent on the waiting list is associated with changes in substance use and other key treatment variables (such as frequency of injecting, physical health, psychological health and social functioning)
- the economic factors associated with time on a waiting list; and enquire whether it is of policy relevance to know what drug users actually do while they are waiting to begin treatment.

The project commenced in September 2000 and is due to complete in February 2003. Further information on the Drug Misuse Research Initiative is available at:

<http://www.mdx.ac.uk/www/drugsmisuse/>

6. Further resources

National Waiting List Toolkit Project: www.demandmanagement.nhs.uk/toolkit/

Capacity and Demand Management: www.npdt.org/cdm/intro.htm

National Treatment Agency: www.nta.nhs.uk

Audit Scotland: www.audit-scotland.gov.uk

NHS Beacons Learning Handbook: www.nhs.uk/beacons

WEST SUSSEX ADDICTIONS SERVICES BEHAVIOURAL RISK ASSESSMENT

This form is to be used both at triage, and again after comprehensive assessment and multidisciplinary review of the history. Complete on all clients scoring 2 or more on risk to self/others. Tick whichever box is appropriate (Y for yes, N for no, or ? for unknown) for each question. Total score is the total number of Y s & ? s.

SELF HARM: Deliberate & Suicide	Y ? N		Y ? N
Depressed mood (subjective)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Impulsivity	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Past history of non-suicidal self-harm	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Suicidal ideas	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Plans made	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Action taken on plan	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous suicide attempt (give details)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Dangerous method (high risk to self & others i.e. irresponsibility)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Discovery avoided	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Final acts (notes etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Accidental Overdose	Y ? N	Regular intravenous use	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Poly-drug use	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Injects alone	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
History of past overdoses	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Has witnessed overdose(s) by others	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

HARM TO OTHERS: Aggression	Y ? N		Y ? N
Past history of violence to others (may include sexual violence)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Lack of provocation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Lack of regret	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Thoughts/threats of violence	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Paranoid thoughts/delusions	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Available weapon	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Identified target	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Impulsivity	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Prone to emotional arousal	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Relevant criminal record	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Conflict	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Child Care	Y ? N	Currently pregnant	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Responsible for child under 5	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Single parent	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Apparently intoxicated while solely responsible for child(ren)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

PERSONAL SAFETY: Self Neglect	Y ? N		
Reliant on others	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Past history	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cannot cope with or needs help or prompting in		Long term institutional	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Taking care of personal hygiene	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cleaning the house	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Doing weekly shopping	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Budgeting/handling money/accommodation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Homeless/no fixed abode (give details)		Cooking for self	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Road/Machinery Safety	Y ? N	Drives/works while intoxicated	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Drink-drive conviction	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Drives/operates as part of occupation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Chronic intoxication but still drives/works	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Uncaring/indifferent to risk	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Risk/threat from others (give details)			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Level of risk for self harm (High/Medium/Low):		Score:
Level of risk for harm to others (High/Medium/Low):		Score:
Level of risk for personal safety (High/Medium/Low):		Score:

WEST SUSSEX ADDICTIONS SERVICES BEHAVIOURAL RISK ASSESSMENT

Guidelines for use of this assessment tool

This is a multidisciplinary tool, and may be filled in by anyone who has completed an assessment and/or knows the service user well.

Assessing risk is a fundamental part of work with people with addictions, as their safety is our first goal, even before their recovery. Much of the time we do this informally, even instinctively; but to communicate with colleagues and formally demonstrate that we are caring properly for the service user, a formal process and record clearly shows we have covered the ground and thought of the service user's needs from all angles.

Remember that a single very high risk may be more important than a large number of minor risks.

The only reason to assess risk is to help know what to do about it ... so high risks need to be managed. The management plans at the end of the E.T.O. triage document and the care plans at the end of the comprehensive assessment tool are the standard places to record care plans.

In complex cases specific guidance on areas of responsibility may help. The list below aims to help assess and manage the main likely risk areas, and is meant to be used in conjunction with both the Behavioural Risk Assessment tool and, if needed, the E.T.O. Complex Care Plan, which contains guidance on recording risk management, contingency and crisis plans.

The table is meant to be indicative rather than prescriptive. As a very rough guide, the level of responsibility should be similar to the level of risk (provided the patient is consenting to that level of care, and resources permit).

** These responsibilities imply care coordination may be needed. If other agencies are involved, the ETO complex care plan (or, for mental health shared care, the equivalent CPA documentation filled out by a mental health CPA care coordinator) is suggested as the best way of agreeing and recording the care plan.

Substance misuse risks	Substance misuse responsibilities
Physical complications Poly-substance misuse Family problems/child care Homeless/reduced social support Forensic issues Psychological disturbance Violence (victim or perpetrator)	Harm minimisation Detox/substitution Family support/child care** Links with PPP (police/probation/prison)** Mental health or general medical services** Complex care plan (other than as above)** Supportive housing

When to complete this form

- At triage
- At comprehensive assessment (if assessment delayed, or risks significantly altered)
- At any joint assessment process or care planning meeting with another team
- At care plan review meetings in complex cases
- At 3, 6 or 12 month STORS review meetings, if there are significant remaining or new risks

If the risk assessment is being done as part of a shared care plan with the mental health services for a patient with mental health/addiction dual diagnosis and complex needs, here is a complementary set of risks and responsibilities. *The inclusion of psychiatric risks and responsibilities in this table is merely an aid to sharing of care with mental health teams, and should in no way be taken as an indication that Tier 3 drug and alcohol problem teams have the resources, contacts or experience to provide mental health care on their own.*

Mental health risks	Mental health responsibilities
Psychosis Deliberate self harm Poor compliance Reduced social support Violence (victim or perpetrator)	Case management Relapse management/crisis planning Compliance therapy Supportive housing Optimised/complex drug therapy

Thanks to Dr. Ken Checinski for permission to reproduce the original version of this table.

NEEDS ASSESSMENT, SERVICE PLANNING AND REVIEW

Needs assessment, service planning, service review and evaluation are key tasks in designing and delivering an integrated care approach. This is a particularly complex set of tasks in the drugs field because of the often wide ranging needs of individual users and the wide range of agencies and service providers that can respond to these needs effectively. We have set out below a four stage process: needs assessment, reviewing existing services, establishing whether services meet existing need and ensuring service provision is adequate. These are not one off exercises, but are part of a **cyclical** process of service review.

1. Needs Assessment

Needs assessment is a critical first step to better understanding the treatment, care and support needs of a population. Conducting a local needs assessment will help to establish the **extent and nature** of the drug problem in the area, to describe the socio-demographic profile of users and to examine the common routes through which clients are referred. This will help build a picture of area population need.

A single 'all purpose' approach to needs assessment simply does not exist. The approach to an assessment exercise will depend upon the characteristics of the area and the data available. Official data sources, prevalence studies, action plans, integrated care plans and the views and experiences of drug users, their families and the wider community can all provide potentially useful information for such an exercise.

In the first instance, DATs and partner agencies need to ascertain:

- ✓ What data are available locally to inform a needs assessment. These can include: prevalence data, information on attendance and attendees at services, waiting times for services, information on socio-demographic characteristics and identified needs on action plans among others.
- ✓ What additional data are needed to inform the needs assessment process (e.g. eliciting users' views and experiences, and those of their families).
- ✓ Whether this can be conducted by the DAT, or whether this needs to be commissioned externally.

A guide on how to conduct needs assessment (specific to the Scottish context) will be produced by the EIU early in 2003. In the meantime, a guide to conducting needs assessment in the substance use field has been prepared by the World Health Organisation (WHO). It is available at: http://www.who.int/substance_abuse/PDFfiles/needsassessment.pdf

2. Reviewing existing services

In conjunction with the needs assessment it will be important to have current information about the appropriateness, accessibility and capacity of existing services. DATs should:

- ✓ Map out which agencies and service providers are currently involved in developing and delivering services for drug users, including (among others) the number of general and specialist health care professionals, pharmacists, social workers, criminal justice social workers, debt counsellors, housing, employment and training professionals engaged in care.
- ✓ Identify the relative roles of these agencies and service providers in caring for drug users; identify where partnership working between agencies exists (and where it does not); and ascertain whether there are referral procedures and joint working arrangements in place.

- ✓ Map out the capacity and characteristics of these services (e.g. opening times, location, waiting times, assessment processes, target client groups, maximum case load and interventions delivered) to help assess how accessible and appropriate these services are to the population of drug users identified in the needs assessment exercise.

3. Establish whether the existing services meet existing need

The next stage will be to examine whether the capacity of both specialist and generic service provision is sufficient. Further, it will be important to assess whether the interventions delivered by these service providers do indeed meet the needs of the local drug using population, and that they are accessible. For example, if there are a substantial number (or a growing number) of stimulant users in your area, you need to establish whether services are attractive to these individuals and whether services are equipped to deal with problems they may present with. This type of exercise is sometimes called a 'gap' analysis. It involves:

- ✓ Systematic comparison of the needs identified in the assessment exercise with the current level, nature and capacity of service provision in the area.
- ✓ Identifying where gaps in provision exist, or indeed where services are under-utilised by the drug using population.

4. Ensure service provision is adequate.

If gaps in service provision are highlighted, DATs need to consider how these gaps can best be addressed. For example, if a DAT has identified a growing problem with stimulant use, how is this best managed? Filling gaps in service provision may be achieved by:

- ✓ developing more effective multi-agency working to ensure a seamless service, ensure that individuals can be moved onto more appropriate services.
- ✓ adjusting service characteristics: for example, by changing opening times, modes of working and location.
- ✓ developing new approaches to meet the needs of the local drug using population: for example, by including more psychosocial approaches in treatment programmes.
- ✓ developing new approaches specifically to target the harder to reach groups: for example, by providing outreach clinics in rural areas, or for women at home with children.



Chapter 4: Assessment

Assessment

- Definitions of assessment and why the assessment process is important
- Factors that influence effective assessment
- Tools used for assessment
- Developing core data sets

This Chapter examines and discusses the **process** of assessment and describes the **key principles** of evidence-based, effective assessment placing the service-user at the centre of the process. We have examined and reviewed evidence from a number of sources including research papers, policy guidance and consultation with commissioners, service providers and service users. This includes a questionnaire survey of drug services in Scotland about their use of assessment tools and focus groups conducted by Scottish Drugs Forum with service users in Scotland. The key findings from the focus groups are set out in Appendix 2.

This Chapter sets out:

- the definition of assessment, its rationale and the wider context
- the evidence on the factors that contribute to an effective assessment process
- key principles and elements of practice

It also offers practical advice on selecting assessment tools.

What is assessment?

The purpose of assessment is to identify the needs and aspirations of the individual in order to inform decisions about treatment, care and support for drug users. It usually takes the form of one-to-one discussions between the staff member and the individual. If the assessment process is working effectively, the individual should be a full participant and understand and agree the goals of treatment, care and support.

Effective assessment is an **ongoing process**, not a one-off event. It seeks to identify the range and level of needs of the individual, not only problems with drug misuse but also health, social and economic circumstances. It explores the individual's attributes and aspirations. The outcome should be informed decisions about treatment, care and support that are regularly reviewed and revised as necessary. Ongoing assessment helps both service users and service providers to measure progress against agreed goals and supports transition to another type of service, when appropriate.

As a result of the assessment process, the individual should understand the purpose of assessment and:

- know where he/she is going and why
- receive the 'right' services
- know how and when progress is being made

The Rationale: why is assessment important?

An effective assessment process is at the **core of effective service delivery and co-ordination**. The assessment is the key to establishing with the individual **as complete a picture as possible of their needs and their state of readiness to change** in order to provide the most appropriate service/s likely to promote a positive outcome. Without this information, the individual may be referred to a service that does not match their needs and aspirations, leading to disillusion and drop-out from services.

The Wider Context

In the wider health and social care arena, there is an increasing emphasis on broader assessment to encompass the wide range of health and social needs of individuals. For example, The World Health Organisation (WHO) define it as:

“(Assessment is) a process designed to reach a thorough understanding of a person’s problems in the overall context of his or her life with the object of developing a treatment plan that stands the best chance of being helpful.”

The development of more effective assessment has been an issue for a number of sectors and services in Scotland in recent years. For example, the Beattie Committee report on post-school education, training and employment for young people who have social, emotional and behavioural problems clearly identified the importance of effective assessment (Scottish Executive 1999). Following the report, the Scottish Executive published a review of assessment for young people who have additional support needs (including disadvantaged and disaffected young people) and a digest of assessment tools (Scottish Executive, 2001). The digest can be downloaded at www.scotland.gov.uk/library3/education/ilsn.pdf. In England, the ConneXions Framework also addresses assessment for this group of young people and has produced guidance and practical tools. More information is available at www.dfes.gov.uk.

Joint Future

One of the key drivers for development of the assessment process for people with drug misuse problems is the Scottish Executive’s Joint Future agenda. As set out in Chapters 1 and 2, the aim of Joint Future is to improve partnership working between agencies (through joint resourcing and joint management) and to secure better outcomes for service users and their carers. <http://www.scotland.gov.uk/health/jointfutureunit/>

A key element of Joint Future is the establishment of locally agreed, **single shared assessment procedures** for all groups within the remit of community care.

In November 2001, the Joint Future Unit of the Scottish Executive issued guidance on single shared assessment. Within this guidance a **minimum standards checklist** was provided in order to ensure that local single shared assessment tools meet a number of specific criteria. The guidance notes, which accompanied this document, confirmed that the minimum standards checklist for single shared assessment **would** apply to all care groups. It states that a core data set is to be established for all community care groups, **including drugs and alcohol** during the course of 2002 to 2003.

The **core data** set currently in use (for elderly services) is divided into 4 sub-sets, as follows:

- personal information core data set
- assessed need core data set (components of need)
- care plan core data set
- important medical conditions guide

What is Single Shared Assessment?

Single Shared Assessment creates a single point of entry to community care services and will lead to better use of resources and more effective outcomes for people in need.

Single shared assessment:

- ensures that agencies adopt a holistic approach to assessing and meeting people's needs, reducing bureaucracy and duplication in assessment and planning care
- should be person-centred and needs led. It should be seen as a continuing process throughout a person's episode of care and relate to the level of need at all times
- is a shared process that supports joint working by seeking information once, co-ordinating all contributions from service providers, clients and people close to them
- has an identified lead professional who co-ordinates documents and shares appropriate information
- actively involves people who use services and their carers
- provides results which are acceptable to all agencies

The **Joint Future Unit** states that in order to achieve this:

'Agencies should put in place single shared assessment processes and a single shared assessment tool. This should be done through the development of joint protocols to ensure agreement locally in the systems for and ownership of assessments and the provision of joint training for staff in assessment practice'.

There are a number of **planned results** of single shared assessment:

- shorter routes to services and faster passage along these routes
- raise assessment practice to new levels
- put people at the centre
- lead professionals to manage process
- information asked for only once
- information shared between professionals appropriately
- outcomes accepted by fellow professionals

The Assessment Process

The development of an effective assessment process at local level for people with drug misuse problems will take place within the wider context of Joint Future and, specifically, single shared assessment. In this Chapter, we set out key areas to address, and principles and elements of effective practice that we have identified from the evidence that we have gathered. We have also produced an outline framework for an assessment process and a draft personal information core data set and an assessed need core data set (Annexes 4A and 4E).

From the evidence, we have identified the following key factors that influence assessment:

- working with the individual
- assessment practices and procedures
- working with other agencies
- transition from assessment to planning and delivery of care

1. Working with the individual

To be effective, the assessment should place the individual at the centre of the process. Assessment should be a process that is done with the individual rather than done to them (EIU consultation workshops 2001, Type 5). The service users' focus groups showed that some clients did not understand what the assessment process was or what it was trying to achieve. Service users often felt assessment was 'done' to them (SDF 2002, Type 4). They saw assessment as an external procedure that must be complied with to get to the next stage of treatment or support.

You get what they offer you. They've only got one thing to offer and you get it.

SDF Focus Group Respondent 2002

You mean after your first couple of interviews when you've got to sit through all that cxxp and tell them your life history and what your granny gave you for tea when you were nine and all that. That's what you mean by assessment is it?

SDF Focus Group Respondent 2002

Assessment should be **needs led**. It should **not** be service-led, resource-focused or unnecessarily time-consuming. The assessment process should be a way of working and an integral **part of the overall care of the drug user**. It may in itself constitute a therapeutic process, allowing the client to explore the wider issues that influence their drug use. This means that the development of a trusting relationship with staff is important. The service users' focus groups suggested that this may be difficult because of the **number of workers** seen during the assessment process.

More recent methods of collecting a broader range of information have moved away from the traditional diagnostic tools that are often performed **on** the individual rather than **with** the individual. This broader approach allows questions to be asked that are fundamental to the ethos of providing **person-centred care**. In recent years there has been a move towards **self-reporting**, which seeks the views, opinions and concerns of the individual.

There are a **number of factors** that impact on the effectiveness of the assessment process:

Time: Both service providers and service users commented on the sometimes lengthy time taken to complete assessments. The service users' focus groups clearly demonstrated that they considered the process to be too long (SDF 2002, Type 4). One group reported that in their area it took eight weeks just for the assessment process to be completed. Others reported four-five weeks and one participant reported three months. This led to further loss of motivation and a view that the process was a 'waste of time'. When deciding the type of assessment (see section 2 below) and the time required for an assessment, it may be felt necessary to "get an

early win for the user”: for example, to secure a prescription for methadone. A broader approach to helping the individual identify the factors associated with their drug misuse problem may have to come later.

Repetition and Duplication: Many drug users will require treatment, care and support from a number of service providers, whether at the same time or serially. One of the main causes of frustration and disillusion was the duplication of assessment and the constant repetition that resulted. This is also an issue for services and the EIU consultation workshops identified the waste of **time and resources** arising from the gathering of the same information through constant re-assessment.

Focus Groups – number of workers

Participants had to see a minimum of three workers during the assessment process. They were asked the same kinds of questions by each and in some cases this felt like the same assessment over again. That lack of information sharing appeared to the individual as frustrating rather than protecting confidentiality.

SDF 2002

Focus Groups – Client involvement in decisions

With one exception participants said that there was no involvement by them in decisions reached because either:

- Participants did not expect to have any say in the decisions reached about them
- Participants agreed totally with the decisions reached, but had no say in it and believed the decision could have been reached a lot quicker
- Participants did not agree with decisions reached but were told that there was no alternative. This appears to be based primarily on disagreement over level of methadone dose or rejected benzodiazepine requests.

SDF 2002

Ownership: The service users’ focus groups on the assessment process also clearly demonstrated that as participants in the assessment process, service users feel a lack of **ownership**, and a lack of **involvement** in the final decisions that were reached about their treatment, care and support. Further, in some cases, users did not necessarily expect to have any say in these decisions either. The key findings from the focus group work on assessment can be found in Appendix 2.

The **key objectives** when working with an individual include:

- to ensure that the individual understands **the purpose of the assessment process and his/her part in it**
- **to identify and agree the individual’s needs and problems** and agree realistic goals
- to reach an understanding **about the individual’ strengths, skills, attributes and support systems** that will need to be utilised to the full in order to help the person to address the difficulties that they face
- to identify and agree with other service providers **the most appropriate service(s) to match the assessed needs**
- to provide a framework within which to help the individual **to measure their progress in achieving change and reaching their goals**

2. Assessment practices and procedures

Levels of assessment

The EIU consultations emphasised the need for **different levels of assessment**. Drug users frequently come into contact with a wide range of agencies at different stages in their treatment or recovery. A drug user may, for example, present at a Housing Department, Employment Service (New Deal) or benefit office. In those settings, the opportunity to identify the nature and extent of a drug problem is probably limited. The service users' focus groups also highlighted the frustration and disappointment that can occur when a first contact is followed by an in-depth, lengthy assessment. During the course of treatment, a referral to a specific service may lead to a more detailed assessment. In line with Joint Future guidance, **three levels of assessment** may be appropriate:

- **simple assessment (or screening)**
- **comprehensive assessment**
- **specialist (or in-depth) assessment**

It may be appropriate to capitalise on the opportunity of a first contact by conducting a **simple assessment (or screening)** to ensure an appropriate referral is made. This first level assessment could be described as the “gateway” into a process of care. It should be a helpful, non-threatening experience designed to encourage the individual to engage in a more in-depth exercise and ultimately promote the development of a therapeutic relationship. The data collected at this stage is likely to be relatively basic, probably socio-demographic information, perhaps cursory information about their drug use and its likely impact on the individual's ability to access services. Simple assessment could allow access to low level services, e.g. harm reduction advice and information.

Comprehensive assessment may be used in health and social care settings when the individual has made a direct approach or has been referred by another agency. This assessment could cover more detailed information on drug use and other factors such as housing, employment, health and benefits. This assessment should allow some decisions about treatment, care and support to be made, or whether it is appropriate to refer an individual elsewhere.

Specialist (in-depth) assessment may be appropriate when a client has been referred to a specialist agency, or has moved on from entry-level assessment. This assessment would cover in detail the nature and extent of drug use, physical and psychological health, personal and social skills, social and economic circumstances, previous treatment episodes and assets and attributes of the individual.

Suggested specific content for each level of assessment is laid out in Annex 4A.

Who can Assess?

The Joint Future Unit has produced a useful breakdown of who could undertake an assessment within the three levels. This could be adapted by DATs and partner agencies at a local level.

Simple assessment –	professionally qualified staff in health, housing and social work who are the first contact; vocationally qualified staff; and unqualified staff with training in assessment.
Comprehensive assessment –	professionally qualified staff in social work or health;
Specialist assessment –	professionally qualified staff in social work, health and housing, who may have recognised expertise; vocationally qualified or trained staff in specialist areas where simple specialist assessment is needed; and professionally qualified or trained staff in specialist independent agencies.

(JFU, 2002)

There are some aspects of the role of assessors within the different levels of assessment to consider:

- what kind of referral they can make
- whether they have any decision-making powers in relation to treatment and care
- whether they have any authority to commit resources

The extent to which assessors are engaged in these aspects of assessment and link to the subsequent care planning has implications for their recruitment, selection and training. For example, generic staff will require basic training in the principles of drug-related assessment and in the use of the tool employed while staff in more specialised services would require a higher level of skill and competence. STRADA now offers interdisciplinary training on the principles and function of assessment, followed by local training on jointly agreed protocols. The new STRADA post-graduate Certificate in Addictions will also include an assessment component.

