

changing habits

The commissioning and management of
community drug treatment services for adults

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changing habits

1



Drug Misuse and Dependence

Tackling drug misuse and the criminal activity and health risks that are often associated with it is a key priority for central Government and local communities.

2



Drug Treatment Services

Drug treatment services play an important role in reducing drug misuse but the pattern of provision is complex and variable.

3



Problems with Drug Treatment Services

Limited treatment options, lengthy delays and poor care management can make it difficult for drug misusers to get the help they need.

4



Improving Performance

Local agencies need to work together to improve the quality and range of drug treatment services and stop drug misusers 'falling through the net'.

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Preface

Drug treatment services exist, above all, to support drug misusers – helping them to minimise the harm they do to themselves, to reduce their use of illicit drugs and to rebuild their lives. But tackling drug misuse also delivers important benefits to the wider community. As drug problems often fuel crime, social exclusion and anti-social behaviour, effective treatment services can potentially improve all citizens’ quality of life and play an important role in wider community renewal and regeneration strategies.

With growing evidence that a range of treatment interventions ‘work’, the Government has sought to increase the capacity of drug treatment services and has allocated new resources to realise this objective.

Changing patterns of drug misuse and recent national initiatives – such as the establishment of a National Treatment Agency for England and new arrangements for the delivery of primary care – will also affect how local services are commissioned and provided. In response to these developments, the Audit Commission decided to undertake a study that would review the current provision of community-based drug treatment services for adults, identify any problems, and suggest how these could be overcome.

Although the nature and scale of drug misuse varies from area to area, most localities face the challenge of increasing the scale of treatment provision and getting best value from existing resources. This report therefore sets out practical recommendations that will enable drug action teams (drug and alcohol action teams in Wales), local commissioners and service providers to review their specialist services and joint commissioning arrangements. The report also highlights the steps that should be taken to strengthen the national framework of funding and policy guidance in order to support local efforts more effectively.

The study on which this report is based was carried out by Sára Kulay, David Bird and Charlotte Brown from the Audit Commission’s Public Services Research Directorate, under the direction of David Browning. A paper summarising the evidence base for drug treatment prepared by Dr John Marsden and Dr Michael Farrell at the National Addiction Centre supplemented this work (Appendix 5). The study team also benefited enormously from the co-operation of staff in the 11 fieldwork sites visited and is grateful to all GPs and service users who gave their time to complete a questionnaire or to be interviewed. An advisory group of practitioners and other interested parties provided further assistance and insight (Appendix 3). The conclusions of the report are, however, the responsibility of the Audit Commission alone.

1



Drug Misuse and Dependence

Over the last 40 years, drug misuse has increased and become more closely associated with social disadvantage. Serious drug problems can wreck lives, fuel crime and have a high economic cost. The policy agenda for tackling drug misuse has developed rapidly in recent years and led to a stronger emphasis on drug treatment services. Increased levels of Government investment offer new opportunities to expand and improve the quality of local services.

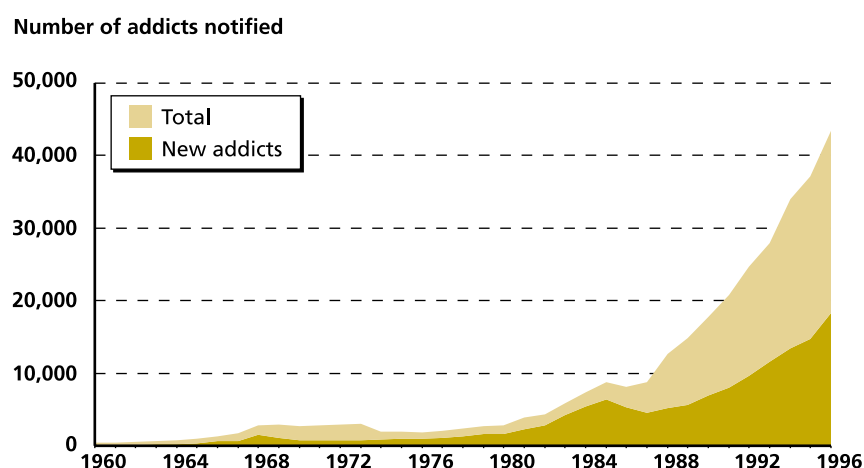
1. Widespread public concern about illicit drugs in Britain is a relatively recent phenomenon. The rise of youth culture in the 1950s and 1960s saw the 'recreational' use of drugs such as amphetamines, cannabis and LSD spread among young people, and the number of young heroin addicts began to grow, albeit slowly. Since then, the use of a wide range of illicit drugs has become more common [APPENDIX 2, page 100]. Drug problems have also increased and become more closely associated with social disadvantage (Ref.1). Many deprived urban areas experienced a steep increase in heroin misuse among teenagers and young adults during the economic downturn in the early 1980s, leading to a sharp rise in the number of addicts notified to the Home Office Addicts Index^I [EXHIBIT 1]. Further increases in drug-related problems were evident in the 1990s. Between 1990 and 1996 addict notifications more than doubled and drug-related deaths increased markedly (Refs.2,3). The number of people found guilty or cautioned by the police for drug offences^{II} also rose from 44,922 in 1990 to 120,007 in 1999 (Ref.4).