Self-reporting

As noted above, there has been increasing interest in **self-reporting** as an important component of the assessment process. It can help where the client feels constrained by the circumstances and unwilling to talk, promote more participation and add valuable information not gathered through the standard tools. Self assessment tools such as the Rickter Scale may assist but service providers have expressed concern about the lack of scope within some current tools to record clients' views and opinions or to allow individual responses (EIU consultation workshops 2001, Type 5, Rome 2002, Type 2/3).

However, Carroll (1995, Type 2) suggests that there are an immeasurable array of factors that may affect the reliability and accuracy of self-reporting. These include:

- the frequency of the individual's substance use
- the type of drugs being used
- the positive or negative consequences of reporting substance use
- the type and precision of information sought
- whether the behaviour assessed is illicit or socially undesirable
- the length of the interval between the substance use and the assessment
- the individual's treatment status
- the use of corroborating sources such as collateral reports and biological markers
- the way in which information is collected: in face-to-face interview, through questionnaire or through a computerised self-report

There is also a need for some caution in how to interpret statements made by the client. There may be a risk in taking clients' self-reports at face value. Wiggins (1973 Type 3) states that accurate measurement requires all four of the following criteria to be met:

- described items (or symptoms) have common meaning among clients and between the client and the assessor
- the client must be able to accurately assess his or her own internal state. Distortions due to defensiveness or insensitive observations must be minimised
- the client must report those internal states honestly to the assessor
- the item or items are in fact related to the concept of the condition as used by the assessor

A study into the assessment of severe mental illness and addictions (Carey 1998, Type 3) stated that self-reporting was an essential tool and the best way to gain access to private information. They suggest four factors that will influence the validity of self-reporting:

- **sobriety:** intoxication at the time of assessment is associated with unreliable and invalid self-reports
- **acute distress:** assessment should take place at a point where the individual is not in acute psychiatric crisis, as under-reporting of recent substance use is likely in acute admission settings
- **cognitive impairment:** it is likely that some people with substance misuse problems experience cognitive deficits sufficient to impair their ability to provide accurate self-reports
- **motivated deception:** concerns about confidentiality can reduce self-reporting accuracy, especially when negative consequences e.g. legal or housing, are contingent upon admitting to using substances.

Errors in reasoning can occur when the assessor can recognise a possible relationship between the symptoms, or situation, which the client describes and the possible effects of drug misuse (Jones 1992, Type 3). While it may be useful and often necessary to believe the client, and to recognise the validity of their reporting, it cannot be assumed that their physical, psychological or social discomforts are drug related or that the client is able to interpret these symptoms in a way which accurately diagnoses the problems. Assessors should consider the possibility that there might be different explanations for the presenting problems, other than drug misuse: for example, the experience of having flu can sometimes produce symptoms similar to those of opiate withdrawal.

Collateral Sources of Information

There may be useful additional information to be gleaned from family members, friends or other people in close contact with the individual. Wilson & Grube (1994 Type 3) describe collateral sources as including:

- friends and family
- other treatment providers (including community pharmacy)
- official records including results of urinalysis or oral solution drug testing
- reports from legal or other agencies

A study into the use of subject and collateral reports to measure alcohol consumption, (Maistro and Connors 1992, Type 3) states that collateral information sources have long been found to be useful in substance abuse treatment settings.

It is important to recognise that these different sources of information may vary in terms of their relative validity. Information provided through official records regarding recent drug consumption (levels and types of drug used) may provide a higher confidence of accuracy than that provided by the people closest to the individual.

“Particularly with the use of illicit substances, collaterals (significant other informants) may have limited opportunity to directly observe participants using behaviour...and thus their reports are likely to be based on the participant’s reports to them rather than on independent observation.”
(Rounsaville 1981, Type 3)

Conversely, family and friends may provide the best source of qualitative information about how a person’s drug use is affecting them and those around them.

Assessment Tools

Assessment tools are used in a range of sectors to aid the assessment process. They are instruments developed by practitioners or academic institutions that facilitate the collection of information in a **systematic** fashion. Outcomes of assessment can be measured, contrasted and compared, in order to assist the practitioner and the client in identifying the nature and extent of problems.

Assessment tools are often used to **help guide and structure dialogue** between worker and client. When used in the assessment of drug users, they commonly collect information on an individual’s:

- drug use
- risk behaviour
- health, social and economic circumstances

Service providers stated that they need assessment tools, which are **tried and tested, fit for purpose and designed to identify the main issues that need to be addressed, and to elicit all the information required to identify individual need** (EIU Consultation workshops, Type 5). Practitioners working with individuals with drug misuse problems will need to be aware of the relative merits of each tool and be able to select tools that will assist them in their practice. A Guide to selecting assessment tools is at Annex 4C.

A Study of Assessment Tools

A study of assessment tools was completed in 2002 (Rome 2002, Type 2/3). The main aim of the study was to **map the use of assessment tools** in drug services in Scotland and to study the nature and extent of their application. The study provides an analysis of the range of assessment tools in use and compares how the circumstances of their actual use differ from the original purpose of the tool. The key objectives of the research were:

- to map and review existing research on assessment tools in the drug misuse field including their purpose, reliability, validity, and service providers' views on their strengths and weaknesses
- to examine service providers' views on the application of the tools, their strengths and weaknesses and the variation in the use of these tools across Scotland
- to investigate the development of a core data set and a standardised assessment tool across drugs services in Scotland.

The research methods included a review of the research literature to identify tools used for assessment, their appropriate application and where the various tools are used both nationally and world-wide. An examination of the tools used in Scottish drug services was investigated using a survey questionnaire. The type of information collated included both qualitative and quantitative data.

The results of this research suggest that there is a wide variation in the use of assessment tools in drug services across Scotland. Significantly, tools are **often not used for their designated purpose** e.g. the SMR 24 Scottish Drug Misuse Database proforma. One of the other key findings was that respondents attached importance to the development of a common or core assessment tool, and core information gathering to facilitate more integration between drug services across Scotland.

The key findings of the study were:

- only five validated tools are being used, primarily for assessment, by drug services in Scotland
- in general, an agency/service provider will use one tool for all client groups
- many of the tools currently used for assessment are not primarily designed for this purpose
- tools take too long to complete and often require additional time to score and input to a database
- many tools are used only once or sporadically rather than as part of planned process of monitoring the effectiveness of care provision.

A summary of the key findings of this study is presented in Annex 4B. EIU will produce a digest of Assessment Tools later in 2002 and it will be available online at <http://www.drugmisuse.isdscotland.org/eiu/eiu.htm>

3. Working with other agencies

Services need to work better together in the interests of the individual, sharing information to avoid duplication of assessment and agreeing common assessment tools, common data sets and referral discharge protocols.

Development of core data sets

As noted above, the Joint Future agenda requires the development of a single, shared assessment and a core data set for people with drug misuse problems. A common assessment that tried to capture all the information needed by key agencies could be lengthy and impractical. However, from our review of the evidence, including the consultations with both service providers and service users, there is support for a **core assessment** to produce an agreed **core set of information or data set** that would be useful to all agencies and service providers. This would cover socio-demographic information, health, housing, employment history, income/benefits as well as the nature of the drug misuse. If such information were available to all the relevant parties, it would benefit clients who would not experience the frustration of answering the same questions on several occasions. It would also offer reassurance that the “system” knows about them and is actively pursuing their care.

The use of a core set of information or data set should also help service providers to do their job better. They will have the basic information and be able to work with the individual on the more detailed assessment necessary to inform decisions about appropriate treatment, care and support within their service. In this way, a core or common assessment could contribute significantly to a **person-centred service**.

In some parts of Scotland, such data sets are already in use (Forth Valley and Aberdeen City). The Study of Assessment Tools (Rome 2002, Type 2/3) included a mapping of tools currently in use in Scotland and, from that information, we have produced a draft core data set.

The core data set consists of the following two sub-sets:

- **Personal information core data set**
- **Assessed need core data set (components of need)**

The two data sets are set out in Annex 4E of this Chapter.

A core data set would also provide consistent information across the area to help DATs with **service evaluation and planning** for the future pattern and provision of services in their area. EIU Evaluation Guide 7, “Using assessment data for evaluation” examines when and how assessment data collected by drug services can be used as part of an evaluation design. It briefly outlines the definitions, purposes and principles of assessment and examines how specific tools can be used in evaluation.

http://www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluation7b.pdf

In order to facilitate the development of integrated care systems at local level there should be a clear and standardised process across all participating agencies. There may be a case for a **standardised assessment protocol** and/or **tool**, for simple, comprehensive and specialist assessments to be available to all these agencies in order to ensure consistency in implementation and in the quality of the information obtained. This would require agreement between agencies and training for staff appropriate to the level of assessment.

The development and use of a single shared assessment tool would require **collaboration and co-operation** between agencies/service providers and their staff:

- to agree the core areas/questions
- to agree joint protocols on information sharing
- to develop robust joint working arrangements between agencies and agreement on how resources can be jointly used to provide the appropriate services for the individual

Staff should be able to provide up-to-date information on the nature and availability of **other services**, to enable their client to make informed choices about what services they would wish to access and from which service provider (see Chapter 3). The skills and attributes of staff are vital to building a relationship with the client and in maintaining and enhancing their motivation to change. In order to do this staff should be trained in line with core competencies, where possible through multi-agency training.

As noted above, STRADA has already identified assessment as a topic for modules that are delivered to a range of staff from a range of agencies. DATs should actively encourage their constituent agencies to ensure that staff receive training and support ongoing joint training locally.

Impact of parental or family drug use on children

At the EIU consultation workshops, service providers voiced concerns about **a lack of information about, or involvement of, the family**, in the assessment process and a lack of attention paid to the needs and welfare of children. The consultation document on guidelines for joint working with children and families affected by drug misuse “Getting Our Priorities Right” (Scottish Executive, 2001) reported that there could be improvements in involving family members in the assessment process. Further, the draft guidelines highlighted the importance of addressing children’s needs and welfare in the assessment process. By identifying potential or actual problems affecting the children as a result of drug misuse, the opportunity arises to alert staff in the appropriate agencies. “Getting Our Priorities Right” contains an assessment framework for assessing problem drug use and its impact on parenting.

The final guidelines on inter agency working for those working with children and families affected by drug misuse will be published later in 2002. We have included a specific item on “risk to dependant children” in the Assessed Need core data set (see Annex 4E).

Information Sharing

One of the key issues for agencies engaged in the treatment, care and support of drug users is **information sharing**. An effective assessment process requires a commitment from agencies and service providers both to share and safeguard client information in order to reduce the risk of inappropriate referrals and to ensure that clients have access to the service that best matches their needs (EIU consultation workshops 2001, Type 5).

While the evidence suggests that there is strong support for information sharing, there is also a recognition that there are potential barriers. Agencies have legitimate concerns about the need for confidentiality but there are also wider concerns that difficulties about the sharing of information are sometimes a result of agencies’ own “confidentiality policy” rather than the best interests of the clients themselves (EIU consultation workshops 2001, Type 5).

From our consultations there was a view that the decision about sharing information should be made between the individual worker and the drug user on the understanding that all the factors had been explained and understood between them. The principle of **informed consent** is a key component of single shared assessment and there is now guidance from the Scottish Executive on informing individuals and obtaining consent (CSAGS (2002) 'Protecting Patient Confidentiality : Final Report').

In Chapter 6, **Information Sharing**, we have set out the key elements of 2 major national initiatives on information sharing:

- the principles and protocols for information sharing produced by the Confidentiality and Security Advisory Group for Scotland (CSAGS)
- the eCARE Programme, to develop the technology to support information sharing

The Chapter also contains practical examples from the substance misuse field of how information sharing issues have been dealt with locally.

4. Transition from Assessment to Planning and Delivery of Care

The assessment process is not an end in itself. Its purpose is to inform decisions about treatment, care and support with a view to matching services to the assessed needs of the individual. The completion of the assessment should, therefore, be a clear statement of the type and level of the individual's needs and an agreed set of goals. There could also be value in a profile of the individual that covers needs, circumstance, attributes and aspirations. The outcome of the assessment process can be summarised in a proposed **Action Plan**. Annex 4A sets out key components of an Action Plan. This could include an **initial pathway to be considered** when planning the care to be delivered.

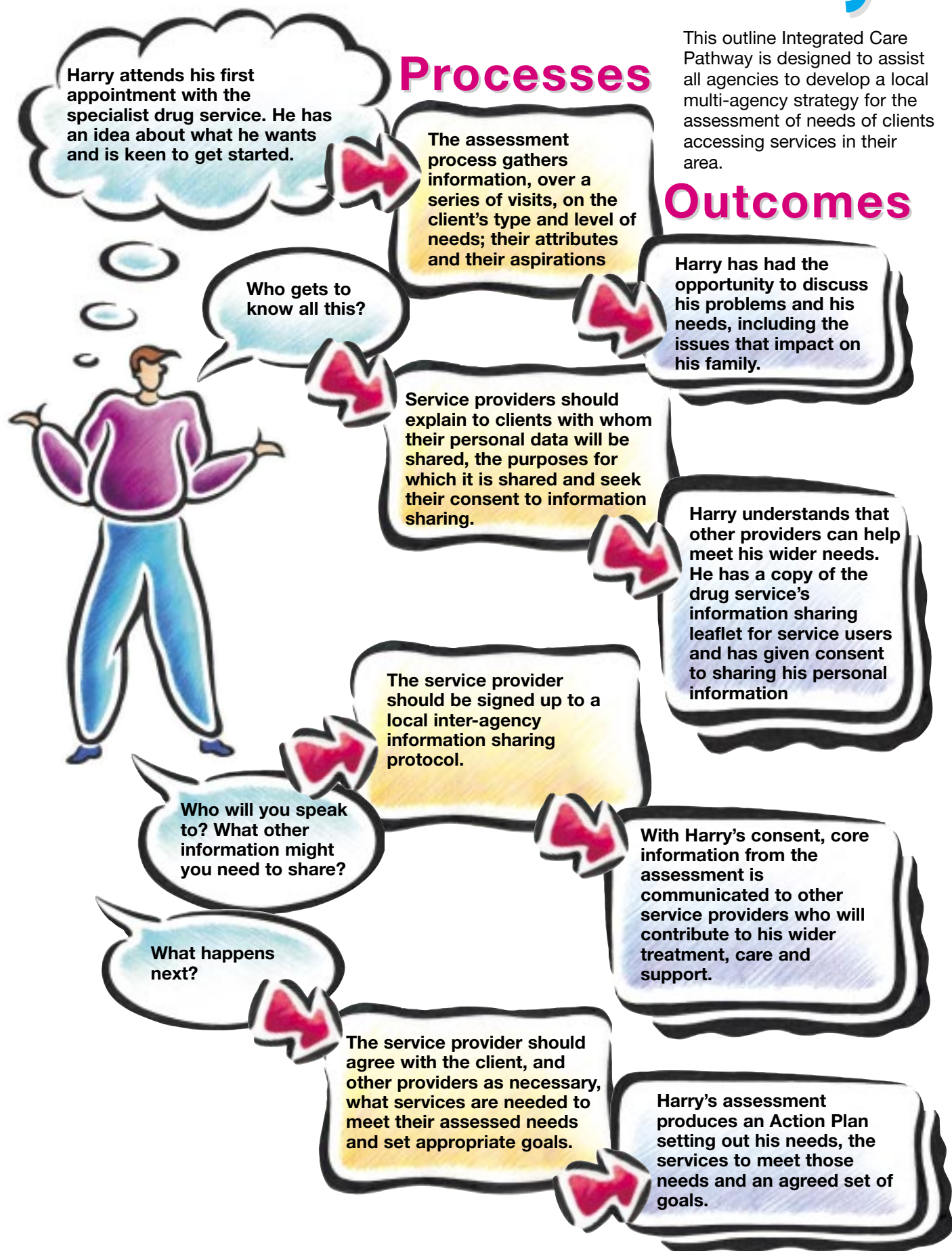
This is the "ideal" process. However, the research and consultation evidence seems to show that in a number of areas the range of available services is limited and may not meet all the needs. Chapter 3 sets out various factors affecting Accessibility and identifies principles and practice that could improve it. This may influence both the conduct and outcome of the assessment process i.e. assessing individuals to see how they fit into the existing services. It could be argued that this is a realistic approach and the service users' focus groups (SDF 2002, Type 4) shows that service users themselves may take that view. However, such an approach would mean that the real nature and extent of the problems faced by drug users would not be recognised and recorded. This would inhibit the potential to compare the needs of drug users with the current level, nature and capacity of service provision. This is an important element of the needs assessment exercise identified in Chapters 2 and 3 and is a key element of service planning.

This potential gap between the "ideal" service(s) for the individual as set out in the Action Plan following assessment and the creation of an integrated care plan that is subject to the constraints of available provision is a difficult issue to address for managers and practitioners. This is discussed in Chapter 5.

Remember Harry?

Having identified a drug service that might suit his needs, Harry's GP has referred him. The first step will be an assessment. The staff will work with Harry to gather information, not just about his problems with drug misuse but about the other things in his life that affect him.

Assessment Pathway



KEY PRINCIPLES AND ELEMENTS OF EFFECTIVE PRACTICE: ASSESSMENT

From our review of the research literature and the evidence that we have gathered through consultation, focus groups and the EIU Working Group, we have identified the following key principles and elements of effective practice:

1. Working with the Individual

An effective assessment process focuses on the individual. It should be:

- ✓ needs-led, not service-led, resource-led or unnecessarily time-consuming
- ✓ ongoing, not a one-off event
- ✓ part of the overall care process

An effective assessment process should encompass:

- ✓ the gathering of information about the type and level of needs, attributes and aspirations of the individual
- ✓ the development of a profile of the individual
- ✓ communication of the assessment outcome to appropriate providers
- ✓ an action plan, agreed with the individual and other agencies as necessary that identifies appropriate goals and the services likely to meet the assessed needs
- ✓ regular review and monitoring with reassessment at agreed intervals

Annex 4A sets out an outline framework for an assessment process for drug users.

The assessment process should cover the current position and changes in an individual's circumstances and needs. This commonly includes collecting information on personal, family and social circumstances, physical and psychological health, injecting-related risk behaviour and offending behaviour. It should also cover:

- ✓ clients' goals
- ✓ clients' expectations
- ✓ strengths
- ✓ support
- ✓ boundaries

The process should have a **clear time frame**. The service user needs to be aware of the proposed length of time involved to complete the assessment process as this appears to have an impact on level of motivation and retention in treatment.

Effective assessment requires the **full involvement and participation** of the individual at every stage, as far as possible, through:

- ✓ **The development of a two-way dialogue** to ensure that the individual understands the purpose of the assessment and that the assessor has fully understood the information offered by the individual. From the staff's perspective, it is crucial that they are satisfied that they understand the service user's own perceptions about their needs and problems.
- ✓ **Encouraging ownership** by the individual: for example, by the use of tools that support **self-assessment**, such as the Rickter Scale. The individual should have at least an equal share in the process and the outcome. There should also be an opportunity to record disagreement and agreements.
- ✓ **Openness** to ensure that the individual knows:
 - who is involved in the assessment
 - what issues are being discussed and by whom
 - what judgement is being made about the type and level of their needs

Service users should be able to participate at every stage if they wish. One suggestion is that clients should be offered copies of their assessment summary and/or care plan.

Staff should be trained in the agreed skills and competencies to enable them to build a trusting relationship with the individual and carry out assessment effectively. As far as possible training should be multi agency.

2. Assessment practice and procedures

Drug users come into contact with a wide range of services at different stages of their treatment, care and support. It may be pragmatic and practical to have **different levels of assessment** to meet the presenting needs of the client; to reduce the risk of over long initial assessments; and to make the most effective use of time and resources. **Three levels of assessment** are set out in Annex 4A.

Assessment tools can help to guide and structure discussion between staff and individuals. Such tools commonly collect information on the individual's drug use, risk behaviour and health, social and economic circumstances. There is a need for tools that are **tried and tested and fit for purpose**. Careful consideration should be given to deciding **whether an appropriate tool does not already exist** and could be used with no or minor modification for the task in hand. A Guide to selecting assessment tools is at Annex 4C.

Self-reporting and collateral reporting are important and vital sources of information in assessing the impact of substance misuse on an individual.

3. Working with other agencies

Agencies should agree the core information (see Annex 4E for draft core data sets) that they are willing to transfer to ensure a smooth transition for the drug user and reduce duplication. Guidance on **informed client consent** will need to be observed. There would also have to be agreement about the sharing of **more detailed information** from a third-level or service specific assessment. There may be particular concerns about sharing of information in rural areas where communities are smaller and closer.

The DAT, working with agencies, should draw up **clear, strict protocols** to support sharing of information between agencies, as well as guidance on information sharing for clients (see Chapter 6 on Information Sharing).

4. From Assessment to Planning and Delivery of Care

From the assessment there should be an Action Plan for the individual. This Action Plan should be produced after **discussion and agreement between the individual and staff who have worked with him/her**. Where possible, it could include service providers who could provide the appropriate treatment, care and support. It should draw on the outcome of assessment tool(s), self-assessment by the individual, and the judgement of staff.

The Action Plan should recognise the needs, attributes and aspirations of the individual. It should offer a systematic way to support the individual to make progress towards agreed goals at a pace suitable for him/her; and to enable provider(s) to design and deliver the appropriate treatment, care and support “package”. An example of what an Action Plan might contain is at Annex 4A.

Outline Framework for an Assessment Process for Drug Users

This framework has been adapted from the outline framework for assessment set out in the Beattie Report 'Implementing Inclusiveness' (Scottish Executive, 1999). While it covers some of the ground already set out in the main body of the Chapter, its aim is to **provide more detail on the key principles and components of the assessment process. It also sets out the specific items that would be covered in the three levels of assessment set out in Section 2 of the Chapter.**

Principles of Assessment:

- ✓ It must be open.
- ✓ It must be fair and accurate.
- ✓ It must be focused on the individual and not designed to accommodate the organisational structures or administrative practices of an agency.
- ✓ It must respect confidentiality.
- ✓ It must encourage full participation and ownership by the individual.
- ✓ It must aid progression.

It should also:

- ✓ Be continuous but not repetitive
- ✓ Be given adequate time and care
- ✓ Be carried out by competent and well-trained staff
- ✓ Be designed to allow the transfer of accurate, relevant and up-to-date information

The objectives of the assessment process:

- ✓ Identification of the type and level of need and the attributes and aspirations of the individual.
- ✓ Agreement jointly with the individual, and other service providers as appropriate, of an action plan for treatment, care and support.
- ✓ Agreed goals and arrangements for review and reassessment.
- ✓ Communication of the outcome of the assessment process to the appropriate providers and the arrangement of matching provision.

The elements of the assessment process:

- ✓ The assessment exercise.
- ✓ The profile.
- ✓ The action plan.

An assessment should be carried out:

- ✓ At initial contact.
- ✓ Regularly – but not too often.
- ✓ At every transition between services.
- ✓ After critical events.

What should it cover?

Simple assessment should cover:

The 21 items included in the Personal Information core data set.

Comprehensive assessment should cover:

The 12 sub-headings listed under the Assessed Need core data set, including detailed assessment of:

- ✓ Presenting problem
- ✓ Primary drug profile
- ✓ Secondary drug profile
- ✓ Injecting behaviour
- ✓ Signs and symptoms of oversedation or withdrawal
- ✓ Risk to self or others, including dependant children

Specialist assessment should cover

Detailed assessment of all data items included under the 12 sub headings of the Assessed need core data set.

Outcome of the assessment

(a) The Profile

From the assessment process, a profile of the individual could be created to cover:

- ✓ The type and level of needs; drug treatment, social support, life skills
- ✓ Particular circumstances e.g. family problems, emotional and behavioural problems, debt, likely to create barriers to progress
- ✓ The aspirations and attributes, with particular attention to positive experiences in the past
- ✓ Goals – short term and longer term

(b) Action Plan

The Action Plan draws together the outcomes of the various stages of the assessment process. It should be produced after discussion between the individual and staff who have worked with him/her and, where possible, service providers who could provide treatment, care and support. It should draw on the outcome of assessment tool(s); self-assessment by the individual; the judgement of staff; and the profile.

The Action Plan should recognise the needs, attributes and aspirations of the individual. It should offer a systematic way to support the individual to make progress towards agreed goals at a pace suitable for him/her; and to enable service provider(s) to design and deliver the appropriate treatment, care and support “package”.

The action plan should specify:

- ✓ The goals
- ✓ The agreed treatment approach for drug use and the service provider
- ✓ The actions to address other problems e.g. housing, family support, offending behaviour, personal and social skills, education and training needs
- ✓ What will constitute progress and how it will be measured
- ✓ Dates for reviewing progress, who will be involved and the format
- ✓ The main contact

(c) Ongoing assessment and review

This should cover progress made by the individual towards goals including:

- ✓ Improvements in health
- ✓ Improvements in family and social functioning
- ✓ Reducing criminal behaviour
- ✓ Reduction in drug use
- ✓ Improvements in self esteem and motivation
- ✓ Movement towards employability

The individual should be offered the opportunity for self-assessment where possible as well as taking into account the use of assessment tools and professional judgement (see Chapter 5, Planning and Delivery of Care).

A planned review should take place at regular intervals to ensure that the care plan is revised to take account of changing needs and circumstances and that service providers are meeting needs appropriately and the agreed quality standards.

(d) Training

Staff should have access to regular training in the competencies appropriate to the level of assessment that they are engaged in. There should be opportunities for multi-disciplinary training at national and local level to support the development of joint working and information sharing.

The Use of Assessment Tools by Drug Services in Scotland Study of the Nature and Extent of Application

Rome A.M. (2002)

ABSTRACT

This study explored the use of assessment tools and frameworks in Scottish treatment services working with adults with drug misuse problems. It provides an analysis of the range of assessment tools in use and compares how the circumstances of their actual use differ from the original intentions of the design.

The main aim of the study was to map the use of assessment tools in drug services in Scotland and to study the nature and extent of their application. There were a number of key objectives to the research. The objectives were to map and review existing research on assessment tools in the drug misuse field including their purpose, reliability, validity, strength and weaknesses. Further, research aimed to examine service provider's views on the application of the tools and the variation in the use of these tools across Scotland. A further objective of the study was to examine the reliability and validity of the tools with the aim of investigating the development of a core data set and a standardised assessment tool across drugs services in Scotland.

The research methods incorporate a data analysis of the current literature to identify assessment tools, their appropriate application and where the various tools are used both nationally and world-wide. An examination of the assessment tools used in Scottish Drug Services was investigated using a Survey Questionnaire. The type of information collated included both qualitative and quantitative data.

The results of this research suggest that there is a wide variation in the use of assessment tools. Significantly, the tools are not often used for their designated purpose. Further, respondents seemed to attach importance to the development of a common assessment tool, and core information gathering to develop more integration between drug services across Scotland.

Guide to choosing assessment tools: Factors to consider

- **Primary use:** Ensure that the stated use of the tool matches your requirements. Tools primarily designed for outcome evaluation tend to collect quantitative rather than qualitative information.
- Ensure that the tool has been validated for use with the **target client group**. Some tools have been found to be inappropriate for some client groups such as prisoners or clients with co-existing mental health problems (Rome 2002, Type 2/3). Often tools are too broad in their scope to highlight particular issues synonymous with specific client groups.
- Available assessment instruments for substance users have been designed with different purposes in mind and vary widely in the **time frame** they capture. The assessor will need to be aware of the time frame covered by the instrument.
- Similarly assessors should be careful to select a measure sensitive to the **type of substance use** involved. Many tools have a focus on opiate injecting behaviour: the focus and nature of questions within the tool may have limited relevance to people using non-opiate drugs and who do not inject.
- Many tools provide a **composite measure or score** of the severity of substance use. This formula approach, multiplying **frequency of use** by **amount**, might indicate that, by comparison, using cocaine twice daily is less problematic than using a similar amount of opiate three times in a day. Assessors will need to be aware of the variance in scoring methods and how this affects the resulting care provision.
- Assessors should recognise that **short periods of abstinence** may be more significant for substances associated with steady use for example opiates or methadone than for those characterised by binge or episodic use e.g. cocaine.
- The **time taken to complete** assessment tools ranged from three minutes to four hours for the tools examined in the assessment tool study (Rome 2002, Type 2/3). Brief screening instruments tend to take less time to complete than comprehensive tools. On average, up to 30 minutes appeared to be a reasonable time to spend on a comprehensive assessment. Specialist or specific assessments, for mental state assessment or social enquiry report may take longer.
- **Administration:** tools that require scoring and/or inputting from paper to computer database will provide additional administrative work for frontline workers or require dedicated administrative support. Frontline workers score 61% of commonly used tools. One third of all tools reported in the study are stored on computer databases (Rome 2002, Type 2/3). The additional administrative requirements of each tool should be taken into consideration.
- **Training requirements:** Typically training of one day or less was required on the use of specific tools (Rome 2002, Type 2/3). Service managers should ensure that initial training and updates are available to all staff who would use these tools. Training should include issues regarding the assessment process and specific guidance on the use of selected tools.
- Developers of new instruments must consider carefully their usefulness across a number of potential substance use disorders and settings. Before embarking on developing a new assessment instrument for substance use, **careful consideration should be given to evaluating whether an appropriate one does not already exist and could be used with no or minor modification for the task in hand.**

Examples of tools currently used for assessment

- **THE RICKTER SCALE**
- **CHRISTO INVENTORY FOR SUBSTANCE MISUSE SERVICES (C.I.S.S.)**
- **PERSONAL LIFESTYLE OUTCOME TRACE (P.L.O.T.)**
- **MAUDSLEY ADDICTION PROFILE (M.A.P.)**
- **ADDICTION SEVERITY INDEX**
- **COMMUNITY CARE ASSESSMENT - DRUGS & ALCOHOL (CCADA)**
- **SMR24: SCOTTISH DRUG MISUSE DATABASE MONITORING PROFORMA**

From the results of the survey of tools currently used for assessment in Scotland (Rome 2002, Type 2/3), a comparison was made between Type A tools (common tool where identified primarily use is assessment) and Type C tools (common tool where identified primary use is **not** assessment) and against the published research literature. Two of the tools identified in the mapping exercise do not appear in any published or unpublished studies, the SMR 24 and the CCDA. Information about SMR24 was provided by ISD and about CCDA by the Glasgow City Council Social Work Department. The information was used to create standalone profiles. Where comparisons are being made between the published research literature and the survey results, this is presented in parallel columns.

All information which has been collated from the results of the survey is presented in shaded boxes.

A digest of tools used for assessment will be produced in October 2002 and will be available online at www.drugmisuse.isdscotland.org/eiu/eiu.htm.

THE RICKTER SCALE

Background		
<p>The Rickter scale is a non-paper based tool (a colourful plastic board) that allows clients to explore their circumstances, identify priority areas for support and interventions. This tool is different from the others previously described because the client (with the support of a worker) completes it, so it is a form of self-assessment. The structure enables clients to explore possibilities, set goals and contribute to their own action plans. Evaluation of the Rickter scale suggests that it positively encourages interaction between the client and the worker.</p> <p>A bank of questions is available including personal social development, key skills, drugs and alcohol issues, preparation for work and community safety.</p>		
Where did you find out about this tool	Commissioners of Service 75% Word of Mouth 16.7% In-house staff training 8.3%	
How long have you used this tool	Mean 12 Months Standard Deviation 7.3	
Origin	Original Format 91.7% Modified for agency's use 8.3%	
Comparative Information	Published Research Literature	Survey Results (n=12)
Application		
Primary Use	Self Assessment	Assessment 75% Evaluation 41.7%
Secondary Use	Evaluation	Evaluation 41.7% Audit 16.7% Assessment 16.7% Screening 8.3% Research 8.3%
Client Groups	This tool has been used by projects funded by the New Futures Fund, which aims to support vulnerable groups (including recovering substance misusers) into employment, training and education.	Adult 83% Adolescent 50% Women 41.7% Ethnic Groups 33.3% Prisoners 25%
How often is this tool completed with each client	No information	3 Monthly 50% Initial & End 16.7% Ongoing 16.7% Monthly 8.3% As Required 8.3%
Administrative Issues		
Guidelines/Manual required	No information	Yes 91.7% No Information 8.3%
Approximate time to complete	The tool can be customised depending upon its intended use; thus completion time varies depending upon the number of questions selected.	Mean 40 minutes Standard Deviation 11.1
Time to score	No information	Mean 12.9 minutes Standard Deviation 7.2
Scoring by		

Validation: Rickter has not been formally validated. However, Scottish Enterprise has commissioned a research consultant to examine the utility of Rickter within the New Futures Fund initiative. Further, there are plans to undertake a validation study of Rickter in the future.

Training requirements	None	Mean 1.3 day
Users Opinion & Comment		
Positive features	Relative Score 55.2% Good evaluation data Can be used for all clients Supports fuller assessment of clients needs Records the clients views / opinions	
Concerns	Relative Score 17.7% Can look like a toy. Some clients feel insulted Only records clients view on day of use Work is progressing for the data input to be easier	

CHRISTO INVENTORY FOR SUBSTANCE MISUSE SERVICES (C.I.S.S.)

Background		
<p>The CISS is a simple, validated, 10-item questionnaire producing a single score of 0 to 20 which is a general index of client problems. It has been used with both drug and alcohol services. CISS was developed to find out workers' impressions of their clients in a quick, standardised and reliable way and outcome areas are scored on a three point scale of problem severity (0 = none, 1 = moderate, 2 = severe).</p> <p>It can be used to monitor client problems at intake and at structured follow-up points. As with the MAP, CISS can be used to establish changes over time. For example, the CISS collects information on HIV risk behaviour that can be compared between first assessment and follow-up assessments, both for individuals and for the population of service users as a whole.</p>		
Where did you find out about this tool	Journal / Research 42% Conference / Seminar 25% Commissioners of Service 25% Word of Mouth 17% Internal 8%	
How long have you used this tool	Mean 7.82 Months Standard Deviation 5.04	
Origin	Original Format 75% Modified for agency's use 8.3% Developed for agency's use 8.3% Developed as joint tool with other agencies 8.3%	
Comparative Information	Published Research Literature	Survey Results (n=12)
Application		
Primary Use	The tool has been validated for outcome monitoring in a practice setting. Outcome measures include physical health, psychological health, drug use, HIV risk and criminal behaviour.	Assessment 83% Evaluation 16.6% Screening 16.6% Audit 8.3% Research 8.3%
Secondary Use	It also measures three areas of client-support interaction: the use of structured support (e.g. AA / NA counselling), compliance (e.g. with treatment requirements), and working relationships (e.g. ease of interviewing).	Evaluation 58.3% Research 33.3% Audit 33.3% Assessment 16.6% Audit 16.6%
Client Groups	All	Adult 100% Adolescent 83% Women 83% Ethnic Groups 83% Prisoners 50%
How often is this tool completed with each client	No information	3 Monthly 50% 6 Monthly 16.6% 12 Monthly 16.6% Monthly 8.3% Once & Review 8.3% As Required 8.3%

Administrative Issues		
Guidelines/Manual required	Guidelines are on form	No 66.6% Yes 33.3%
Approximate time to complete	The author notes that a worker familiar with the tool can complete it in three to five minutes.	Mean 13.6 minutes Standard Deviation 12.59
Time to score	No information	Mean 4.8 minutes Standard Deviation 3.6
Scoring by	No information	No information
<p>Validation: A validation study conducted by Christo and his colleagues was positive (Christo et al 2000). The CISS demonstrates good face validity because its items were acceptable to workers and clients. The CISS also scored well against other existing multi-dimensional instruments suggesting that content validity is also good. Further it appears to have good discriminant validity - the spread of scores was good and there were no ceilings on the scores.</p>		
Training requirements	None	Mean 0.7 day
Users Opinion & Comment		
Positive features	<p>Relative Score 60.4%</p> <p>Quick to complete Good evaluation data Tick boxes make information easy to record Can be used for all clients Supports fuller assessment of clients needs Records information in a consistent manner which can be shared with other agencies</p>	
Concerns	<p>Relative Score 16.7%</p> <p>Too simplified Does not record the clients views / opinions</p>	

Christo G, Spurrell S, Alcorn R. Christo Inventory for Substance- Misuse Services. Drug and Alcohol Dependence 2000; 59: 189-197.

PERSONAL LIFESTYLE OUTCOME TRACE (P.L.O.T.)

Background		
The PLOT is a five-minute outcomes tool for assessment of behavioural dysfunction in drug misusers developed by the Community Alcohol and Drug Service at Forth Valley Primary Health Care Trust. PLOT is a self-contained, 'self-marking' tool that describes the status of a user at any stage in treatment.		
Where did you find out about this tool	Journal / Research 40% Word of Mouth 60% Member of team developed it 20%	
How long have you used this tool	Mean 9.8 Months Standard Deviation 7.12	
Origin	Modified for agency's use 60% Original Format 20% Developed for agency's use 20%	
Comparative Information	Published Research Literature	Survey Results (n=5)
Application		
Primary Use	outcomes tool for assessment of behavioural dysfunction	Assessment 60% Evaluation 60% Screening 20% Audit 20%
Secondary Use	No information	Evaluation 40% Research 20% Assessment 20% Audit 20%
Client Groups	No information	Adult 100% Adolescent 60% Women 100% Ethnic Groups 80%
How often is this tool completed with each client	No information	3 Monthly 80% 2 Monthly 20%
Administrative Issues		
Guidelines/Manual required	No information	Yes 80% No Information 20%
Approximate time to complete	It can be completed in around 5 minutes.	Mean 9.6 minutes Standard Deviation 5.6
Time to score	No information	Mean 5.8 minutes Standard Deviation 3.0
Scoring by	No information	No information
Validity: A three component research study was designed to examine the PLOT's validity, reliability and ability to measure change over time. Firstly PLOT was tested against the ASI and OTI and showed highly significant correlation with both. Secondly, the PLOT was shown to be highly reliable between users. Thirdly, a longitudinal study with 35 subjects showed change in most domains over time.		
Training requirements	None	Mean 1.0 day Standard Deviation

Users Opinion & Comment	
Positive features	Relative Score 77.5% <ul style="list-style-type: none"> • Quick to complete • Good evaluation data • Tick boxes make information easy to record • Can be used for all clients • Supports fuller assessment of clients needs • Records information in a consistent manner which can be shared with other agencies
Concerns	Relative Score 14.3% <ul style="list-style-type: none"> • Format of date collection does not easily lead itself to audit or evaluation

MAUDSLEY ADDICTION PROFILE (M.A.P.)

Background		
<p>The MAP is a brief, multi-dimensional tool designed for assessing treatment outcome. It was developed at the National Addiction Centre in London. The MAP was developed from the interview instrument used in the National Treatment Outcome Research Study (NTORS). It includes 60 self-reported items and covers four main areas: substance use, health risk behaviour, physical and psychological health, and personal/social functioning. The authors stress the advantages of incorporating (not replacing) the MAP within existing assessment procedures. The MAP can also be extended and amended to suit local conditions (e.g. prevalence of specific drugs and patterns of use) and the recall periods can be adjusted for practical application.</p>		
Where did you find out about this tool	Journal/Research 83% Conference 17% Word of Mouth 50%	
How long have you used this tool	Mean 18.7 Months Standard Deviation 9.7	
Origin	Original Format 33% Modified for agency's use 67%	
Comparative Information	Published Research Literature	Survey Results (n=6)
Application		
Primary Use	Assessing treatment outcome	Assessment 67% Evaluation 50% Screening 17%
Secondary Use	The results generated by using MAP are commonly used for service evaluation. In particular, it can be used to assess treatment outcomes.	Assessment 17% Research 33% Evaluation 33% Audit 33%
Client Groups	All	Adult 100% Adolescent 67% Prisoners 17% Women 67% Ethnic Groups 67%
How often is this tool completed with each client	Can be used routinely	Monthly 17% 3 Monthly 50% 6 Monthly 17% 12 Monthly 17%
Administrative Issues		
Guidelines/Manual required	Yes	Yes 67% No 17% No Information 17%
Approximate time to complete	Field-testing shows that the MAP takes an estimated 12 minutes to administer.	Mean 26.7 minutes Standard Deviation 15
Time to score	No information	Mean 13.3 minutes Standard Deviation 7.6
Scoring by	No information	No information

Validity: A validation study showed that the content of MAP was acceptable to clients and easily comprehended (Marsden et al 1998). Further. Results from the test-retest were highly acceptable and self-report validity was confirmed by the high level of agreement with results of urinalysis in a sub-sample.		
Training requirements	None	Mean 0.7 days Standard Deviation
Users Opinion & Comment		
Positive features	Relative Score 58% <ul style="list-style-type: none"> • Quick to complete • Good evaluation data • Records the clients views / opinions 	
Concerns	Relative Score 16.7% <ul style="list-style-type: none"> • Too long to input data to computer 	

- Marsden J, Gossop M, Stewart D, Best D, Farrell M, Lehmann P, Edwards C, Strang J. The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome. *Addiction* 1998; 93(12): 1857-1868.

ADDICTION SEVERITY INDEX

<p>Background</p> <p>Researchers in the United States first developed the Addiction Severity Index (ASI) in the late 1970s. It is one of the most commonly used instruments in the addictions field internationally. The primary use of the ASI is screening. However, a secondary (and not unusual) use of the ASI is for outcome evaluation. The ASI has been used as the primary tool in numerous clinical outcome trials. Further, those commissioning substance misuse services have adopted some ASI items as performance indicators.</p> <p>The ASI collects information on 200 items across seven domains; medical status, employment status, drug use, alcohol use, legal status, family / social status and psychiatric status.</p> <p>Multiple versions of the ASI have been developed, including the Euro-ASI (developed with European funding in the 1990s).</p>		
Where did you find out about this tool	Training & Education 75% Conference 25%	
How long have you used this tool	Mean 23.3 Months Standard Deviation 26.2	
Origin	Original Format 75%	
Comparative Information	Published Research Literature	Survey Results (n=4)
Application		
Primary Use	Screening	Assessment
Secondary Use	Service Evaluation	Screening 25% Evaluation 25% Audit 25%
Client Groups	The ASI is most useful for adults who report substance misuse as a major difficulty.	Adult 75% Adolescent 25% Prisoners 25% Women 25% Ethnic Groups 25%
How often is this tool completed with each client	No information	Initially 25% Initially & Review 25% 3 Monthly 25% 6 Monthly 25%
Administrative Issues		
Guidelines/Manual required	The original research team has sought to help standardise the use of the ASI, including the provision of a specification for a standard database and suggestions for uniform coding and storage	Yes 50% No 50%
Approximate time to complete	50 - 60 minutes	Mean 67.5 minutes Standard Deviation 15
Time to score	5 minutes	Mean 18.8 minutes Standard Deviation 13.5
Scoring by	Technician Computer	No information

<p>Validity: It is shown to be reliable and valid (when correctly administered) across a range of clinical populations and treatment settings (McLellan et al 1980; McLennan et al 1985; Kosten et al 1985; Leonhard et al 2000). However, a study examining the reliability and validity of the ASI among clients with severe and persistent mental illness did not produce such positive results. This study showed that inter-observer reliability was satisfactory, but the test-retest results were relatively poor (Zanis et al 1997).</p>		
Training requirements	2 days - Training in the use of the tool and subsequent monitoring of ASI interviewers appears to be associated with increased validity (Alterman et al 2001).	Mean 1.8 days
Users Opinion & Comment		
Positive features	<p>Relative Score 59%</p> <ul style="list-style-type: none"> • Can be used for all clients • Supports fuller assessment of clients needs • Records information in a consistent manner which can be shared with other agencies • Records the clients views / opinions 	
Concerns	<p>Relative Score 14%</p> <p>Comments:</p> <ul style="list-style-type: none"> • Due to format, interview can become quite deep • Some questions quite sensitive 	

References

- Alterman AI, Mulvaney FD, Cacciola JS, Cnaan A, McDermott PA, Brown LS. The validity of the interviewer severity ratings in groups of ASI interviewers with varying training. *Addiction* 2001; 96: 1297-1305.
- Kosten TR, Rounsaville BJ, Kleber HD. Concurrent validity of the Addiction Severity Index. *Journal of Nervous and Mental Disorders* 1985; 171: 606-610.
- Leonhard C, Mulvey K, Gastfield D, Schwartz M. The Addiction Severity Index: A field study of internal consistency and validity. 2000; 18: 129-135.
- McLennan AT, Cacciola J, Kushner H, Peters R, Smith I, Pettinati H. The Fifth Edition of the Addiction Severity Index: cautions, additions and normative data. *Journal of Substance Misuse Treatment* 1992; 9(5): 461-480.