EXHIBIT 1

Increases in notifications to the Home Office Addicts Index, 1960 to 1996

Problem drug misuse remained comparatively rare in the first part of the 20th century but has grown significantly over the last forty years.

Source: Home Office Addicts Index/Corkery (unpublished) (Ref.2)



- I From 1968 to April 1997 doctors had a statutory duty to notify the Home Office of patients who, in their judgement, were addicted to one or more of a number of Class A drugs, including cocaine, heroin and methadone. The numbers were serious underestimates of the true position because many addicts did not seek treatment, and many of those who did were not notified by their doctors.
- II Offences involving controlled drugs under the Misuse of Drugs Act 1971 include unlawful possession, unlawful production, unlawful supply, possession with an intent to supply unlawfully and permitting premises to be used for unlawful purposes.

Policing drug misuse and supporting those affected by a drug habit also have a high economic cost.

2. The growth of drug problems has had a profound impact upon individuals, communities and society as whole. Although many people in England and Wales have taken drugs experimentally, a small minority has developed a myriad of health, social and legal problems as a result of their drug misuse or dependency. The impact of their drug problems often spreads to local communities who face a rise in anti-social behaviour, family breakdown and higher levels of crime. Deprived areas usually suffer most, frequently becoming a focus for drug dealing that can fuel a cycle of decline and lead to heightened levels of fear and intimidation among local residents. Policing drug misuse and supporting those affected by a drug habit also have a high economic cost. Recent Government estimates put the total bill to the public purse at £3–4 billion in 2001/02 (Ref.5).

3. Against this backdrop, it is not surprising that combating drug misuse has become a principal concern of government. The importance of drug treatment services has also been increasingly recognised, as evidence of their effectiveness has grown. The National Treatment Outcome Research study¹ (NTORs) tracking over 1,000 drug misusers in treatment in the UK, for example, calculated a return of £3 due to savings in the criminal justice system and lower levels of victim costs of crime for every £1 spent on treatment (Ref.6). Improving the accessibility of drug treatment services is therefore a crucial element of the Government's current strategy, supported by an ambitious target to double the number of drug misusers in treatment between 1998 and 2008 (Ref.7). Providing effective community-based drug treatment services is the primary focus of this report.

Defining drug misuse and dependence

4. Views differ on how drug misuse should be defined (Ref.8). Some argue that since the use of any illicit drug may result in harm or even death, the term 'misuse' or 'abuse' should always apply. Others choose to distinguish between 'use' and 'misuse', often to recognise that a significant number of people who use drugs in an occasional or recreational context do not develop drug-related problems. Clinical definitions in turn describe a variety of distinct disorders related to the misuse of substances, including intoxication, harmful use, dependence syndrome and withdrawal state. For example, the World Health Organisation's International Classification of Disease (ICD-10) – the most commonly used diagnostic classification in England – distinguishes between harmful use and dependence syndrome:

The scale and nature of the problem

¹ The National Treatment Outcome Research study is a longitudinal study of 1,075 drug misusers entering 53 UK treatment services in 1995. The study was established as part of the effectiveness review commissioned by the Department of Health in 1994.

- **Harmful use** is defined as a pattern of psychoactive substance use that is causing damage to health...either physical or mental.
 - **Dependence syndrome** is defined as a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance misuse and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in use despite harmful consequences, a higher priority given to drug use than other activities and obligations, increased tolerance and sometimes a physical withdrawal state (Ref.9).
5. Ongoing debate about terminology and the need for greater specificity in a clinical setting inevitably mean that a number of different terms continue to be used to describe drug-taking behaviour. However, for the purposes of this report, the terms ‘drug use’ and ‘drug misuse’ will be used throughout, adapted from previous definitions adopted by the Health Advisory Service (HAS) (Ref.10) and Advisory Council on the Misuse of Drugs (ACMD) (Ref.11):
- **Drug use** will be used to describe illegal and illicit drug taking that does not cause any perceived immediate harm – even though it may carry some risk of harm, such as health problems.
 - **Drug misuse** will be used to describe illegal and illicit drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence.