COMMUNITY CARE ASSESSMENT - DRUGS & ALCOHOL (CCADA)

<p>Background</p> <p>The development of the CCADA arose from addiction workers’ views that the Community Care (CC1) Assessment Form was not appropriate (e.g. only 1 section on “nature of any dependencies”) to record all the relevant elements within an addiction assessment. Thus, a group of Senior Addiction workers determined that an addiction assessment tool was required to cover</p> <ul style="list-style-type: none"> • Nature of Drug Use (Past and Present) • Treatment History, including current medication • Nature of Dependency, including any symptoms arising • Legal Issues • Potential for Change (positive and negative indicators) • Future Community Support <p>The CCADA was first used in Maryhill ADAPT in 1993. It is presently used within all Social Work Community Addiction Services and by some generic social workers</p>		
Where did you find out about this tool	Internal Development 44% Commissioners of Service 22% Community Care 11% Don't Know 11%	
How long have you used this tool	Mean 83.5 Months Standard Deviation 34.57	
Origin	Original Format 56% Modified for agency's use 11% Developed for agency's use 33%	
Comparative Information	Published Research Literature	Survey Results (n=9)
Application		
Primary Use	Assessment	Assessment 100% Screening 22% Evaluation 11% Audit 11%
Secondary Use	None	Screening 22% Research 11% Evaluation 11%
Client Groups	All except Prisoners	Adult 100% Adolescent 56% Prisoners 44% Women 89% Ethnic Groups 78% Residential 11%
How often is this tool completed with each client	Initially then as client's situation changes a new assessment is carried out.	Once 33% As Required 22% 6 Monthly 22% Once & Review 11%

Administrative Issues		
Guidelines/Manual required	No	Yes 11% No 78% Don't Know 11%
Approximate time to complete	45 minutes	Mean 123 minutes Standard Deviation 72.25
Time to score	No scoring	No Information
Scoring by	No scoring	
Validity: No studies undertaken		
Training requirements	None	Mean 0.6 days
Users Opinion & Comment		
Positive features	Relative Score 33.3% <ul style="list-style-type: none"> • Can be used for all clients • Records the clients views / opinions 	
Concerns	Relative Score 23.8% <ul style="list-style-type: none"> • Too long to complete • Format of data collection does not easily lend itself to audit or evaluation Other Comments: <ul style="list-style-type: none"> • Being replaced by longer version & questions • Impossible to extract useful information • Piloting new assessment Tool for Glasgow City Council 	

SMR24

Background

The SMR24 monitoring form was one of the most commonly identified assessment tools from the questionnaire survey, however it is not designed to be used as an 'assessment tool'.

The SMR24 is the data collection tool for the Scottish Drug Misuse Database, which offers a profile of drug misuse in Scotland based on anonymous information on new problem drug misusers in contact with services.

Established in 1990 at ISD Scotland on behalf of the Scottish Executive, the Database gathers information from most specialist drug services in Scotland and from a number of general practitioners, providing a unique source of information on drug misuse in Scotland. Statistics from the Database are published in the annual Drug Misuse Statistics Scotland publication, available via the Drug Misuse In Scotland website at:

<http://www.drugmisuse.isdscotland.org/index.shtml>

The information presented on the SMR24 form relates to new patients/clients. As such, the statistics do not reflect the total number of drug misusers seen by services during any period.

The SMR24 form has been in use since April 2001. Prior to that date there were two forms in use: the SMR22 for prescribing services and SMR23 for non-prescribing services.

For further information on providing information to the Scottish Drug Misuse Database, contact ISD Scotland at: <http://www.drugmisuse.isdscotland.org/sdmd/sdmd.htm>

Where did you find out about this tool	Commissioners of Service 42% National tool 25% Conference / Seminar 8.3% Developed In-house 8.3%	
How long have you used this tool	Mean 16.6 Months Standard Deviation 18.1	
Origin	Original Format 75% Developed for agency's use 16.6% Developed as joint tool with other agencies 8.3%	
Comparative Information	Published Research Literature	Survey Results (n=12)
Application		
Primary Use	Audit: It offers a profile of drug misuse in Scotland, based on anonymous information on 'new' problem drug users in contact with services.	Assessment 66.7% Research 25% Evaluation 16.6% Screening 8.3% Audit 8.3%
Secondary Use	Research	Audit 50% Evaluation 33.3% Screening 33.3% Assessment 25% Research 16.6%
Client Groups	All – although for the purpose of compilation of reports, excludes penal establishments inmates, to improve validity of comparisons between areas (as limited coverage)	Adult 100% Women 83% Adolescent 75% Ethnic Groups 75% Prisoners 66.7%

How often is this tool completed with each client	Initial contact, or if it has been at least 6 months since last attendance at the service.	Initial Contact 66.7% 6 Monthly 16.6% 3 Monthly 8.3% Initially & 6 Mthly 8.3%
Administrative Issues		
Guidelines/Manual required	Yes, there is a detailed manual and service providers have a copy.	Yes 66.7% No 25% No Information 8.3%
Approximate time to complete	No information	Mean 22 minutes Standard Deviation 16.8
Time to score	Not applicable	Mean 15 minutes Standard Deviation N/A
Scoring by	No scoring	N/A
Validity: No studies undertaken		
Training requirements	Less than, or equal to, one day. Training was provided in conjunction with introduction of the new SMR24 form.	Mean 0.75 day
Users Opinion & Comment		
Positive features	Relative Score 60.4% <ul style="list-style-type: none"> • Quick to complete • Good evaluation data • Tick boxes make information easy to record • Can be used for all clients 	
Concerns	Relative Score 16.7% <ul style="list-style-type: none"> • Tick boxes do not allow individual responses to questions • Format of date collection does not easily lead itself to audit or evaluation • Does not record the clients views / opinions 	

Development of Core Data Sets

Sources of Information

In order to construct an initial **Personal Information** and **Assessed Need** core data set, four existing data sets were examined:

- SSA Personal Information core data set (Elderly services)
- SMR24 form
- Christo G., “Common data set”, Druglink May/June 2001
- Forth Valley Substance Action Team core data set (Draft)

Using the SSA core data set as a template, the four sets were integrated to produce a 21-item draft Personal Information core data set and the Assessed Need core data set.

Comparison with existing Assessment tools

Through the initial mapping exercise, 26 assessment tools were returned by drug services with the questionnaires.

One of these tools, the SMR24, has already been used to construct the draft core data sets. The remaining 25 tools were used to measure the extent to which the draft core data sets matched with the information currently collected by drug services.

A record was made of how often the items in the two draft data sets appeared in the 25 assessment tools.

KEY FINDINGS:

Comparison of Assessment tools

- Two of the 21 data items (name and date of birth) in the **Personal Information core data set**, were found in over 75% of the 25 Assessment tools studied.
- Four items appeared in 50-75% of tools, 9 items in 25-50% and 6 in less than 25% of the 25 Assessment tools studied.
- 7 of the 12 sub-headings identified in the **Assessed Need core data set**, appeared as either sub-headings or data items in one or more of the 25 Assessment tools studied
- One (Employment) of the 82 data items in the **Assessed Need core data set** were found in over 75% of the Assessment tools studied.
- Four items appeared in 50-75% of tools, 11 items in 25-50% and 47 in less than 25% of the 25 Assessment tools studied.

19 of the core data items in the **Assessed Need core data set** did not feature in any of the 25 Assessment tools studied.

The following core data sets were developed in collaboration with the Joint Future Unit drawing on the information gained from this study. These data sets should be used as a basis for the development of single shared assessment protocols and documentation for people with drug problems.

1. Personal Information core data set

- Family name and forename
- Present address and postcode
- Unique identifier
- Previously known
- Date of birth
- Gender
- Ethnicity

- Referral Source
- G.P Name
- G.P Address
- Other professionals/agencies involved
- Next of kin
- Dependant children at home
- Previously known
- Previous Interventions

- Presenting problem
- Primary drug profile
- Secondary drug profile
- Injecting
- Signs and symptoms of over sedation and/or withdrawal

- Consent to assessment
- Signed permission to share information with other agencies

2. Assessed Need core data set

Drug Use

- Other problem drug profile
- Alcohol use
- Prescribed drugs/medication
- Effects on user (positive and negative)
- Problems/concerns
- Drug history including alcohol

Living Arrangements

- Household composition
- Status of residency
- Accommodation type
- Carer/cared for
- Other drug user(s) in household
- Housing support needs
- Benefits
- Heating

Physical Health

- Past medical history
- Permanent or long-standing health condition or disability
- Current care provision
- Seen by GP in last 18 months
- Current medical condition
- Current medication
- Current treatments
- Registered disabled

Disease Prevention

- Sleep patterns
- Diet and food preparation
- General physical state
- Body Mass Index
- Injecting practices/techniques
- Wound management
- Oral health
- Vaccination history
- History of cervical or breast screening

Mental Health

- Past psychiatric history
- Current signs and symptoms
- Risk assessment
- Current medication
- Seen by psychiatric services in last 18 months
- Current diagnosis

Social Functioning

- Relationships
- Family contacts
- Social contacts
- Spiritual and religious matters
- Cultural and ethnic matters
- Leisure/hobbies
- Employment, past and current
- Learning

Legal Situation

- Current offending behaviour
- Previous convictions
- Outcomes
- Prison
- Other

Service User's Perspective

- Problems and issues perceived and conveyed by the person
- Person's motivation
- Advocacy required?

Collateral Information

- Carer/significant others' perspective
- Other service provider

Biological Measures

- Biochemistry
- Virology
- Hepatitis B
- Hepatitis C
- HIV
- Pregnancy

Readiness to Change

- Stage of change
- Motivational state
- Strengths
- Barriers to change
- Support system
- Self-efficacy

Risk and Safety

- Needle sharing/exchange/cleaning
- Sharing of injecting paraphernalia including filters, water and spoons
- Sexual risk
- Blood borne virus
- Sexually transmitted diseases
- Personal safety- Risk from self
- Personal safety- Risk from other
- Risk to dependant children
- Public Safety



Chapter 5: Planning and Delivery of Care

Planning and Delivery of Care

- Definitions of planning and delivery and why they are important
- From Action Plan to Care Plan
- Co-ordination of care
- The role of advocacy

This Chapter examines and discusses the process of planning and delivery of care for the individual drug user and sets out key principles and elements of effective practice. The key sources of evidence include research studies, consultation seminars and the EIU Working Group. We have also drawn on a qualitative study with service users conducted by SDF to explore their views and experiences of planning and delivery of care (Appendix 3).

This chapter sets out:

- definitions of planning and delivery, their rationale and wider context
- key issues in planning and delivering care
- key principles and elements of practice

What is planning and delivery of care?

The **planning** of care is the process of making decisions about the treatment, care and support that the individual will receive and about who will be involved in providing the appropriate services. It follows from the outcome of the assessment process discussed in Chapter 4 and should produce an integrated care plan.

The **delivery** of care is the process of co-ordinating, managing and providing the care so that the individual receives the 'right' services at the right time and in the right way to match their assessed needs and in accordance with the agreed integrated care plan. It is important to clearly identify the level of intervention required according to individual need and to identify how best to manage care effectively.

The Rationale: Why is planning and delivery of care important?

Effective planning and delivery of care is important in order to ensure that individuals receive services **in an integrated way**. This will reduce duplication and overlap, maximise the benefits of the efforts of all agencies and service providers, and minimise the number of contacts that individuals have to make with different professionals (EIU Consultation Workshops 2001, Type 5).

Twice I got a date, and twice those dates got put back. The person dealing with it was going round in circles. Took about a year to get help

SDF Focus Group Respondent 2002

As the service user focus groups have shown, fragmented or disjointed care can lead to disillusion and frustration (SDF 2002, Type 4). An integrated planning and delivery of care process should reduce the complexities for the individual, provide consistency of care and enhance the likelihood of a positive outcome. However, it is worth noting that there are **few robust evaluations** of integrated care planning and delivery.

What evidence is available suggests that the planning and delivery of care is best provided by **careful co-ordination** of the range of service providers that can address the assessed needs of the individual. It also suggests that it is useful to include family, partners, friends and drug users themselves in the planning and delivery of care. The key requirements are:

- communication between agencies and service providers and the individual
- co-operation and consistency between agencies and service providers
- co-ordination of services and interventions
- involvement of drug users and their families / partners / friends

The Wider Context

As set out in chapter 2, the Joint Future agenda will be a **key driver** for change in community care generally, which is equally applicable to the drugs field. The key principles and ways of working that are particularly relevant to the planning and delivery of care are: joint resourcing; joint management; intensive care management; and information sharing.

It is anticipated that this will result in improved co-ordination, management and delivery of services. This will have a number of **benefits** for service users, providers and carers. These should include the provision of a more consistent, comprehensive and integrated service and an improvement in treatment and care outcomes. This should also have benefits for service providers who (within an integrated care approach) should be working in a supportive, multi-disciplinary team. The survey of NHS services for opiate users in Scotland showed that respondents were positive about working in multi-disciplinary teams (Cameron 2002, Type 3, Appendix 5). The main reasons cited were mutual support and working with enthusiastic, trustworthy and like-minded colleagues.

It is important to recognise that the idea of integrated care is not new. It is **how** integrated care planning and integrated care delivery are defined and described that can vary. Despite these variations, however, there are principles of good practice that cut across a number of fields in health and social care. These are presented throughout this Chapter.

One example that has relevance for drug users is the **Care Programme Approach** in the field of mental health. It promotes a level of integrated practice because it is a **'whole system approach'**. It takes a holistic approach to treatment, care and support. A key element of this 'whole system' approach is effective care co-ordination for individuals with **complex needs**. As with drug users, links need to be made across social work or care services, health, education and employment, housing, criminal justice and voluntary agencies to facilitate access for individuals to the range of services required to meet their needs.

The Care Programme Approach aims to ensure effective collaboration between agencies so that the individual client receives a fully co-ordinated range of services. It entitles clients to:

- A systematic assessment of health and social care needs
- An agreed care plan
- Allocation of a care worker
- Regular review of progress

(SWSI 1999)

A recent and relevant research review - 'A Review of Care Management in Scotland' - was commissioned by the Scottish Executive in 2001 (CRU 2002, Type 3). The overall aim of the review was to identify how local authorities are using care management to maintain people at home. Although this review did not focus on drug users, some of the conclusions are relevant to effective care planning for this group. The research identified gaps in funding systems, in training, and in the reviewing of cases for service users. The report also highlighted a need for **clearer differentiation between complex and more straightforward cases** in care co-ordination and subsequent levels of intervention.

There are a number of different definitions of care and case management in the health and social care sectors. Overall, a useful distinction can be made between **care management and care co-ordination**. Care management is often described as an intensive approach for individuals with complex, frequent or rapidly changing needs usually requiring complex packages of active, ongoing support. Care co-ordination is described as relating more to individuals with straightforward needs and may revolve around "simple" or single services.

When care management was introduced in 1991, it was intended to be an intensive approach for individuals with complex needs and, therefore, to be carried out by professionally qualified staff. Care co-ordination, on the other hand, was considered to require that staff are suitably trained and supported in their tasks. The **key point is that it is important to match the level of management and intervention with the level of need**. This ensures best use of existing resources.

Key issues in planning and delivering care

When considering how to develop effective planning and delivery of care within an integrated approach, there are a number of key issues to address.

In this section we cover **seven key themes**:

1. Working with the individual
2. The link between assessment and care planning
3. The care planning process
4. Integrated care pathways
5. Advocacy
6. Goal setting
7. Delivery and management of care

1. Working with the individual

The focus groups with service users (SDF 2002, Type 4) suggested that planning their care was largely a negative experience for the individual. Service users **did not feel involved** in the planning of their care nor did they know what a care plan was. Most of the participants were confused about what constituted planning in relation to their treatment care and support, and did not feel that meetings with GPs or other professionals were about planning or changing treatment. Further there was a view that **treatment changes were episodic and reactive**, not planned. No participants had heard of shared care.

In addition to lack of participation, there appeared to be **a lack of trust** between clients and workers made worse by arbitrary decisions e.g. to reduce prescriptions without the client's consent or by the sense of the "luck" involved in getting a 'good' key worker. Service users themselves believe that if they could be involved more in discussions to plan their care it would improve relations with the staff in agencies and lead to better access to services.

It's only really when something happens that's quite drastic – say like if you get lifted or you really fall on your ass – its only then that you can really talk about getting changes in treatment

SDF Focus Group Respondent 2002

The planning of care for the individual in an integrated way will depend on **good communication and liaison** between agencies and service providers. This should help to ensure sharing of information and a smooth transition between services. The service users' focus groups (SDF 2002, Type 4) stated that most participants were in favour of having one person responsible for contacting other people to provide the services required: a lead person. They thought that it would save time, stop confusion and facilitate better relationships and clearer communication between agencies and service providers. However, while the majority was in favour of a single contact, some also felt that it would depend on the person and the kind of relationship that they could build up with them.

Further, many of the service users felt that they had to be at a very serious or crisis stage of drug misuse i.e. injecting, before they could get access to services or a **review of their current care plan**. One of the ways in which service users felt that they could have more of a say in the process was through the help of another person (usually a family member or friend) who could speak on their behalf. The role of an advocate is discussed later in this Chapter.

2. The link between Assessment and Planning

The information generated by the assessment process described in Chapter 4 should form the **foundation** for decisions about treatment, care and support. To be effective, the planning of care should flow from the outcome of the assessment process, including the Action Plan (if one has been produced), that sets out the individual's needs and aspirations, goals and treatment, care and support choices.

The EIU consultation workshops (EIU 2001, Type 5) highlighted that an **integrated care plan** should aim to meet the assessed needs of the individual. However, there may be constraints on the ability of agencies and service providers to match the type and level of services proposed (in the Action Plan). This may arise from the availability of certain services in the local area or problems with access e.g. distance, waiting times (see Chapters 3 and 4).

As noted in Chapter 4, this is a difficult issue to resolve for the agencies responsible for the pattern and provision of services in the DAT area, for service providers and for service users. The service users' focus groups (SDF 2002, Type 4) highlight the risk that, if the range of services identified through the assessment process cannot be delivered in the proposed way, the individual will feel disillusioned. However, the agencies who have responsibility for planning services in an area will require the information from that assessment process (and resulting Action Plan) to identify mismatch of provision or lack of availability in order to inform future planning. This should be part of ongoing monitoring to identify gaps in services (see Annex 3B and Chapter 7).

While the focus groups did highlight the frustration arising from unrealistic expectations (as a result of the assessment), it also indicated that there was an understanding among service users of the likely realities and a wish to be told about them. For the service users, the important factors seem to be:

- receiving **good information** about what local services can offer most suitable to meet their assessed needs and what is available to them at the time
- **clear and open communication** with the client and between service providers to choose the most appropriate type and level of services within existing opportunities and constraints
- **full participation** in deciding on the components of the care plan and how it will be delivered.

3. The Care Planning process

There is a growing body of evidence which highlights the importance of **clearly developed treatment and care plans** (BPADIWG 2000, Type 2). While the additions literature on care planning is not extensive, there is much that can be learned from other fields. The fields of education (and in particular) working with children with special needs have highlighted the importance of individual programme planning (a type of treatment plan) (BPADIWG 2000, Type 2).

To ensure that the **integrated care plan** addresses the different type and level of needs of the individual over time, it should be discussed and agreed with all the agencies identified as service providers and the client (EIU consultation workshops 2001, Type 5). As noted above, an important part of the integrated care planning process will be **open dialogue** between the individual, the main contact person (who has taken forward the action from the assessment) and the service providers. The objective is to agree the best possible approach within any existing constraints or opportunities.

The key to establishing better communication between service providers is honesty and openness (EIU consultation workshops 2001, Type 5). They should be honest about the limitations of their own service and open about examining what others may have to offer to complement it. There may be concerns about potentially conflicting priorities. Ongoing communication between service providers is necessary to promote and support the development of a more integrated approach for the benefit of the individual.

For the individual, it is important that they are encouraged to take some responsibility – at a pace that is comfortable – for their part in the treatment, care and support programme and the achievement of the goals (see the section on goal setting later in this Chapter).

Annex 5A sets out ‘Harry’s Integrated Care Plan’ as an example.

4. Integrated Care Pathways

There is an interest in developing the concept of integrated care pathways (ICPs) for drug users among those consulted by EIU. We have presented outline ICPs in Chapters 3, 4 and 5 as a starting point for their potential development in accessibility, assessment and planning and delivery of care.

ICPs use the current best evidence gained from systematic reviews, as well as input from multidisciplinary teams, to outline the optimal course of care for all clients who have a specific condition or who are undergoing a specific procedure. Other common names for these tools include clinical pathways, clinical care pathways, and Care Maps.

ICPs plot out for a particular diagnosis or procedure the optimal sequence and timing of interventions by physicians, nurses, and other professionals. Because pathways prescribe treatment across different care settings and even between different districts, they help ensure that a **consistent, co-ordinated, quality service** is provided over the full continuum of care. Care pathways are designed to minimise delays, make best use of resources, and maximise quality of care.

ICPs that are inter-sectoral, multidisciplinary, and portable between regions or districts have the potential to improve discharge planning and co-ordination, and information flow between professionals, care settings, and districts (Health Services Utilisation Research Commission, 2001). HSURC is online at www.hsunc.sk.ca.

Middleton & Roberts (2001) identify 6 stages to the development of ICPs:

1. Define the **desired outcome** of the activity under investigation
2. Define and **set the start point** of the activity
3. **Agree the boundaries** and identify related issues and departments (agencies)
4. Identify and map the **high level process elements** that you use now to deliver the service objective
5. Identify **failure points** and responsibilities
6. Use the above to **define the project**, data requirements and likely benchmarking partners

EIU will produce a more detailed guide to the development of integrated care pathways for use in the treatment, care and support of people with drug misuse problems later in 2002.

5. Advocacy

Independent advocacy is recognised as an important way of enabling people to make informed choices about, and remain in control of, their own health care. Advocacy helps people have access to information they need to understand the options open to them, and to make their wishes known. There is currently a renewed interest in advocacy as a way of promoting and supporting people to achieve the best outcomes from treatment and care across a number of sectors, including the drugs field.

Advocacy: A guide to good practice (Scottish Health Advisory Service, Scottish Office 1997) suggests that advocacy is normally considered to have two main aims:

- **protecting** people who are vulnerable or discriminated against or difficult to provide services to
- **empowering** people who need a stronger voice by enabling them to express their own needs and make their own decisions

Advocacy is based on a number of **beliefs and values**:

- the development of a partnership between providers and users of services
- the right of service users to be heard
- empowerment of the individual in issues concerning their care
- ensuring individuals are not excluded from any aspect of the provision of care

The purpose of **Advocacy is not**:

- to create a substitute for making services more accessible or to bypass user involvement in the planning and delivery of services
- to avoid the need to provide person-centred services
- about making complaints, although advocacy may involve supporting people who want to make a complaint and helping them to do so effectively

This good practice guidance has been complemented by the publication of 'Independent Advocacy: A Guide to Commissioners' (Scottish Executive, 2001) which supports the health service and their planning partners in establishing and developing independent and integrated advocacy services in their area.

The Health Plan 'Our National Health: A plan for action, a plan for change' (Scottish Executive, 2000) required all NHS Boards to work with their local authority partners to ensure that independent advocacy is available to all those that require it. Implementation plans have been submitted to the Health Department by all NHS Boards and are currently being turned into practice with the support of the Advocacy Safeguards Agency.

The EIU Working Group (Type 5) highlighted a number of areas of importance when developing advocacy in the drugs field within local areas:

- advocacy in the substance misuse field has not always been the best it can be. For example, anecdotal evidence suggests that GPs often feel pressurised by someone else's presence during consultation

- there can be conflict between the professional and the advocate: for example, between a G.P. providing a prescription and an advocate supporting a change in prescription on behalf of a service user
- advocacy is often used when people are unhappy with services, although it should really be used to put across people's views who cannot or do not do it themselves
- advocacy is about promoting someone's rights, in an assertive, non-aggressive manner

In the service users' focus groups, several users commented on the better outcomes achieved from their perspective when someone else explained their problems and views on treatment options. The value of incorporating information and views from family or friends, is highlighted in Chapter 4 on Assessment. A number of service users felt that they were too 'chaotic' to respond in a coherent way during an assessment process (SDF 2002, Type 4). The study on assessment tools also highlighted the potential value of collateral information (see Chapter 4).

In the light of these findings and in the context of the development of advocacy in their sectors, DATs and partner agencies may wish to consider incorporating advocacy within an integrated care approach.

6. Goal setting

The setting of goals in discussion and agreement with the individual and the agencies identified as service providers is an important part of the care planning process. The goals need to reflect the outcome of the assessment and the individual's current state and motivation. They should include the defined goals of treatment: for example, reductions in drug use or stabilisation, reductions in offending, improvements in physical health. These are often quantifiable and are sometimes known as 'hard' outcomes. It is also important to include 'softer' outcomes such as increased self confidence, motivation and improved relationships with family and friends (EIU Consultation Workshops 2001, Type 5). EIU Evaluation Guide 7 explains the concept of 'hard' and 'soft' outcomes in more detail. It can be downloaded at: www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluation7b.pdf.

Goals should be negotiated and should be:

- SMART – specific, measurable, achievable, realistic and timebound
- Service-user directed
- Respectful of service-user's stage of change
- Overall treatment goals to be broken down into their smallest components

Goals should reflect the philosophy of care:

- To reduce the harm associated with the individual's drug use
- To provide alternatives to drug use which are appropriate to the individual's interests and attributes
- To empower the individual to maintain positive changes that are made

The integrated care plan should set out clearly the stages of progress which the individual wants to achieve. Most importantly, **goal setting is a developmental process**. The goals should change as the individual's circumstances change and he/she progresses. (EIU consultation workshops 2001, Type 5; EIU Evaluation Guide 7, 2002).

7. Delivery and management of care

The **delivery of an integrated service** involving a number of service providers with varying levels of input can be complex. As the diversity of services increases the delivery of care will require the establishment or improvement of multidisciplinary teamwork, as well as care management systems. This will require agreement at strategic level by DATs and partner agencies and at operational level supported by locally agreed policies and procedures.

It will be important to have a **clear system** of planning and delivering of care for individuals who need more than one service throughout the course of their treatment, care and support. The main functions of co-ordination would be:

- to bring individuals together with the service providers that best suit their needs
- to identify a point of contact for both the individuals and the service providers
- to promote and support closer working practices e.g. communication and information sharing to enable joint decision making

There are many different ways in which care delivery can be organised. Currently there is limited evidence on how best this can be achieved within an integrated care approach. What is clear is that it is important to match the level of support with the complexity or severity of individual need. Earlier in this chapter we discussed the relatively simplistic differentiation between a care management approach (for more complex and rapidly changing cases) and a care co-ordination approach for a more straightforward cases.

The EIU consultation workshops offered support for the role of a key worker or **care co-ordinator** to plan and deliver care for an individual. This is probably most appropriate when the needs of the individual are relatively straightforward. There are, however, concerns about the potential for large caseloads and the creation of an extra layer of bureaucracy. An alternative approach would be to establish a **multi-agency team** drawn from the main agencies involved in the care of the individual. This will be essential for individuals with complex needs. A lead co-ordinator would probably still be required, but would work closely with a co-ordinating team that can promote a consistent approach to the client and offer a holistic view of the individual's needs.

One process often used to promote co-ordination is to hold regular **case conferences**. Case conferences are forums of discussion that commonly involve all the parties with a role and interest in the individual's care and progress. As well as service providers, this may include the individual, friends, relatives or an advocate. A chairperson will facilitate discussion. However, the service users' focus groups (SDF 2002, Type 4) highlighted difficulties in this area for service users.

The term 'case conference' had to be explained and outlined carefully to the focus group participants, indicating a lack of understanding about the process. Unanimously, those (and there were several) who had experience of a case conference had found it to be a negative experience (SDF 2002, Type 4, Appendix 3). The service users invariably viewed the case conference as a highly charged affair, with participants feeling intimidated and largely passive. The other participants at the conference were seen almost as adversaries apart from key workers (and not always these). The service users felt that they had no say, control or apparent influence over the course of events, nor who should be in attendance. (SDF 2002, Type 4).

Overall, the delivery of care in an integrated care approach **is a developing area**. The **Models of Care** approach to services for drug users being developed in England is promoting a care management system with the aim of providing **person-centred care** (Models of Care 2001). The overarching aim of care co-ordination is that those who enter into treatment services receive the appropriate level of response by the appropriate service provider.

The **aims** are to:

- Provide a network of care and ensure that drug users have access to a comprehensive range of services
- Ensure the co-ordination of care across all agencies involved with the service user
- Develop, manage and review documented care plans
- Ensure continuity of care and follow the individual throughout his or her contact with the treatment system
- Maximise the retention of service-users within the treatment system and minimise the risk of losing contact with the treatment and care services
- Re-engage individuals who have dropped out of the treatment system
- Avoid duplication of interventions
- Prevent individuals ‘falling between services’

In response, eight **Enhanced Treatment Outcomes (ETO) pilots** have been established to explore co-ordination of care. There will be lessons from these pilots in due course. There may also be scope for pilots in Scotland to test out how co-ordination might work in areas with different characteristics e.g. geography and patterns of drug use. The ETO pilots are:

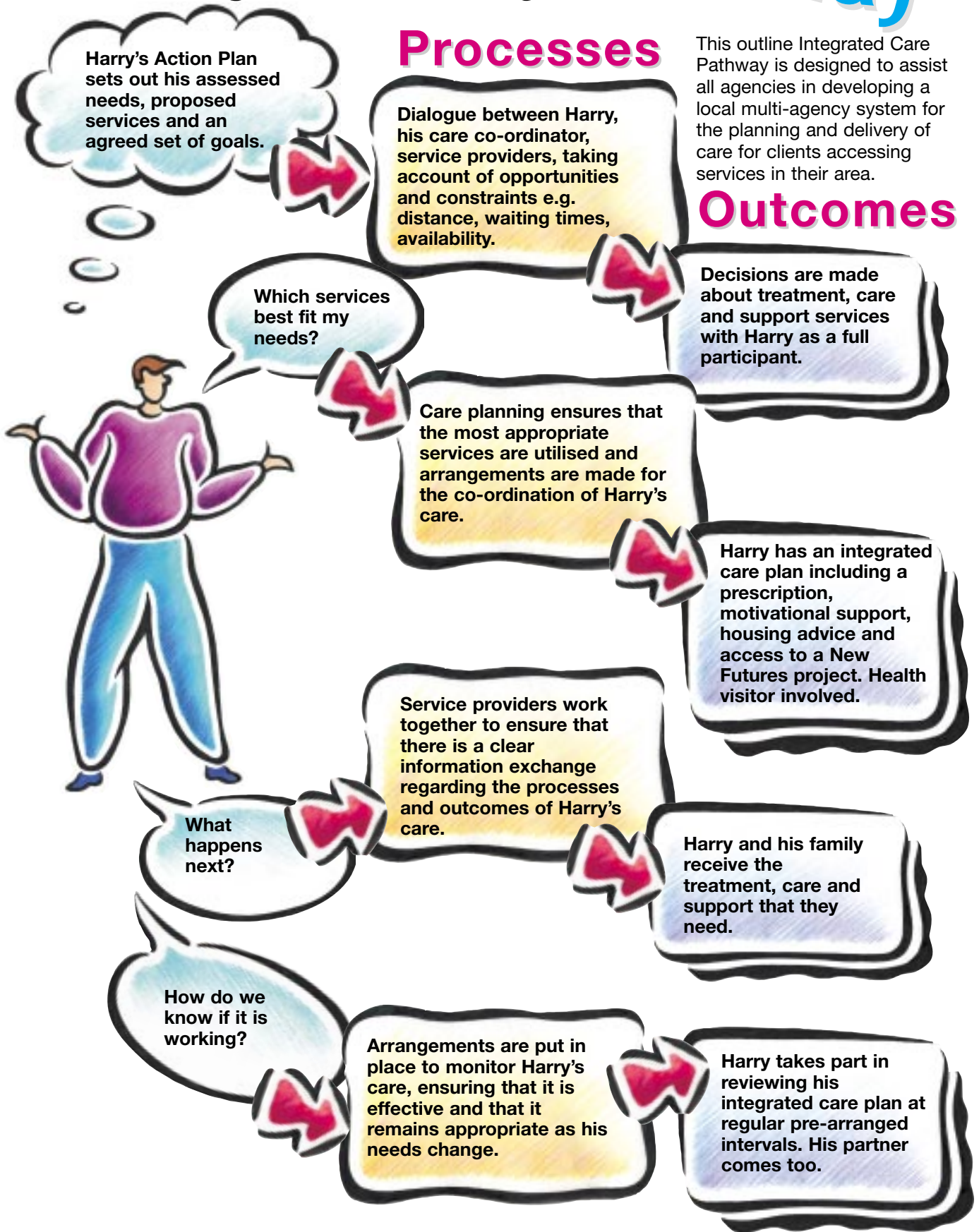
- Screening, referral and enhanced key working in a rural area (Fenlands, Cambridge)
- Treatment system involving multiple agencies in a suburban area (Hertford)
- Co-ordinating service systems across a large geographic area (Kent and Medway)
- Inner city issues and IT links between agencies (Leeds)
- Multiple need clients (Liverpool)
- Screening and triage systems across a large geographic area (West Sussex)
- Black and minority ethnic communities (Bristol)
- Co-ordinating care in inner London (Greenwich)

The screening, referral and triage tools used in these pilots are available from the National Treatment Agency (NTA) on request. Please contact the EIU (EIU@scotland.gsi.gov.uk) if you would like us to access these for you.

Remember Harry?

Harry attended a specialist drugs service and participated in a comprehensive assessment. He was able to talk about various difficulties in his life and his partner had a chance to discuss her concerns about the children. The result was a profile of his needs, family situation, attributes (the things he has going for him) and an Action Plan identifying goals and proposed services. He is now going to talk about **putting together an integrated care plan**

Planning & Delivery Pathway



KEY PRINCIPLES AND ELEMENTS: PLANNING AND DELIVERY OF CARE

From our review of the research literature, the evidence that we have gathered through consultation, focus groups and the EIU working Groups and the developments within Joint Future, we have identified the following key principles and elements of effective practice:

1. Use the outcome of the assessment process as the foundation for decisions on treatment, care and support.

This requires an effective assessment process with agreed mechanisms for sharing information between service providers (see Chapters 4 and 6). The production of an Action Plan (from the assessment) should be agreed with the individual. This would set out their needs, attributes and aspirations and would support and enable service providers to design and deliver treatment, care and support in a consistent and integrated way. The data collected in the Action Plan will also - and importantly - aid the needs assessment and 'gap' analysis exercises set out in Annex 3B.

2. Involve all relevant agencies, service providers and the service user to formulate an Integrated Care Plan.

It is important to agree **how, when and by who** services will be delivered. An integrated care plan will set out how the agreed goals are to be achieved and how treatment, care and support are to be delivered. To create an integrated care plan, detailed individual service plans should be brought together through case discussions between staff in the various service providers. With the agreement of the service user, copies should be given to all relevant staff. An integrated care plan should cover:

- ✓ an individual's needs as identified from assessment
- ✓ the goals of treatment and milestones to be achieved
- ✓ the interventions and services planned to achieve the goal and the support required
- ✓ which service provider and/or professional is responsible for carrying out the interventions
- ✓ timing – when, how often, frequency of attendance and expected length of duration
- ✓ explicit reference to risk management, risk management plans and contingency plans
- ✓ arrangements for information sharing between service providers
- ✓ arrangements for monitoring and review with dates

3. Include the service user in planning their care, including goal setting.

This requires regular, clear and open communication. There should be openness about constraints to delivering aspects of the services as proposed in the Action Plan and good information about the services available and best suited to meet their needs as part of an integrated care plan. The individual should have the opportunity to participate fully in making decisions about the most appropriate services for them.

4. **Ensure that all involved understand the role of the advocate** (if there is one).

Advocacy should help to ensure that individuals and their families have access to information, understand the options open to them, and to make their wishes known. Advocacy should enable the individual's opinions and concerns to be articulated through:

- ✓ informed consent: individuals should be advised of treatment and service protocols, particularly in the sharing of information. An advocacy service could promote individual's awareness of service procedures and information sharing.
- ✓ informed choice: clients should have an awareness and an understanding of the range of services available to them, and the relative merits of each with regard to the achievement of their individual goals.
- ✓ informed decision making: advocacy can enable clients to have an active influence in the decision making process regarding the planning and evaluation of care.

5. **Introduce a clear system of co-ordination for delivery of care.**

This involves being clear about who is doing what, when and how. It is also important to decide whether there should be a **lead care manager (or co-ordinator) or a multi-agency team**. To be effective, co-ordination requires a person and/or persons who are knowledgeable about services and have good links to the range of services required. Effective co-ordination of care delivery requires that:

- ✓ the individual knows who they are working with and why
- ✓ staff are aware of the parties involved, their role and responsibilities
- ✓ communication is open and information shared (with individual's consent)
- ✓ service providers offer a consistent approach
- ✓ regular formal reviews take place to monitor and evaluate joint progress
- ✓ a co-ordinator is identified if required
- ✓ a co-ordinating team is identified if required
- ✓ contact in emergency situations is clear and agreed by parties

NAME: Harry Smith**M/F:** Male**D.O.B:** 03.12.68**Ethnic Origin:** White UK**ADDRESS:** Flat G, 38 Roxburgh Drive, Edinburgh, EH2 3IU**Referrer/Location/No.** Dr Bryce, Health Centre, 0131 123 4567**Reason for Referral:** Mr Smith requested help for his heroin problem, appeared to have complex level of needs requiring assessment.**Family Group**

Name	Relationship	D.O.B.	Address
Clare Jones	Partner	14.02.71	As Above
John Smith	Son	23.04.97	As Above
Jackie Smith	Daughter	05.11.99	As Above
Ronnie Smith	Father	12.03.50	Not given

Professionals involved

Name	Position	Date became involved	Address/Tel/Email
Dr Bryce	G.P.	20.06.94	City East Health Centre
Joyce Well	Drugs Worker	(referral-12.07.02)	EAS Drug Project
Brian Kerr	Social Worker (childcare)	At case discussion 24.07.02	SWD, Edinburgh
Bill McPhee	Social Inclusion	24.07.02	SIP, Edinburgh
Rose White	Housing	24.07.02	Housing Department

Substance Misuse Profile

Primary Substance	Secondary Substance	Other substance use	Length of Use
Heroin for two years, injecting, daily, had no health checks	Cannabis, been smoking for fifteen years	Valium and alcohol on sporadic basis	Poly-use for eighteen months

Integrated Care Plan

Assessed Need	Action/Service Required	Contact Person	Evaluation/ Review date
Drug Use	1. Methadone maintenance 2. Specialist intervention	1. Dr Bryce 2. Joyce Well	At next case discussion 24.11.02
Living Arrangements	1. Partner doesn't use drugs, request support with childcare	1. Brian Kerr	As above
Physical Health	1. Full medical required	1. Dr Bryce	As above
Disease Prevention	1. One to One discussion pending medical results	1. Dr Bryce 2. Joyce Well	As above
Mental Health	No concerns reported at this time		
Social Functioning	Supportive family, support requested to remain in employment	Bill McPhee	Individual contact to be arranged.
Legal Situation	Support in maintaining home	1. Rose White	Meeting with Housing next week
Service-users perspective	High motivation to reduce drug use/ stabilise home		
Collateral Information	Partner concerned for children's welfare, planning to leave if not change	1. Brian Kerr	1. Ongoing, visit two weekly
Biological Measure	To be established	1. Dr Bryce	Appointment for next week
Readiness to Change	High Motivation		
Risk and Safety	1. Welfare of children monitored and parenting skills supported. 2. Individual does not appear aware of injecting risks/information required	1. Brian Kerr 2. Joyce Well	1. Ongoing, visit two weekly to c/d 2. Weekly appointments for first month, initial review thereafter

Co-ordinate by _____

Confidentiality agreement (see attached)

Notes on use of Integrated Care Plan

Information is collated from data from single shared assessment. The assessment of need is based on the subsections within each category of the core data sets i.e. living arrangements looks at household composition including children, status of residency, accommodation type, carer issues, other drug users, housing support needs, benefits, heating.

The Integrated Care Plan is designed to highlight specific needs to be addressed. The next column establishes how this is going to be done; by what action or service. We suggest that this form be completed following a full, comprehensive assessment and discussion with all relevant parties, when roles and responsibilities are clarified.

At the end of this table is the option for identifying a co-ordinator or co-ordination system, if there is a particular person to link people together or a specific team that is dealing with majority of service provision.

Consent to share information may be on a separate pro-forma where the individual has provided informed consent for information to be shared across agencies (details of this process in Information Sharing, Chapter 6).



Chapter 6: Information Sharing

Information Sharing

- Policy initiatives on information sharing
- A framework for obtaining consent
- Draft protocols

This chapter offers **practical guidance to DATs and agencies** on the exchange of personal client information across treatment, care and support services. In doing so it draws upon current Scottish Executive policy initiatives in relation to the development of information sharing, as well as providing local examples from the substance misuse field of how information sharing issues have been addressed.

What is information sharing?

The purpose of sharing personal information on individuals between partner agencies is **to ensure access to the appropriate treatment, care and support services** for those individuals. This requires:

- a culture of openness and trust between agencies
- agreement on the core elements of information to be transferred
- agreement on the circumstances when additional, possibly sensitive, information should be shared
- agreed inter-agency protocols governing information sharing
- respect for patient's/client's rights to privacy, confidentiality and consent to the sharing of their personal information.

There are various stages at which information sharing should take place, beginning at referral stage when the sharing of information between staff will assist decision making on the level of assessment required and the speed of response needed to address the individual's circumstances, continuing through assessment, care planning and delivery.

The Rationale: why is information sharing important?

A commitment from partner agencies to **the sharing and the safeguarding of client information** is essential to the development and delivery of integrated services for drug users. The exchange of information will assist service providers to provide individuals with the best possible service. A common criticism, when things go wrong, is that the right information was not provided to the right people at the right time. For the client, deficiencies in information sharing may result, for example, in delays in getting access to treatment, care and support, or referral on to an inappropriate service. This, in turn, may reduce the chances of a positive outcome, and lead to disillusion and non-attendance. A bad experience of attending a service in the past may also reduce the motivation to seek treatment in the future.

Where a service provider has access to an individual's personal information and is referring them on to another provider, they should be mindful of the information needs of the receiving service. At the same time, service providers have a responsibility to clients to share only that information which is necessary to ensure that they benefit fully from the service.

Improving Information Sharing

Information sharing should take place within an environment of **informed client consent**. In order to achieve informed consent, the client must be advised of the implications of giving or of refusing consent, amongst whom their personal information is being shared and the purposes for which it is being shared. It is important that this process is not undertaken in a manner divorced from the rest of the dialogue between practitioner and client. For example, it makes good sense to embed the seeking of consent for the sharing of referral information within the

dialogue over making the referral itself and the treatment, care and support that it is intended to set in motion.

The service users' focus groups found that service users did not see sharing information as a problem. Clients were aware of the lack of adequate information sharing between agencies and service providers: they found themselves being asked the same list of questions by different personnel. As long as information was kept within and between agencies, they were happy for information to be shared (SDF 2002, Type 4).

I just don't understand why there can't be one file that's got all the information on you and that goes from place to place and they've all got the same facts. What's difficult about that?

SDF Focus Group Respondent 2002

At service level, however, there may be a number of impediments, both real and perceived to information sharing. Amongst these barriers are elements of personal, inter-professional or inter-organisational mistrust. From the EIU consultation workshops with service providers (EIU 2001, Type 5) information sharing and confidentiality was identified as the main factor that could inhibit the assessment process. As noted in Chapter 4 on Assessment there was concern too that the difficulties surrounding the sharing of information between agencies were often a result of agency "confidentiality policies" rather than in the best interests of clients.

This Chapter describes how the development of information sharing protocols, together with time for consultation and discussion amongst staff, can help to break down these institutional barriers.

The Wider Context

The Scottish Executive are currently taking a strategic lead on the development of community care information, information sharing, and systems integration. Outlined below are the main policy initiatives in relation to the development of information sharing: the **Joint Future Agenda**; the work of the Confidentiality and Security Advisory Group for Scotland (**CSAGS**); the **eCARE** Programme; and the Scottish Social Care Data Standards (**SCDS**) Project.

The Joint Future Group and the work of the Joint Future Unit

The Joint Future Group (JFG) was set up by Susan Deacon, under the chair of Iain Gray, then Deputy Minister for Community Care, **to improve partnership working between agencies and to secure better outcomes for service users and their carers**. The group published its recommendations in November 2000 in the report 'Community Care: A Joint Future'. Ministerial approval was granted in January 2001 and a multi-disciplinary team, **the Joint Future Unit**, based at the Scottish Executive, set up to implement the key recommendations.