Although a number of illicit drugs may lead to harm, drug misuse often involves the use of opiates, particularly heroin, as well as crack cocaine or other stimulants, often taken by the same people as a pattern of ‘polydrug’ use.

Estimating the extent of drug misuse

6. As drug taking is an illicit activity, reliable data on prevalence are hard to obtain. The results of self-report surveys may be questionable, as some respondents may not admit to the use of more heavily stigmatised drugs such as heroin and crack cocaine or conceal their drug taking because of the punitive legal framework [APPENDIX 4, page 103]. Surveys are also likely to under-represent drug misusers who are more difficult to capture, including those with chaotic lifestyles, homeless people and people resident in institutions. Moreover, studies that simply focus on lifetime prevalence do not provide useful information about current behaviour. As a recent report by the Police Foundation recognised: ‘*The important issues are whether people are using drugs regularly, and if so how often and how recently*’ (Ref.12).

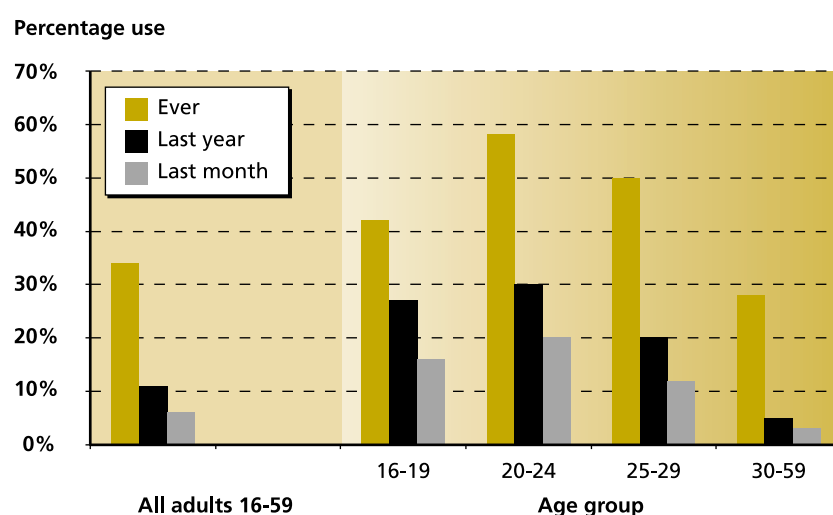
7. The British Crime Survey¹ (BCS) provides the best available guide to changing patterns of drug use among the adult population in England and Wales (Ref.13). This shows that in 2000, around a third of adults aged 16–59 had used illicit drugs at some time during their lives, 11 per cent had used these substances within the past year, and almost 6 per cent were regular users, defined as any use of these substances within the past month. The use of ‘any drug’ in the last year remained relatively stable between 1994 and 2000, though use of any illicit drug among 16–19 year olds was significantly lower in 2000. While there were significant increases in the use of both powder and crack cocaine, consumption of more addictive drugs remains rare: only 1 per cent of the population reported use of heroin and crack cocaine.

8. The nature and extent of drug use differs across the population. A higher proportion of males than females reported drug use, with men outstripping women by a ratio of three to two. Prevalence is also higher among unemployed people (though cocaine use has the highest prevalence among those who are working) and young people [EXHIBIT 2]. Ethnic comparisons show that drug use is more prevalent among white people than other ethnic groups. A third of white people reported lifetime use of any drug in the BCS, compared to 28 per cent among Black respondents, 15 per cent of Indians and 10 per cent of Pakistanis and Bangladeshis. Variations in drug use by region are also evident [EXHIBIT 3]. London has consistently higher rates for use of ‘any drug’, cocaine and ecstasy, though other regions, including the North, South and Midlands, report higher rates of heroin use (Ref.13).

EXHIBIT 2

Consumption of any drug ever, in the last year, or last month, by age group

Drug use declines with age, probably reflecting changing lifestyle options.