These include:

- **Single Shared Assessments:** Agencies locally should have in place single, shared assessment procedures for older people and for those with dementia by April 2002, and for all client groups by April 2003.
- **Information Sharing:** The Scottish Executive should, by 2002, offer a strategic lead on the development of community care information, information sharing and systems integration. Locally, the arrangements for single shared assessments should include specific proposals for the necessary sharing of information between agencies, by obtaining explicit client approval.

There are two major national initiatives, both supported by the Scottish Executive, dealing with the development of information sharing between health and social care services:

- Work on the **principles and protocols** for information sharing has been co-ordinated by the **Confidentiality and Security Advisory Group for Scotland (CSAGS)** and its sub-group on information sharing.
- Work on **developing the technology** to support information sharing is being progressed within the Modernising Government Fund (MGF) sponsored 'eCARE' Programme.

The work of the Confidentiality and Security Advisory Group for Scotland

The Confidentiality and Security Advisory Group for Scotland (CSAGS) was set up in September 2000 as an independent committee, supported by the Scottish Executive Health Department, 'to provide advice on the confidentiality and security of health related information to the Scottish Executive, the public and health care professionals'. The Group undertook a review of the use of patient information by health care services and in April 2002 published its final report to Scottish Ministers on 'Protecting Patient Confidentiality'.

We set out below some of the **key conclusions** from the report, which although written for use by health care services, are also of relevance to DATs and to the range of health and social care agencies working with drug users:

'Protecting the rights of the individual - the regulatory framework'

- The Data Protection Act 1998 places a legal duty on data controllers to process data fairly and lawfully, to use no more data than is necessary for the task and to retain it for only as long as it is needed.
- The Human Rights Act 1998 guarantees respect for a person's private and family life. Under the terms of the Act, this right to privacy may be overridden, but only when there is a lawful reason to do so.
- The common law reinforces the need to obtain patient/client consent before sharing information.
- Professional guidelines require clinicians to ensure patients/clients are informed about how information about them is used and that consent requirements are met.
- A substantial organisational framework for protecting the use of patient /client identifying information already exists in Scotland. An example is the Caldicott Framework, set up in March 1999 in response to the Caldicott Committee 'Report on the Review of Patient-Identifiable Information'. This requires all NHSScotland organisations to appoint a senior clinician as 'Caldicott Guardian'¹.

¹Guardians are responsible for: auditing current practice and procedures; managing an improvement plan; and developing local protocols for inter-agency information sharing. Caldicott Guardians are also involved in decision-making about how their organisation uses patient identifying information. A review of the Caldicott process is planned.

‘Informing the public and patients’

- Staff need to be fully aware of legal, professional and organisational requirements and procedures.
- Most patients/clients do not have a full understanding of the ways in which their information is used. They have a right to know more.
- When patients/clients come into contact with services, the uses to which the information gleaned from that episode might be put should be explained.

‘Obtaining consent’

- Uses of patient/client-identifiable information can be broadly categorised to provide guidelines on consent requirements, see Table 1.
- These categories allow for implied consent in some circumstances, explicit consent in others and situations where data can be used without consent.
- Even if data may be processed lawfully without consent, they should be anonymised wherever possible. Consent is not required where information has been acceptably anonymised, but the individual should still be informed of its use.
- Consent, whether implied or explicit, must always be preceded by effective information for patients/clients.
- Explicit consent is best practice and should become the norm as better informed patients/clients share in decisions about the uses of information about them.
- There are circumstances where, even though explicit consent would be best practice, implied consent can be accepted in the interests of the health of the population and future health needs and improvements. It is only acceptable if patients/clients have been clearly informed about the uses to which data may be put. In addition, data controllers must only use the information needed for the task in hand and have a strict code of confidentiality in place.
- Patients/clients have the right to ‘opt-out’ of sharing their data, but must be made aware of the implications of doing so.

Table 1. Consent categories: a framework to guide staff in assessing consent requirements

CONSENT NOT REQUIRED
a. Legal requirement to share information e.g. if individual contracts certain notifiable diseases; Home Office inspectors must be given access to the Controlled Drugs Register held at community pharmacies (the register contains the names and addresses of individuals dispensed controlled drugs, including methadone).
b. Legal defence e.g. where there are concerns that a child or vulnerable adult is at risk of abuse.
c. Anonymised information e.g. personal identifiers removed.
IMPLIED CONSENT ACCEPTABLE
a. Patient/client care e.g. referral letter to GP or another treatment/care agency.
b. Operational management & public health e.g. planning; managing; funding and auditing; where identifiable data cannot be anonymised.
c. Multiple uses (if information cannot be anonymised) e.g. disease registries; epidemiology; national data banks.
PRIOR EXPLICIT CONSENT REQUIRED
a. Multi-agency care e.g. sharing data with other treatment and care services.
b. Research using identifiable data e.g. clinical trials.
c. Education and Training e.g. identifiable patient records used to lecture medical students.

Multi-agency care

Whilst staff in both health and social care services are bound by strict arrangements for protecting patient/client confidentiality and information sharing, their ways of working are different and have to meet different statutory and regulatory requirements. In recognition of this, CSAGS set up an inter-agency sub-group to develop **local protocols between partner agencies to support front-line information sharing practice**.

Draft protocols for inter-agency data sharing have now been published for consultation and can be found at www.show.scot.nhs.uk/ecare/draftprotocols/.

These incorporate a series of linked documents:

- a template for a brief patient/client information sharing leaflet
- short and longer-form information sharing protocols
- a set of briefing notes for staff

The protocols are based on the premise that explicit and informed consent is required before personal details are shared between social care and health care services.

Such protocols offer a shared governance and accountability framework for information sharing. They are not, however, an end in themselves but are developed to support trust between clients/patients and their practitioners and clinicians. Equally important for the re-affirmation or establishment of this trust are the ‘purposeful discussions’ needed between practitioners of different disciplines if potential differences in approach are to be resolved. A series of aids to such group or team discussions can be found in the ‘Workbook’ section of the protocols website above.

Drug Action Teams and drug agencies/partnerships of drug agencies may find it helpful to use the framework protocols in designing their own patient/client information sharing leaflets or agency information sharing protocols. This could save time. Also, by using the framework context-specific protocols may be dovetailed more easily with the over-arching inter-organisational framework. It is important that individual protocols are consistent with others used locally, since information flows involving personal information will only rarely be wholly internal to drug misuse settings.

There are also examples from the substance misuse field to draw on, for example from Forth Valley Substance Action Team; Highland Drug & Alcohol Strategy Group; and Aberdeen City DAT - Integrated Drug Service.

Forth Valley Substance Action Team have produced an **information note for patients/service users** entitled ‘The protection and use of patient or service user information’.

The note describes the reasons why patient/service user information may be needed; and individual’s rights of access to their records; as well as explaining that it is the legal duty of staff working for drug and alcohol services in Forth Valley to keep information about patients/service users confidential.

Information Sharing in Forth Valley



SERVICE PROVIDERS NAME (to be inserted)

THE PROTECTION AND USE OF PATIENT OR SERVICE USER INFORMATION:

NOTICE FOR PATIENTS/SERVICE USERS (can delete as appropriate)

We ask you for information about yourself so that you can receive proper support and treatment. This is why we ask you to indicate whether you are willing for such information to be shared with other professionals involved in your care. If you do not wish to give such permission, you can indicate this wish on the form.

We keep this information, together with details of your care and treatment, because it may be needed if we see you again.

We may use some of this information for other reasons: for example, to help us plan and develop services and to see that current services in Forth Valley run efficiently, train their staff, and can account for their actions. Information may also be needed to help educate tomorrow's staff and to carry out health and social care needs assessment for the benefit of everyone.

If you do not wish your information to be used in this way do not sign the consent box on the form. Your wishes will be respected.

Sometimes the law requires us to pass on information: for example, to notify a birth.

You have a right of access to your records held by this service.

EVERYONE WORKING FOR FORTH VALLEY DRUG & ALCOHOL SERVICES HAS A LEGAL DUTY TO KEEP INFORMATION ABOUT YOU CONFIDENTIAL

You may be receiving care and treatment from other people as well as (insert name of service). So that we can all work together for your benefit we may need to share some information about you.

We only ever use or pass on information about you if people have a genuine need for it in your and everyone's interests. Whenever we can we shall remove details, which identify you. The sharing of some types of very sensitive, personal information is strictly controlled by law.

Anyone who receives information from us is also under a legal duty to keep it confidential.

THE MAIN REASONS FOR WHICH YOUR INFORMATION MAY BE NEEDED ARE:

- Providing integrated Drug and Alcohol Services.
- Looking after the health and well-being of the general public.
- Managing and planning the work of Forth Valley Substance Action Team by analysing information collected and the use of mapping software. This is where the anonymised information is placed on a coloured map of Forth Valley to identify things like service uptake across Forth Valley. You cannot identify individual incidents or addresses from the maps.
- Making sure that Forth Valley Drug & Alcohol services can meet patient/service user needs in the future.
- Auditing accounts.
- Preparing statistics on performance and activity (where steps will be taken to ensure you cannot be identified).
- Investigating complaints or legal claims.
- Helping staff to review the care and treatment they provide to make sure it is of the highest standard.

If at any time you would like to know more about how we use your information you can speak to the person in charge of your care or contact the receptionist and they will put you in touch with the service manager.

Highland Drug & Alcohol Strategy Group – Protocol on Information Sharing

The Highland Drug & Alcohol Strategy Group's goal is "to enable individuals, families and communities in the Highlands to minimise the harmful use and effects of drugs and alcohol". To help achieve this the partners within the Strategy Group (who include: police, health, social work, Scottish Prison Service) have agreed a joint information sharing protocol to:

- share general information and where appropriate confidential information regarding the misuse of drugs, having due regard to the Law, Human Rights and Data Protection
- identify and use credible, accessible information about current drug and alcohol patterns and trends
- use information more effectively to ensure that resources reach the areas of greatest need

The protocol is designed to ensure that the relevant statutory agencies and others as appropriate have effective co-operative working arrangements in place to address issues that arise from substance misuse.

Aberdeen City DAT – Integrated Drug Service

The first phase of the integrated drug service initiative has been to develop the infrastructure for organisations to work together. Partners in the project include: Grampian NHS Board, Aberdeen City Council and non-statutory drug services. Key features of the service that have been developed so far include:

- common assessment, care planning and review tools
- a common policy on confidentiality
- a common policy on sharing information

Recording Consent to the Sharing of Personal Information

Chapter 4 on Assessment sets out **a personal information core data set incorporating signed permission from the client/patient to the sharing of this information with other agencies.**

When recording client consent to the sharing of their personal information, it should be clear:

- what information the client has agreed can be shared
- with whom it can be shared
- the purpose(s) for which information will be shared
- over what time period this consent applies

Forth Valley Substance Action Team have developed a **common screening and referral form.**

The form has a section for recording client consent to information from their case file being shared with particular individuals/services (specify which) and the option to withdraw this consent. Also, at the end of the form the client gives signed acceptance to support for their substance use and, as part of this, inter-agency information sharing.

The Client's Capacity to Give 'Informed Consent'

The section on self-reporting in the Assessment Chapter suggests four factors that would influence validity of reporting. These four factors might also determine validity of consent.

These are:

- level of sobriety
- acute distress
- cognitive impairment
- motivational deception

See also Chapter 5 on Planning and Delivery of Care, section on the role of advocacy.

The eCARE Programme: Developing the Technical Framework for Information Sharing

While the principles and protocols for information sharing have been addressed by the Confidentiality and Security Advisory Group for Scotland (CSAGS) and its sub-group on information sharing, work on **developing the technology** to support information sharing is going forward within the Modernising Government Fund (MGF) sponsored eCARE Programme.

This programme is intended to provide a generic standard framework for information sharing between health and social care organisations, across Scotland, which could offer opportunities to support integrated drugs services.

There are **four local eCARE** projects in the first (pilot) phase: NHS Argyll & Clyde and Renfrewshire & Inverclyde councils; NHS Borders, and Scottish Borders Council; NHS Forth Valley and Stirling Council; and NHS Lanarkshire, and North & South Lanarkshire councils.

The work of these projects complements the development of a **draft Strategy for Information and Communications Technology (ICT) support for Community Care**.

The eCARE Projects are working on a common approach to technology support for information sharing. The main components of this are:

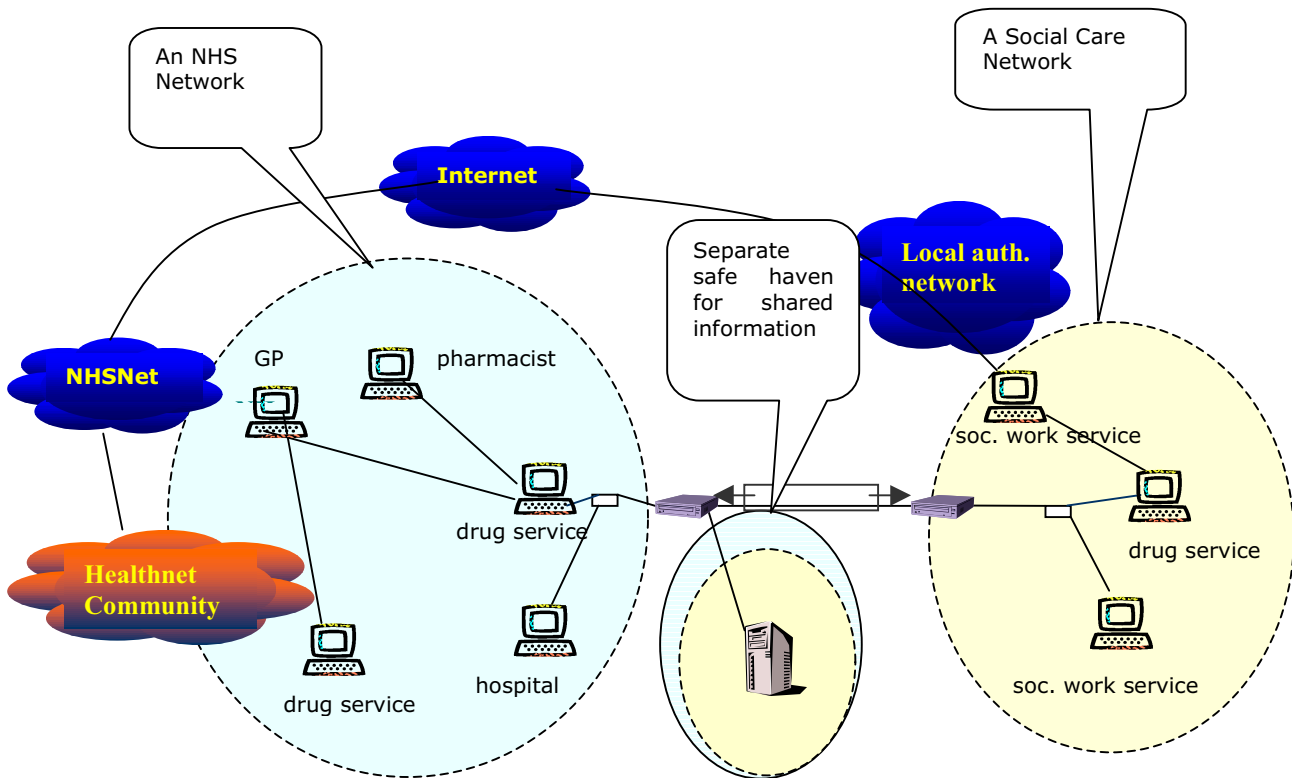
- a way of cross-referencing the NHS & social work patient/client identifiers
- standard electronic structures for frequently used documents such as referrals, assessments
- a 'safe haven' between NHS & local authority networks, for safeguarding shared information
- information 'repositories' or stores for holding shared information, closely modelled upon equivalent NHSScotland tools

My Information: my key to a Joint Future' – a National Joint Future ICT Strategy

The draft Strategy aims:

- 'to enable Community Care Partner agencies – systematically (shared investment, support arrangements etc. under the umbrella of their developing Local Partnership Agreements) – to establish shared ICT support for key operational processes, using as far as possible a familiar set of non-proprietary 'Crown copyright' tools'
- to provide a supportive framework for the cultural change needed as agencies move from 'owning' their patients' and clients' information, to acting as 'custodians' of it

In a drug misuse context this common approach may be represented diagrammatically thus:



There is consensus across the eCARE projects that this approach is best because:

- it makes a very clear distinction between shared and unshared information, allowing for access by the variety of systems used in any local partnership
- it allows for future growth, to cater for managed access to shared information by both other authorised organisations (including voluntary sector agencies), and clients/patients themselves

In an example from the substance misuse field, the five **Turning Point Arrest Referral Schemes in Tyne and Wear** have developed a **dual internet/intranet computer based application to enable staff to access information via a secure entry.**

Clients have one file shared over the intranet, so providing better communication for staff. Risk assessment and appropriate engagement with clients/treatment services can be managed through a daily 'bulletin board'. Also, local steering groups have a section in the intranet that allows them to retrieve KPIs, demographic breakdowns, or activity within the custody suite using a 'report builder'.

The Scottish Social Care Data Standards (SCDS) and E-Government Project

The use of common data standards and definitions facilitates the development of integrated services and the sharing of information between them.

The SCDS Project has been set up by the Scottish Executive, the Association of Directors of Social Work, COSLA and Audit Scotland **to produce data definitions and standards to improve the consistency and quality of social care information, both locally and nationally.** Other project sponsors include ISD Scotland, OLM plc, and Anite Public Sector (formerly Sheridan).

The Project runs from June 2001 until September 2002 and is financed largely by the Modernising Government Fund (MGF). The project is based at Trinity Park House in Edinburgh (hosted by ISD Scotland). A bid for a further SCDS Project of 18 months duration has been approved under the second round of MGF funding (MGF2). This project's working arrangements are yet to be confirmed, but it is likely to commence in January 2003.

A Data Standards Manual will be produced by the end of 2002 containing definitions for key terminology, standard classifications and codelists for priority social care areas. The project will also assist the 'eCARE' projects, also funded under MGF. The manual will be produced with the specific objective of ensuring consistency between these data standards and those developed or being developed for related health, criminal justice and education information systems.

In July 2002 the Social Care Data Standards Project issued a **consultation paper on 'Draft Drug Misuse Definitions'**.

Further resources:

Joint Future Unit website: <http://www.scotland.gov.uk/health/jointfutureunit/>

eCARE website: <http://www.show.scot.nhs.uk/ecare/>

CSAGS (Confidentiality and Security Advisory Group for Scotland) website: <http://www.show.scot.nhs.uk/csags/>

Scottish Social Care Data Standards and E-Government Project website: <http://www.scds.org.uk/>

Report by the Performance and Innovation Unit (PIU) on 'Privacy and data-sharing: the way forward for public services': <http://www.cabinet-office.gov.uk/innovation/2002/privacy/report/>

KEY PRINCIPLES OF EFFECTIVE PRACTICE: INFORMATION SHARING

ECARE Project colleagues have helpfully identified 10 key principles which should underpin the sharing of person identifiable information between those **'partner agencies'** who agree to an **'information sharing protocol'**. These are:

1. All staff will respect the service user's rights to privacy and confidentiality.
2. No information will be shared without the prior consent¹ of the service user (or their representative), except in the circumstances referred to in Principle 10 below.
3. Information will only be shared for the purposes agreed to by the service user.
4. The partner agencies will only use shared information for the purposes set out in the information sharing protocol.
5. Service users have a right of access².
6. If service users refuse consent to the sharing of information, the partner agencies will ensure that they are aware of the implications of their decision.
7. Access to person identifiable information will be on a need to know basis.
8. The partner agencies will ensure records are accurate, complete and up-to-date.
9. The partner agencies will make sure that person identifiable information is safe and secure.
10. You may share information without consent if you are obliged to by law, if required to do so to protect an individual's vital interests, or if you must do so in the public interest.

¹In terms of the practicalities, consent should not have to be sought for each and every incident of data sharing. The information sharing protocol will need to create a framework that defines the scope of consent appropriately, balancing administrative practicality with service user rights.

²i.e. access to information regarding their care.

GLOSSARY OF TERMS

Term	Meaning
Service providers	Service providers should include: GPs and primary care teams; community-based specialist drug services (statutory and voluntary); pharmacies; Scottish Prison Service (SPS); providers of SPS transitional care arrangements; housing services; employment and training providers; health specialties such as A & E departments, antenatal services and hepatology departments; social inclusion partnership initiatives; social work community care, child care and criminal justice teams; drug courts, arrest referral schemes and DTTOs; providers of residential detoxification or rehabilitation services; employment, education and training providers e.g. further education colleges and enterprise networks; business organisations; and after care services such as those provided through New Futures Projects (see Chapter 2 Integrated Care: Definitions and Concepts).
Acceptably anonymised data	Data from which in practice the patient/client cannot be identified by the recipient of the information, and where the theoretical probability of the patient's identity being discovered is extremely small.
Anonymised data	Data from which there is no theoretical or practical risk that a patient/client could be identified by the recipient of the information.
Explicit consent	Agreement which is expressed orally or in writing (except where patients cannot write or speak, when other forms of communication may be sufficient).
Implied consent	Assumption that circumstances allow disclosure of information without seeking explicit consent.
Informed patient/client consent	Explicit consent, plus situations where it is acceptable to rely on implied consent because the patient/client has been informed and has not used available mechanisms to refuse consent.
Patient/client identifying information	A data set which may include some or all of the following: a picture of the patient/client, their name, address, full post- code or date of birth.



Chapter 7: Monitoring and Evaluation

Monitoring and Evaluation

- **Definitions of monitoring and evaluation and why it is important**
- **Describing service level evaluation and strategic evaluation**
- **Developing and evaluation culture**

This chapter discusses the monitoring and evaluation of integrated care for drug users. It examines and discusses the concepts of monitoring and evaluation, service level and strategic level evaluation and developing an evaluation culture.

The key sources of **evidence** that have been drawn on for this section are the EIU evaluation guides and the EIU consultation workshops. The EIU evaluation guides have been developed and produced by EIU since 2001 and draw heavily on the published evaluation literature.

What are monitoring and evaluation?

Monitoring is an on-going process involving the continuous and regular collection of key information on the inputs, outputs and outcomes of a service, intervention or partnership. The main aim of monitoring is to establish if something is going to plan, and whether any change in activity is necessary.

Evaluation is a systematic assessment of whether a service / intervention / partnership has achieved its stated aims and objectives. Evaluations commonly address questions about effectiveness, efficiency and acceptability. An evaluation can address the context and process of evaluation as well as the outcomes achieved.

For further information on the definitions and core concepts of monitoring and evaluation, please see the Effective Interventions Unit Evaluation Guide 1. Definitions of aims, objectives, inputs, outputs, outcomes and rationale are provided. This guide can be downloaded at www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluation1.pdf

The Rationale: why are monitoring and evaluation important?

Systematic monitoring and evaluation of integrated care is crucial to help assess how and why integrated care is or is not working, and to highlight areas which need improvement. Good evaluation has the potential to improve systems and services. It can help to identify what works, what could be done better and what is ineffective. This should inform decision making about service provision in an area, and therefore help to ensure that clients are receiving the best possible treatment, care and support.

How can integrated care be monitored and evaluated?

Integrated care is likely to be monitored and evaluated at two main levels: service level and strategic level.

Service level – Monitoring will generally focus on the inputs, outputs and outcomes of service activity. Evaluations will generally focus on whether the service is achieving its stated aims and objectives, i.e. that the service is providing the support and care expected and agreed as part of the integrated care process.

Strategic level – Monitoring activities will generally record the inputs, outputs and outcomes of strategic activities. Evaluations will generally focus on whether the necessary partnerships and joint working arrangements are in place to achieve the aims and objectives of integrated care i.e. providing services and maximising their co-ordination to provide person-centred treatment, care and support.

Evaluations at both the service level and strategic level will only be worthwhile if the aims and objectives of specific services and integrated care as a whole are clearly set out and 'SMART'. The '**SMART**' approach works by helping to focus on exactly what has to be achieved, who will be involved, how it will happen and when it has to be done:

- ✓ **Specific**
- ✓ **Measurable**
- ✓ **Achievable**
- ✓ **Realistic**
- ✓ **Timebound**

It will also be crucial that the aims and objectives are based on an **underlying rationale** or logic. Setting out the underlying assumptions and logic about why a service or intervention will have the desired impact will help focus the aims and objectives. These assumptions are often based upon existing evidence or previous experience with the target group.

In the case of integrated care, one of the underlying assumptions is that by improving co-ordination and promoting joint working, the pathway of care for the individual drug user will be more seamless and based on their individual needs. There is experience, and some limited evidence, to support this hypothesis. For further information on setting aims and objectives, formulating evaluation questions and planning an evaluation see EIU Evaluation Guide www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluation2.pdf

Service level evaluation

Service level evaluations will generally focus on whether the aims and objectives of a service have been achieved. It will be important that each service within an integrated care approach is meeting its own aims and objectives. These aims will, of course, vary widely depending upon the type of service provided. However, common questions for an evaluation to address include:

- ✓ Is the service successful in attracting and retaining their target client group?
- ✓ Does the service 'work' and who for?
- ✓ Why and how does the service 'work'?
- ✓ What do clients and their families think of the service?
- ✓ How can the service be improved?
- ✓ Is the service cost effective?

The methods employed to undertake the evaluation will depend upon the question(s) posed. There are a number of key considerations to resolve before a final method is agreed. For example:

- ✓ who to include in the evaluation
- ✓ when and how often data will be collected
- ✓ whether comparison with another group is appropriate
- ✓ which inputs, outputs and outcomes will be included

The choice of design will also depend on what stage of development a service is at. For example, if the service is being piloted, it may be important to focus on the **process** of service delivery (which staff do which jobs, where and how often clients are seen, how long clients stay

in contact). However, if the service is fully developed it may be important to focus on the **outcomes / impact** of the service (were the desired outcomes achieved?).

Often service evaluations can make good use of **existing information** by conducting some systematic analysis of data. This commonly includes monitoring data, assessment data (see EIU evaluation guide 7), and management information. In this way, evaluation can be built into day to day practice.

However, there is sometimes a need to collect **additional information** using both quantitative and qualitative research methods. For example, it may be useful to follow up clients who have left the service, or to ask family members for their views and experiences of engaging with the service. Further information about the range of methods that can be used to evaluate services and interventions is set out in EIU Evaluation Guide 3, including a description of three core evaluation designs. This guide can be downloaded at www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg3.pdf

Strategic level evaluation

Periodically, it will also be essential to examine more broadly how the range of services in an area are meeting the needs of drug users. The overall aim of integrated care is **to combine and co-ordinate** all the services required to meet the assessed needs of the individual. Integrated care promotes and supports collaborative working between agencies at each stage in the progress of the individual through treatment and care, rehabilitation and reintegration into the community. Evaluations of the integrated care approach will commonly address questions including:

- ✓ Do existing services that contribute to the integrated care approach meet the wide ranging needs of drug users in the area?
- ✓ Do existing services that contribute to the integrated care approach have the capacity to deal with the needs of drug users in the area?
- ✓ Are there appropriate and effective joint assessment arrangements (e.g. single shared assessment)?
- ✓ Are there appropriate and effective information sharing protocols and referral procedures?
- ✓ Are there appropriate and effective partnership working arrangements?
- ✓ Are there appropriate and effective joint resourcing arrangements and joint management arrangements?
- ✓ Are there barriers to providing an integrated approach and / or opportunities to improve collaboration between key agencies?
- ✓ Do current monitoring and evaluation arrangements provide sufficient information for on-going review and improvement?

An important precursor to evaluating the capacity and accessibility of services in an area to meet local need may be to conduct a systematic **needs assessment**. This is discussed in Chapter 3 on Accessibility and an associated Annex 3B. These data help provide a baseline against which to assess capacity, accessibility and appropriateness of services. As already mentioned, the EIU will be publishing a Guide to Needs Assessment in Scotland early in 2003.

A range of methods is likely to be required to address the questions raised in an evaluation of an integrated care approach. These may include interviews and focus groups with service users and their families, representatives of the range of both specialist and generic service providers in the area and service commissioners to elicit their impressions, views and experiences.

However, if a core principle of integrated care is to provide person-centred care it will also be essential to look at whether integrated care is delivering improved outcomes for service users and their families. It should, for example, be possible to identify how a representative sample of individuals has moved through an integrated care approach. Ideally it would be useful to compare their integrated care experience with previous experiences, or to compare an integrated care approach with a 'non-integrated' care approach. As with service evaluations, there may also be existing management information that can contribute in such an evaluation.

It may also be desirable to include an **economic evaluation** component into strategic evaluations of integrated care. As with all public services, only limited resources are available for tackling substance misuse. Resources need to be used wisely so that they have the maximum impact in helping individuals and the wider community. Economic evaluation allows the costs (the resources that they use) of different services and interventions to be considered alongside the outcomes or 'benefits' achieved. This can help to inform comparisons between different approaches and can allow resources to be used more effectively. For further information on economic evaluation, please see EIU Evaluation Guide 6 at www.drugmisuse.isdscotland.org/goodpractice/EIU_%20evaluation6.pdf

Ensuring a feasible, inclusive and worthwhile evaluation

There are some important considerations when planning either a service level or a strategic level evaluation. It is essential to be clear from the outset why evaluations are being conducted, whether the evaluation is feasible and how the results of the evaluation will be used. Each evaluation will be unique, but there are some common principles to apply to ensure a feasible, inclusive and worthwhile evaluation. It is important to be clear about:

- Utility**
 - Who needs or has requested the evaluation?
 - What use will it have?
 - What audiences will be able to use the results?
- Feasibility**
 - What resources are available?
 - What is the timescale?
 - Are there data to support the evaluation (or can they be collected)?
- Inclusiveness**
 - Who are the key stakeholders?
 - How can stakeholders best be involved in the evaluation?
 - Are there steps that can be taken to promote involvement?
- Propriety**
 - Are there ethical issues to be considered?
 - Are there legal issues to be considered?
 - Who should conduct the evaluation and how will they be selected?

Considering these questions early in the evaluation process can make the whole process much easier. In particular, it will be important to decide whether an external evaluator should be commissioned to undertake such exercises. For strategic evaluations involving a number of different agencies it may be particularly important to commission the evaluation externally.

Implementing the evaluation

There are some special considerations when implementing evaluations. These include recruiting and training monitoring and evaluation staff (if not commissioned externally), obtaining consent from those participating, complying with the Data Protection Act and seeking ethical approval (if required). If service users and their families are asked to participate in an evaluation, it is also good practice to provide them with travel expenses, childcare expenses and a small incentive for their participation. Further information about implementing an evaluation is set out in EIU Evaluation Guide 4. This can be downloaded at www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg4.pdf

Reporting and dissemination

Often evaluations are conducted because they are a condition of funding. In these cases, evaluation is often perceived as a burden. However, this is a missed opportunity for learning and development. Such learning will only happen if the results of the evaluation are effectively disseminated and discussed.

It is, of course, useful to set out the key findings from evaluations in written reports or feedback sheets appropriate to the audience and circulated widely to all stakeholders, including service users. However, there are other (more innovative) ways in which the results of evaluations can be disseminated and used. For example:

- ✓ using the results as the basis for seminars and workshops with service staff
- ✓ using the results as a basis for discussion with managers and commissioners
- ✓ compiling the main results into 'do's' and 'don'ts'
- ✓ preparing 'recipes for success' and building them into service procedures
- ✓ preparing case studies to bring the evaluation to life

Developing an evaluation culture

It will be important that all stakeholders involved in the evaluation process understand the purposes of evaluation and are committed to making it work. This can be a long process, particularly when evaluation is often perceived as something that is undertaken to apportion blame, rather than to help improve services and interventions. Developing an 'evaluation culture' that values the process and learns from its results will not happen immediately, but over time will ensure that evaluations are even better in the future. Often this process needs a 'facilitator' or 'champion' who will ensure that evaluation activities are developed in an area and that training is provided. As part of our activities to promote evaluation in the drugs field, the EIU have produced a series of evaluation guides and supported evaluation workshops in most Drug Action Team areas in Scotland. The guides produced to date are listed at the end of this section. If you would like a copy of the materials used as a basis for the evaluation workshops, please email us at eiu@scotland.gsi.gov.uk.

EFFECTIVE INTERVENTIONS UNIT EVALUATION GUIDES

For more information on evaluation in the drugs field, please see the EIU Evaluation Guides. The first 5 guide the reader through the evaluation process. The second 5 guides focus on specific aspects of evaluation and evaluating specific types of projects.

GUIDE 1	Definitions and common concepts www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg1.pdf
GUIDE 2	Planning an evaluation www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg2.pdf
GUIDE 3	Designing an evaluation www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg3.pdf
GUIDE 4	Implementing an evaluation www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg4.pdf
GUIDE 5	Reporting and dissemination www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg5.pdf
GUIDE 6	Designing and economic evaluation www.drugmisuse.isdscotland.org/goodpractice/EIU_%20evaluationg6.pdf
GUIDE 7	Using assessment data for evaluation www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg7b.pdf
GUIDE 8	Evaluating outreach services www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg8.pdf
GUIDE 9	Evaluating employability programmes www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg9.pdf
GUIDE 10	Evaluating community engagement www.drugmisuse.isdscotland.org/goodpractice/EIU_evaluationg10.pdf

Or you can request copies of these at EIU@scotland.gsi.gov.uk or on 0131 244 5117.

Further resources

The resources below are useful if you are planning undertake some monitoring and evaluation activities. Other resources can be found in the EIU evaluation guides.

EMCDDA evaluation instruments bank www.emcdda.org/eib/databases_eib.shtml

WHO evaluation workbooks www.who.int/substance_abuse/pubs_pschoactive_drugs.htm

W.K Kellogg Foundation Evaluation Handbook
www.wkkf.org/documents/WKKF/EvaluationHandbook



Appendices

Appendix 1	Membership of Groups and Seminars
Appendix 2	Scottish Drugs Forum – Service Users’ Views on Assessment – Summary
Appendix 3	Scottish Drugs Forum – Service Users’ Views on Planning and Delivery of Care – Summary
Appendix 4	Scottish Drugs Forum – Study of Service Provision Needs of psychostimulant Users
Appendix 5	A Survey of NHS Services for Opiate Dependants in Scotland
Appendix 6	The Effectiveness of Treatment for Opiate Dependant Drug Users: An International Systematic Review of the Evidence – Summary
Appendix 7	STRADA – Scottish Training on Drugs and Alcohol
Appendix 8	Community Based Criminal Justice Interventions With Drug Offenders
Appendix 9	Effective Interventions Unit Publication List
Bibliography	

Shared/Integrated Care Reference Group

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Integrated Care Seminars

Ayr, March 2001

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Robert Pirrie	The Vernon Centre
Dr Rhianne Richmond	Linwood Health Centre
Kay Roberts	Greater Glasgow Primary Care NHS Trust
Anne Sinclair	Ayr, Prestwick and Troon Local Health Care Co-operative
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Brian Williamson	Scottish Drugs Forum
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Glasgow, March 2001

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David Greenwell	Co-ordinated Addictions Network (Argyll and Clyde)
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Marie Hayes	Lanarkshire Health Board
Mary Hepburn	Glasgow Royal Maternity Hospital
Phil Hogben	Phoenix House
Anne Howe	Tayside Drug Problem Service
Dr Jane Jay	Glasgow Drug Problem Service
Michael Knox	HM Prison Shotts
Gavin Lawson	Cumbernauld and Kilsyth Addiction Service
Marion Logan	Forth Valley Health Board
Gerard Lymas	Bridgeton and Environs Local Health Care Co-operative
Steven MacDonald	South Lanarkshire Council
Flora MacKenzie	Church of Scotland Board of Social Responsibility
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Dumfries, March 2001

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Introduction

The Scottish Drugs Forum (SDF) and its two ancillary service users' groups, Glasgow Street Intervention Group (GSIG) and Tayside Street Intervention Group (TSIG) were commissioned by the Effective Interventions Unit (EIU) to undertake a short project on the assessment process. The results of this project form part of the evidence base on assessment presented in the assessment chapter of this report.

Aim

The aim of the project was to elicit the views and experiences of current and former drug users of the assessment process.

Methods

Five focus groups comprising current and former service users were conducted in five localities: Aberdeen, Dumfries and Galloway, Glasgow, Perth and Kinross and West Lothian. This ensured representation from urban, semi-rural and rural areas of Scotland. A total of 49 respondents participated. Of these, two-thirds were male and the age range was 24-31 years (average age 28 years). The groups' discussions focused on six key themes:

- General views and experiences of the assessment process
- The length of the process
- The number of workers seen by the user during the assessment process
- The influence users had in reaching decisions about their treatment and care
- Whether subsequent treatment and care met the expectations raised at assessment
- Improvements that could be made to the assessment process

Key Results

- There were no unconditional, positive responses about the assessment process. It was unanimously regarded as an alien, external procedure that 'happened' to participants in order to obtain a service.
- About half the participants were too chaotic to know or remember what was going on, particularly at initial assessment.
- For those who were more stable and were cognisant of the process, assessment was either an uncomfortable procedure to get to where they wanted to go to in the first place or something that had to be put up with to get a desired service.
- Service users felt that they were not valued, included or listened to during the assessment process (irrespective of whether they get the services they want).
- Service users (at least at their initial assessment) are largely unaware of what the process entails, who will be involved and what the outcomes will be.
- With one exception, all participants indicated that the assessment process was too lengthy.

- The present position of numerous assessments and reassessments by different agencies is unacceptable to service users. In particular, the need to provide the same information repeatedly was frustrating for users.
- Overall clients did not perceive the assessment process to be intrusive. This may reflect an (almost fatalistic) expectation that the process will be intrusive in nature. However, respondents were often unclear why questions on offending were included in assessments.
- With one exception, all participants said they had little or no involvement in the decisions reached about their treatment and care.
- The assessment process can raise client's expectations about service delivery and possible outcomes to an unrealistic level as these expectations cannot be met locally.
- The main suggestions for improving the assessment process were: dispelling the 'them' and 'us' syndrome, having one assessor to complete the whole process, to improve communication between agencies and to share information among agencies to avoid repetition.

Key Conclusions

Overall, users felt that:

- Service providers should clearly set out at the start of the process what the assessment entails.
- Where possible, assessment should not be undertaken when service users are in an unstable or chaotic condition.
- Every effort should be made to speed up the assessment process.
- Service providers should raise awareness of local services by providing a 'map' of locally available treatment and care services for service users.
- Assessment should be tied into what is available locally. An assessment that is not tied in to service availability will be an abstract affair that will inevitably lead to raised expectations and disappointment.
- There should be just one assessor who would provide a gateway to other services. The assessment details, with the client's permission, should be held in one file and provided to other services as and when needed.
- Service providers should consider how best to involve service users in the assessment process without raising unrealistic expectations.

Acknowledgement

SDF and EIU would like to thank all service users and recruitment sources for their assistance and help. SDF would particularly like to thank all those who participated in the focus groups.

Introduction

The Scottish Drugs Forum (SDF) and its two ancillary service users' groups, Glasgow Street Intervention Group (GSIG) and Tayside Street Intervention Group (TSIG) were commissioned by the Effective Interventions Unit (EIU) to undertake a short project on the planning and delivery of care for drug users.

Aim

The aim of the project was to elicit the views and experiences of current and former drug users on the planning and delivery of their care.

Methods

Five focus groups comprising current and former service users were conducted in five localities: Dundee, Edinburgh, Inverclyde, Stirling and Shetland. This ensured representation from urban, semi-rural and rural areas of Scotland. A total of 52 respondents participated. Of these, two-thirds were male and the age range was 26-32 years (average age 28 years). The groups' discussions focused on six key themes:

- Views and experiences of how their care was planned
- Who had been involved in deciding what treatment and care was provided
- How often users met with the people involved in planning and delivering their care
- Views and experiences of having one worker as a facilitator
- Whether users had a say in what treatment and care they received
- Ideally, who would be involved in regular meetings about treatment and care

Key Results

- There was confusion among participants about the terms 'care plan', 'care planning' and 'shared care' and what these processes were supposed to achieve.
- Users identified the best things about their experiences of care planning and delivery as: not having to pay for drugs, not mixing with other drug users and having less debt.
- Users identified the following as the most negative things about their care planning experiences: reducing or cutting prescription without their consent, the arbitrary way in which a good key worker was provided and the lack of trust between workers and service users.
- The majority of participants thought that it would be helpful to have one person co-ordinating their care. The reasons given were that it was time saving, avoids confusion, results in better relationships between workers and service users and promotes clearer communication between agencies.
- Some participants specifically mentioned the role of a relative (usually a parent) or partner in helping them access treatment.

- Five professions were identified as being involved in the planning and delivery of the participants' care: doctors, key workers, generic social workers, probation and criminal justice social workers and psychiatrists.
- Generally, service users met weekly with those involved in the planning and delivery of their treatment and care. However, few felt that these sessions were an opportunity to discuss changes in treatment unless there was a crisis situation.
- Overall, participants felt that they had little say in getting the services that they needed. They often felt that treatment and care could only be accessed once their drug use and route of drug use (i.e. injecting) reached a certain level.
- Case conferences were cited as particularly intimidating for participants. Participants felt they had no control over the proceedings, or over who should be present.

Key Conclusions

- Terms commonly used by service providers such as 'care plan', 'care planning' and 'shared care' were largely unknown to participants.
- The planning and delivery of care appears to be a process that happens passively to participants. This was not something that users felt they had much control over.
- Most participants were in favour of having a lead worker.
- From the users' perspective, treatment routes and changes in treatment provision were largely haphazard, often occurring in a reactive fashion in response to events in the users life.
- Many users felt that they had to be in a crisis situation to be able to access services. In particular, some respondents indicated that they needed to be injecting to access services.
- The presence or advocacy of significant others could often make the difference between getting a specific form of treatment or not.
- Case conferences were a largely hostile, alienating experience for users.

Acknowledgement

SDF and EIU would like to thank all service users and recruitment sources for their assistance and help. SDF would particularly like to thank all those who participated in the focus groups.

Introduction

The Scottish Drugs Forum (SDF) were commissioned by the Psychostimulants Working Group of the Scottish Advisory Committee on Drugs (SACDM) to undertake a short project on the service provision needs of psychostimulant users in spring 2002. This work has also helped inform the present document on integrated care for drug users.

Aim

The primary aim of the study was to obtain a snapshot of the views and experiences of stimulant users on their needs and available service provision.

Methods

The two qualitative methods were used: one-to-one interviews and focus groups. The study focused on three psycho-stimulants: cocaine, crack cocaine and amphetamine. The study sought to identify the views and service needs of different groups of stimulant users, including both primary and secondary psychostimulant users. The total sample of respondents was thirty-three. Questions related to seven key themes:

- Their reasons for psychostimulant use
- The problems they experienced relating to stimulant use
- The services they had accessed
- The support they had received at services
- Their views on service satisfaction
- Their views on future service provision

Results

- The study showed that stimulant users are not a homogenous group. They include opiate users who also use psychostimulants, primary (and heavy) psychostimulant users, and recreational users.
- Users felt there was an information and training deficit among health professionals and specialist drug agency workers regarding psychostimulants.
- Users felt that drug services are primarily, and predominantly, geared to dealing with problems of opiate use.
- Stimulant users are not keen to discuss their drug use with GPs, due to GPs' lack of knowledge about stimulants. There was also concern about losing their methadone script if the GP knew about their stimulant use.
- Many respondents stated a preference to be seen by drug agency workers who had personal experience of drug use.

- Alternative therapies were regarded positively by respondents as a treatment option for those experiencing problems.
- Respondents expressed a need for employment skills and help in finding work.
- Respondents expressed a desire for counselling to explore the reasons behind their drug use.

Conclusions

Overall users felt:

- There should be different approaches to care which recognises the diversity of users.
- Drug agency workers and health care professionals generally need more information and training about psychostimulants.
- There is a need for improved co-ordination between agencies.
- There is a need for early access to confidential, trustworthy advice and information without recourse to a GP.
- Short-term prescribing of dexamphetamine may be helpful to keep users off the streets.
- The present variety of treatment approaches should be encouraged.
- Employment support and associated aftercare services are needed.
- Ex psychostimulant users should be involved in delivering services.

Acknowledgement

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Introduction

The Department of Health guidelines on clinical management for drug misuse and dependence outline a range of drug treatments and other therapeutic interventions appropriate for treating opiate dependents. These treatments vary in what they set out to achieve, according to what is deemed appropriate for individuals. This study examines the range of treatment options available to opiate users across Scotland and looks at how clinical decisions about treatment are made. The study was conducted by a team from the Health Services Research Unit (Aberdeen University), Ayrshire and Arran NHS Primary Care Trust and the Centre for Drug Misuse Research (Glasgow University).