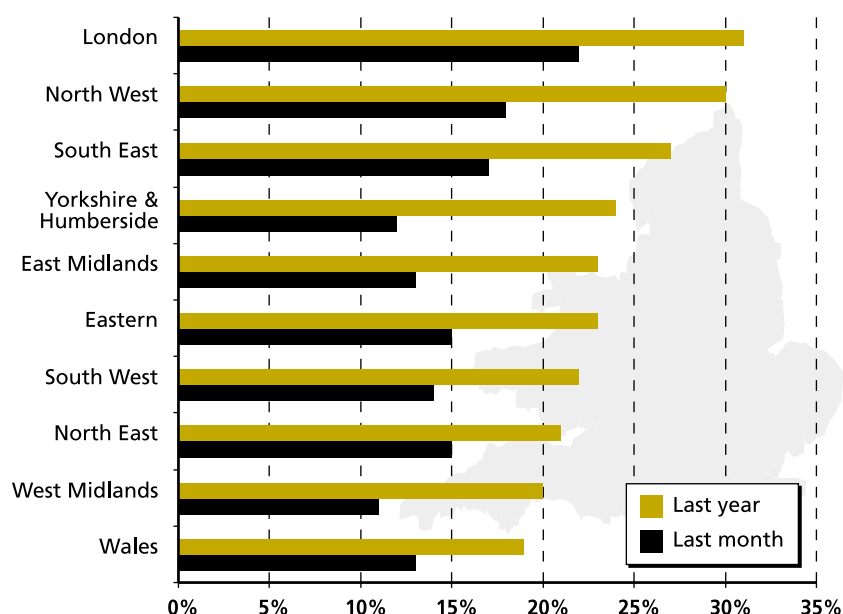
Source: British Crime Survey, 2000 (Ref.13)

¹ The British Crime Survey is designed to be representative of the population of England and Wales. The 1994, 1996, 1998 and 2000 surveys all include the same self-report drugs component, completed by between 9,500 and 13,000 people aged 16 to 59.

EXHIBIT 3

Regional variations in drug use among young people

Percentage of respondents aged 16 to 29 using any drugs in the last year and month by Government Office Region.



Source: British Crime Survey, 2000 (Ref.13)

9. Estimating the number of people who experience serious problems or dependence because of their drug use is difficult. Many drug misusers do not contact local services until late in their drug-using career, and not all medical practitioners report contacts to the National Drug Treatment Monitoring System^I (NDTMS). Attempts to gauge prevalence have resulted in widely varying estimates. An Office of Population, Censuses and Surveys (OPCS) national survey of psychiatric morbidity, which obtained data on levels of dependent drug use in 10,000 adults in the UK in 1992, estimated that 728,000 individuals were dependent on drugs (Ref.14). However, a stricter definition of dependence^{II} or the exclusion of cannabis could easily have halved this estimate (Ref.15). More recent work, based on ‘capture-recapture’^{III} research, suggests that there could be around 266,000 problem drug misusers in Britain – about 0.5 per cent of the population (Ref.16). Between 161,000 and 169,000 of these are estimated to have injected drugs.

I The Department of Health’s National Drug Treatment Monitoring System (NDTMS) in England and Wales collects information on drug misusers who present to treatment services.

II The survey used a broad definition of dependence, including all individuals who reported one or more of the following over the previous 12 months: needing to use an increasing amount of the drug over the last 12 months to achieve the desired effect; feeling dependent upon one or more of the drugs used; having tried unsuccessfully to reduce their level of drug use; and/or having experienced withdrawal symptoms. The survey covered a range of drugs and solvents. Some prescribed drugs (such as valium) were included, but alcohol was excluded.

III Capture-recapture methods are based upon identifying the overlap between various statutory and non-statutory agencies’ samples of drug misusers. The size of the overlap between samples allows a statistical model to be created in which to estimate the wider drug-using population (Ref.15).

More problematic forms of drug misuse do appear to be related to geographical and individual measures of deprivation.

Drug misuse and deprivation

10. Although there is a common assumption that poor social conditions and poverty exacerbate drug misuse problems, the relationship is far from straightforward. Drug use per se is clearly not confined to any one social group or type of neighbourhood. Results from the BCS, for example, show that the highest levels of drug use tend to be at the two extremes of the household income scale, and that the lowest prevalence is in the middle income groups (Ref.13). An analysis of the findings by residential neighbourhoods in turn reveals uniformly higher levels of drug use among 16 to 29 year olds living in ‘affluent urban areas’ compared to other neighbourhoods, including both council estates and low income areas (Ref.13). The reasons why people develop problematic habits are equally hard to determine, not least because the causes may be ‘biological, psychological and social and usually interact’ (Ref.8).