Aims and Objectives

The main objectives of the study were to investigate:

- the range of options made available in different areas within the Scottish NHS Board areas for treating patients with opiate dependence
- the processes that underlie clinical decision making

Methods

Qualitative interviews were conducted with clinicians working in specialist addiction services across Scotland, Drug Action Team representatives and NHS Board representatives responsible for commissioning of out of area referrals. This report focuses on the findings from the interviews with clinicians. The majority were consultant psychiatrists. An interview schedule was used to conduct the structured interviews. Clinicians were asked about a range of issues including:

- Opiate drugs prescribed
- Methadone dose
- Methadone supervision
- Short-term/long-term prescribing
- Abstinence
- Non opiate drugs prescribed
- Use of Protocols
- Counselling
- Alternative therapies
- Treatment settings
- Professional make up of the addiction service
- Links with other health care settings
- Links with non-NHS care settings
- Likes and difficulties of working with opiate dependents

Key Findings

- All clinicians reported that methadone was available in their area. 80% were involved in prescribing methadone, the remaining 20% treated clients who were prescribed methadone from another source. Half of clinicians reported that all (or nearly all) their clients were on daily supervised dispensing.
- Almost half of clinicians did not have an 'upper limit' of methadone dose. They reported prescribing at a level required to achieve stability in their clients. The remaining respondents reported an 'upper limit' of between 70-150mgs. Methadone is widely perceived as a long term treatment.
- More than half of clinicians were involved in dihydrocodeine prescribing. The rationale for doing this was not consistent among clinicians.

- Buprenorphine was being prescribed within specialist services in two NHS Board areas. There is interest among clinicians in other NHS Board areas to look at the potential contribution of buprenorphine prescribing in opiate users.
- All clinicians were involved in lofexidine prescribing and almost all clinicians were involved in prescribing naltrexone. Lofexidine and naltrexone were viewed as appropriate for small proportions of specialist addiction services' case loads.
- Almost all clinicians prescribe benzodiazepines. The proportion of patients prescribed benzodiazepines varies greatly among clinicians from less than 5% to over 80%.
- Over half of clinicians identified a sub-group of their caseload (5-33%) who could achieve abstinence relatively quickly. A third thought the majority of their caseload could become abstinent with time.
- Most specialist addiction services offer psychological interventions. A range was identified including relapse prevention, cognitive behavioural therapy, motivational interviewing and anxiety management. Counselling is not always offered and is only mandatory in two settings.
- About one fifth of specialist services offer some form of alternative therapy. Where available, these were provided opportunistically by a staff member in the team trained to provide a specific therapy.
- Approximately three quarters of clinicians identified protocols, often locally developed but based on, or adding to, information in the Department of Health Guidelines on Clinical Management.
- Clinicians reported links between specialist addiction teams and maternity services, mental health services, accident and emergency departments, primary care, social work and criminal justice services. However, the quality of those links, and the extent to which they were formalised, varied.
- The professional make up the addictions team varied between two and six different professions. Teams usually including doctors, nurses and drugs workers. Clinical psychologists, social workers and pharmacists are also commonly represented. Most clinicians were positive about the benefits of multi-disciplinary working. The most common benefit cited was mutual support.
- Fifteen NHS Boards made over 250 'out of area' referrals between April 2000 and March 2001. In some cases these include referrals for people with alcohol problems. In most cases, the clinician responsible for addiction in each area approved these referrals.

Key Conclusions

- Methadone prescribing is almost universally available across Scotland. However, there is some variation in the form that methadone prescribing takes in terms of the dose of prescription and rationale, supervision arrangements and the degree to which it is integrated with counselling services.
- Small amounts of dihydrocodeine prescribing and buprenorphine prescribing are evident. In particular, there is interest among clinicians in looking at the potential contribution of buprenorphine prescribing in opiate users.

- Lofexidine and naltrexone prescribing were widely available, but tended to be for relatively small proportions of clients. This may be a reflection on the small number of patients who were detoxifying.
- The availability of psychological interventions was variable and the use of alternative therapies was not widespread. However, there was interest in developing these.
- Varying degrees of partnership working between and within statutory and non-statutory services were reported. There were examples of good partnership working between agencies, in particular between addiction teams and maternity services.

Key Recommendations

- A co-ordinated and integrated approach to service delivery should be implemented to maximise service effectiveness and minimise service duplication.
- Local service protocols based on the Department of Health Guidelines on clinical management should be developed and regularly reviewed for all drugs prescribed to opiate users.
- There should be greater integration of substitute prescribing and counselling and psychosocial interventions. Further, attention should be given to the role of alternative therapies.

Introduction

The Department of General Practice and Primary Care and the Health Economics Research Unit (HERU) at the University of Aberdeen were commissioned by the Effective Interventions Unit (EIU) to conduct a systematic review of the international literature on treatment for opiate users. This research summary provides an overview of the key findings.

Aims and Methods

The aim of this study was to identify, review, and critically appraise the quality of reviews and trials in the international research literature on drug misuse concerning the effectiveness and cost effectiveness of interventions, and the demographic and programme factors that influence treatment outcomes.

A systematic search of databases, journals, and the grey literature was carried out from 1990 to 2002. Reviews and primary studies that examine the effectiveness and cost-effectiveness of the following interventions were included: community maintenance, community detoxification and residential rehabilitation (see mini-glossary for definitions). Demographic and programme factors that influence treatment outcomes are noted where possible. Gaps in existing knowledge are highlighted and policy recommendations based on existing knowledge are presented.

Following a comprehensive, systematic search of the literature 819 papers were initially identified and of these, 141 were included in the review. The primary outcome measures examined were abstinence from opiate use, reduction in illicit opiate use, withdrawal severity, the length of time in treatment and retention in treatment. The findings outlined in this summary are based on randomised controlled trials (RCTs).

KEY FINDINGS

Community Maintenance

There was an extensive and high-quality literature investigating the effectiveness of community maintenance with a variety of drugs. The key findings were:

- community maintenance is effective at reducing use of illicit drugs and maintaining people in treatment across a wide range of age and ethnic groups, and among clients with a long history of opiate misuse
- higher doses of methadone, buprenorphine, and LAAM are associated with better primary outcomes
- higher doses of methadone (> 50 - 65 mg per day) appear to be slightly more effective than buprenorphine (2 to 8 mg per day)
- those maintenance programmes that provide more and better psychosocial services have a higher effectiveness at reducing illicit drug use and retaining people in treatment for longer

- contingent reinforcement is an effective method to reduce illicit drug use and promote client use of other services
- treating opiate dependence with methadone or buprenorphine in a primary care setting is feasible and effective
- less-than-daily dosing regimens with multiples of the daily dose of buprenorphine are effective and preferred by clients
- prescribing maintenance naltrexone following detoxification can be effective at maintaining abstinence from opiates, reducing illicit opiate use and retaining people in treatment
- results need to be interpreted with caution as they depend almost exclusively on studies conducted outwith the U.K

Community Detoxification

The literature on community detoxification contained a substantial number of RCTs comparing different (adrenergic agonists, comparing opiates with (adrenergic agonists or various models of opiate-based detoxification. The key findings were:

- a wide range of different models of community detoxification have been studied
- between 19% and 83% of participants returned to opiate use before the end of the programme
- alpha adrenergic agonists are reasonably effective at relieving opiate withdrawal symptoms and, thus, improve outcomes
- lofexidine is slightly more effective at reducing opiate withdrawal symptoms and, importantly, has considerably less adverse effects on blood pressure than clonidine
- buprenorphine could have an important role in detoxification but further U.K. based studies are required
- the role of methadone appears to be limited in detoxification as it was associated with particularly high drop-out rates
- reinforcement based intensive treatment is associated with longer retention in treatment and higher rates of abstinence

Residential Rehabilitation

There was a small literature concerning the effectiveness of residential rehabilitation programmes. From the evidence available, the key findings were:

- residential rehabilitation is effective in terms of reduction in illicit opiate use, employment status, risk behaviours, and crime rates
- retention in and completion of treatment are more important than length of treatment in influencing outcomes
- residential rehabilitation programmes that provide more health and treatment services and encourage client participation are more effective at retaining people in treatment

Economic Evaluation

There were few economic evaluations that evaluated the cost-effectiveness of treatment modalities for drug dependence. From the evidence available, the key findings were:

- the results of studies employing modelling approaches critically depend on the quality and validity of estimates of model parameters
- cost assessment is generally restricted to costs of health care interventions and does not consider indirect costs such as travel costs
- health benefits and benefits related to reduced criminal activity are rarely examined
- cost-benefit studies of treatment show positive net (overall) benefits from intervention
- there is no strong evidence to support the cost-effectiveness of any particular intervention

Gaps in the Research Literature

There are a number of areas in which the evidence base on the effectiveness of treatment for opiate users is weak. It is recommended that further research should be undertaken to examine:

- the relative effectiveness of community maintenance with methadone and buprenorphine
- the appropriate starting dose and most effective maintenance dose of methadone and buprenorphine
- the effectiveness of buprenorphine at maintenance doses exceeding 8 mg per day
- the optimal treatment length of community maintenance
- the effectiveness of buprenorphine in short-term detoxification
- the effectiveness and practical implications of supervised administration of buprenorphine
- the effectiveness of dihydrocodeine in short-term detoxification
- the effectiveness of psychosocial services accompanying maintenance or detoxification
- the effectiveness of residential rehabilitation programmes using well designed methods
- the long term outcomes for clients following discharge from community maintenance, community detoxification, or residential rehabilitation
- the effectiveness of interventions closely simulating clinical practice to improve the transferability of the results to community settings
- the cost effectiveness of all available treatment for opiate users

Policy Recommendations

Overall, this review of the international research literature generated a number of key policy recommendations:

- more emphasis should be placed on psychosocial support in both community maintenance and detoxification
- contingent reinforcement should be more widely used in community maintenance programmes
- naltrexone prescribing to maintain abstinence following detoxification should be more widely utilised
- buprenorphine use should be more widely considered for use with clients who have lower levels of opiate dependence.

Mini Glossary

Community Detoxification: A programme based on the elimination of the drug of dependence from the body. Programmes vary between 3 days and 180 days and often involve the short term use of other drugs to manage withdrawal symptoms.

Community Maintenance: A community based treatment which stabilises clients on a substitute drug for as long as it is necessary to help them avoid returning to previous patterns of drug use. A longer term aim can be to gradually reduce the quantity prescribed. A community maintenance programme generally consists of drug administration, and the provision of psychosocial treatment and motivational interventions.

Residential Rehabilitation: A programme to establish a state in which clients become drug-free and physically, psychologically, and socially capable of coping with situations encountered. Residential rehabilitation generally involves communal living with other drug misusers in recovery and can include group and individual relapse prevention counselling, individual key working, improving skills for daily living, training and vocational experience, housing and resettlement services, and aftercare support.

The STRADA Partnership

The partnership is between the University of Glasgow and DrugScope. The University is represented by the Centre for Drug Misuse Research and the Department of Adult and Continuing Education.

The joint aims are to:

- ensure that the competence of the professional staff addressing drug and alcohol misuse is raised throughout Scotland
- ensure that interventions to address drug and alcohol misuse are based on the evidence of what works

The objectives are to:

- embed the training provided in national and UK wide recognised frameworks of competence
- integrate information, research policy and practice development activities with training delivery throughout Scotland
- ensure that the training activities are underpinned by the research and evidence base in Scotland and, where relevant, from the rest of the UK, Europe and internationally
- ensure that the training activity utilises the resources of the partnership, in order to support the Plan for Action on Alcohol Problems and the National Drugs Strategy

Training portfolio

- A basic, introductory module of 2 days inter-disciplinary training for frontline staff, based on Drug and Alcohol Action Team Areas
- Supplementary, optional specialist one or two day modules - delivered on an interdisciplinary basis, or where appropriate to single or discrete professional groups
- A one-year post- graduate Management Certificate qualification for those managing alcohol and drug services
- A one year post- graduate Certificate qualification in Addictions
- A leadership programme for DAT/AAT members

Regional Training Programme Content

- A number of key specialist modules were identified for development within the first year's implementation, based upon current policy and legislative emphases.
- A Training Needs Analysis, conducted in the autumn of 2001, has informed the development of the next tranche of modules, being developed for presentation from November 2002.
- Further modules will be developed based on policy priorities and training need, in 2003.

Current modules

- Knowing Where to Start – 2 day introductory
- Fatal and non Fatal overdose and drug-related death – 1 day
- Blood borne Viruses – 2 day
- Drugs, Alcohol and Young People – 1 day
- Drugs, Alcohol and Housing – 1 day
- Children and Families Affected by Drug and Alcohol Misuse – 2 day

Modules in development

- Mental Health and Dual Diagnosis – 2 day
- Psychostimulant Use – 1 day introductory (to be complemented by further modules)
- Research into Practice – 1 day
- Working with Black and Ethnic Minority Communities – 2 day
- Drugs, Alcohol and Women – 2 day
- Training for Trainers – 3 days spread over a number of months

Further Modular Development

This will include:

- Employability – moving drug and alcohol service users into employment.
- Assessment and Care Management
- Drugs, Alcohol and the Criminal Justice System
- Drugs, Alcohol and Crime

Certificate in Addictions

This is a post-qualifying course at post-graduate level that is designed to develop, enhance and refine participants' practical skills and knowledge in the substance misuse field, as well as explore further attitudes, which facilitate effective person-centred services.

The three components of the programme will include:

- Understanding substance misuse
- Assessment and Brief Intervention
- Interventions

The Certificate will begin its presentations in September 2002.

Developing Competence in Managing Addiction Services

This course is being developed in partnership with the University Of Glasgow Business School and will be ready for presentation in October 2002.

Leadership Programme

The programme will focus on partnership planning a leadership within the substance misuse field, paying attention to responsibilities and accountability at local and national level. Customised programmes agreed at ADAT/DAT level will be available from autumn 2002.

Evaluation of the STRADA Programme and its Delivery

The evaluation strategy for the service has two aims:

- To evaluate the extent to which a training event has achieved its learning outcomes
- The extent to which practice has changed following training.

A variety of different evaluation tools, including questionnaire; practice scenario and telephone interview follow-up will inform the evaluation process. It is anticipated that both course participants and managers will be involved in this exercise, where appropriate. In addition, other data will be collected about the participant's career history including professional background, current job remit. This will permit reporting on the take-up of training by targeting professional groups, and will provide indicators for future targeting.

Evidence of evaluation exercises will be reported to course boards, which will meet on an annual basis to review the specific training interventions. The board will consist of:

- Course students
- Employer organisations
- Representatives of relevant professional bodies
- Representatives from relevant departments of the Scottish Executive

Regular reporting mechanisms on evaluation and review of the service as a whole have been developed with the Scottish Executive. These include the quantitative and qualitative data analysis on service review as well as financial performance indicators.

The STRADA partnership reports regularly to an Advisory Group set up by the Scottish Executive.

There has been an increasing interest in Arrest referral Schemes across Scotland within the last year or so. There are a number of schemes already in operation in D.A.T. areas and other schemes are being planned. Most of the schemes are still at an early stage of development and it has not yet been possible to fully evaluate these schemes.

Arrest Referral Schemes

- Arrest referral schemes attempt to identify accused, either in custody suites within police stations or court cells, who appear to have a drug related problem and encourage/direct them to some form of treatment programme
- The purpose of an arrest referral service is to offer an opportunity to drug users who have been arrested to engage with drug treatment and/or other appropriate services with a view to reducing their offending behaviour. It has no formal link with the due process of law
- Engagement with treatment programmes does not imply that the case will not be dealt with through the criminal justice processes although successful participation could suggest the possibility of an alternative sentence (or diversion from prosecution) where a conviction is secured
- Arrest referral schemes tend to fall in to 3 distinct models viz.; - information leaflet; proactive (addiction workers employed in custody suites) ; and incentive model
- Schemes currently operate in a number of areas of Scotland including Tayside, Aberdeenshire and Glasgow (for women offenders) and others are at the planning stage.

Diversion from Prosecution

- Diversion from prosecution is the referral by a procurator fiscal of an accused to the supervision of a social worker, psychiatrist, psychologist or mediator in cases where the public interest does not require formal criminal proceedings
- Allows individuals accused of relatively minor offences (and where there is no overriding public interest for a prosecution) to be dealt with outwith the court system
- Following successful piloting across 18 local authority areas, the Executive announced in September 2000 the national roll-out of more focussed diversion from prosecution schemes. Drug misusing accused were one of 4 priority groups identified for targeting under the revamped schemes, which will adopt the deferred model approach
- It is intended that procurators fiscal across Scotland will have access to local diversion schemes.

Probation (with treatment)

- A probation order provides community based supervision for a period of 6 months to 3 years, which offers a range of programmes providing constructive support for the offender focused on assisting him/her to change his behaviour
- Courts have powers to apply specific additional conditions to a Probation Order, one of the most commonly used being that an offender must undertake treatment for his/her drug misuse
- Specialist programmes have been provided to address the specific needs of drug misusing offenders who have been subject to a probation order with a condition of treatment.

Drug Treatment and Testing Orders (DTTOs)

- The Drug Treatment and Testing Order is a disposal targeted on high tariff offenders with a dependency on drugs who consent to imposition of an order. Frequency of offending is a greater determinant of appropriate targeting than single possibly “one-off” serious offences
- The objectives of the Order are twofold: - 1) to reduce the amount of acquisitive crime committed to fund drug misuse; 2) to reduce the level of drug misuse
- Offenders are placed on specialist treatment programmes lasting between 6 months and 3 years; failure to comply with the terms of the order can result in revocation - an alternative sentence may then be imposed
- Treatment is a mixture of programmes ranging from detoxification, methadone substitution through to intensive day programmes offering lifeskills
- Courts are required to carry out reviews at not less than monthly intervals; first review at least must be at a court hearing with the offender present; thereafter if progress is satisfactory, reviews may be carried out in chambers
- Random but regular drug testing is carried out throughout the duration of the order to provide a means of monitoring progress; a failed test does not necessarily preclude continuation of treatment and of the order
- Drug Treatment and Testing Orders are currently available to courts in the Glasgow, Fife, and Aberdeen/Aberdeenshire local authority areas.

Drug Court

- Designed to deal with offenders aged 21 years or older where there is an established pattern between the pattern of serious drugs misuse and the pattern of offending
- The objective is to reduce or eliminate an offender’s dependence on or propensity to misuse drugs and in so doing to reduce the level of associated offending behaviour
- The Drug Court is intended to provide rapid access to treatment programmes combined with regular court reviews and regular but random testing
- The principal community disposals used by the drug court are drug treatment and testing orders and enhanced probation i.e. probation orders with conditions of drug treatment, testing and court reviews
- The drug court model is being piloted in Glasgow with a second pilot due to start in Fife in summer 2002.

- Consultation Workshops Report (November 2000)
- Initial Guidance on Shared Care (January 2001)
- Work Programme (January 2001)
- Scottish Executive Drug Misuse Research Programme 2001-2004 (February 2001)
- Dissemination policy (April 2001)
- Initial Guidance on Shared Care Arrangements: Consultation Workshops Report (May 2001)
- Evaluation framework (May 2001)
- Drug Misuse Research Seminars Report (June 2001)
- Evaluation Guide 1: Definitions and Common Concepts (June 2001)
- Evaluation Guide 2: Planning an Evaluation (July 2001)
- Evaluation Guide 3: Designing an Evaluation (August 2001)
- Evaluation Guide 4: Implementing an Evaluation (September 2001)
- Moving On: Education, Training and Employment for Recovering Drug Users (October 2001)
- Evaluation Guide 5: Reporting and Dissemination (October 2001)
- Evaluation Guide 6: Designing an Economic Evaluation (November 2001)
- Effective Engagement: A Guide to Principles and Practice (January 2002)
- Evaluation Guide 7: Using Assessment Data for Evaluation (February 2002)
- Arrest Referral: A Guide to Principles and Practice (March 2002)
- Arrest Referral: A Guide to Principles and Practice – Summary (March 2002)
- Evaluation Guide 8: Evaluating Outreach Services (March 2002)
- Evaluation Guide 9: Evaluating Employability Programmes (April 2002)
- Effective Interventions Unit Programme 2002-2003 (April 2002)
- Effective Interventions Unit Programme 2002-2003 – Summary (April 2002)
- Hepatitis C: Risks and Prevention Strategies in Injecting Drug Users – Research Review (April 2002)
- Hepatitis C: Risks and Prevention Strategies in Injecting Drug Users – Summary (April 2002)

- Evaluation Guide 10: Evaluating Community Engagement (June 2002)
- Drug Treatment Services for Young People: A Research Review (June 2002)
- Drug Treatment Services for Young People: A Research Review – Summary (June 2002)
- Drug Treatment Services for Young People: A Systematic Review of Effectiveness and the Legal Framework (June 2002)
- Drug Treatment Services for Young People: A Systematic Review of Effectiveness and the Legal Framework – Summary (June 2002)
- A Survey of NHS Services for opiate dependants in Scotland (July 2002)
- A Survey of NHS Services for opiate dependants in Scotland – Summary
- The Effectiveness of Treatment for Opiate Dependant Drug Users: An international systematic review of the evidence (July 2002)
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Scottish Executive Effective Interventions Unit Dissemination Policy

1. We will aim to disseminate the right material, to the right audience, in the right format, at the right time.
2. The Unit will have an active dissemination style. It will be outward looking and interactive. Documents published or sent out by the Unit will be easily accessible and written in plain language.
3. All materials produced by the Unit will be free of charge.
4. Material to be disseminated includes:
 - Research and its findings
 - Reports
 - Project descriptions and evaluations
 - Models of services
 - Evaluation tools and frameworks for practitioners, managers and commissioners.
5. Dissemination methods will be varied, and will be selected to reflect the required message, and the needs of the target audience.

These methods are:

- Web-based – using the ISD website ‘Drug misuse in Scotland’ which can be found at: <http://www.drugmisuse.isdscotland.org/eiu/eiu.htm>
 - Published documents – which will be written in plain language, and designed to turn policy into practice.
 - Drug Action Team channels – recognising the central role of Drug Action Teams in developing effective practice.
 - Events – recognising that face-to-face communication can help develop effective practice.
 - Indirect dissemination – recognising that the Unit may not always be best placed to communicate directly with some sections of its audience.
6. This initial policy statement will be evaluated at six-monthly intervals to ensure that the Unit is reaching its key audiences and that its output continues to be relevant and to add value to the work of those in the field.

Further copies are available from:

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We welcome feedback on this report.

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