11. More problematic forms of drug misuse do appear to be related to geographical and individual measures of deprivation (Ref.15). Results from the BCS show that use of heroin – the drug most frequently associated with dependency – was notably higher in the lowest income group and less affluent areas (Ref.13). Several studies in the UK have also identified a statistically significant relationship between problem drug misuse and social deprivation, and found deprived areas to have significantly higher rates of presentation at drug treatment services and drug-related hospital admissions (Refs.17,18). Certain groups of young people – including those ‘looked after’ by authorities, truants, those excluded from school and young offenders – are more vulnerable to drug problems. A recent review of the UK evidence led the ACMD to conclude that: ‘*on strong balance of probability, deprivation is today in Britain likely often to make a significant causal contribution to the cause, complications and intractability of damaging kinds of drug misuse*’ (Ref.15). A number of factors may explain this relationship, though causality is difficult to establish [BOX A].

BOX A

Drug misuse and deprivation

The Advisory Council on the Misuse of Drugs identified a number of factors that may explain the link between drug misuse and deprivation.



Deprivation may weaken family and social bonding and cohesiveness. Those growing up in these circumstances may be prone to ignore the expectations of a society they have little attachment to.



Deprivation gives rise to personal distress and psychological discomfort that can lead to depressive illnesses and mood disturbances. Mind acting drugs (and illicit drugs) can be used as self-medication to relieve distress or act as a substitute source of excitement and good feelings.



A poor area with high levels of unemployment can provide an environment where drug dealing becomes established as part of an alternative economy. Where unemployment is high and young people are without a job-related role or structure, being a dealer or a drug taker can confer status and/or provide a meaningful occupation.



Deprivation may make spontaneous or post-treatment recovery more difficult. Lack of access to positive alternatives may provide little incentive to cease use.



Deprived areas may find it more difficult to deal with drug problems at community level. Equally, a potentially vulnerable community may be deliberately targeted by drug dealers. In such circumstances, an initially low prevalence drug problem will easily spread and become endemic.

Source: Adapted from 'Drug Misuse and the Environment', Advisory Council on the Misuse of Drugs, 1998 (Ref.15)

Harms associated with drug misuse

12. Not all drug misusers are dependent and the severity and nature of an individual's problems often change over time. However, for many people, drug misuse frequently becomes a *chronic relapsing condition* – recovery occurs but it is followed at some later point by a reoccurrence of abuse or dependence. Many also experience major health problems as a result of their habit. Injecting heroin users face an increased risk of overdose, respiratory failure and deep vein thrombosis. Mental health problems, including anxiety and depressive disorders, are also common among some heavy users, though it may be difficult to establish which came first. Some of the problems experienced – like the heightened risk of acquiring Hepatitis B and C and HIV – relate directly to high risk behaviours such as needle sharing and unsafe sex (Refs.19,20). Heavy crack cocaine use can lead to problems such as paranoia, weight loss and breathing difficulties (Ref.21). Recent research based on 288 primary crack cocaine users in a

crisis intervention service found that 64 per cent had experienced suicidal thoughts and 37 per cent had attempted suicide (Ref.21).

13. Poor health inevitably leads to high levels of contact with casualty and general medical services. NTORs found that, in the two years prior to starting the NTORs treatment episode, almost half the drug misusers in their cohort had received treatment in an accident and emergency department and a quarter had been admitted to a general hospital bed (Ref.6). The study of crack misusers in a crisis intervention service found that 30 per cent had previous contact with a statutory mental health service. High levels of morbidity and chance of overdose increase the risk of premature death among heroin users. A long-term follow-up study of dependent heroin misusers recently estimated that the sample had a twelvefold increased risk of mortality compared to the general population (Ref.22).

The high cost of consumption...also means that some users rely on criminal activity to fund their habit.

14. As the severity of drug misuse increases, many people struggle to hold down jobs. They report difficulties in their personal relationships with family and friends and face legal and financial problems. The high cost of consumption on a regular basis also means that some users rely on criminal activity to fund their habit. NTORs reported high rates of criminal behaviour among their sample of drug misusers, with 61 per cent reporting 70,728 separate crimes during the three months prior to entering treatment (Ref.6) – an average of about one crime a day each. Although shoplifting was the most commonly reported offence, more serious crimes such as burglary and robbery were reported by 12 per cent and 5 per cent. Recent research among 506 people arrested found that 69 per cent tested positive for drugs, of whom 29 per cent tested positive for opiates (including heroin) and 20 per cent for cocaine (including crack) (Ref.23). The relationship between drugs and crime is also manifest in the prison population, with a recent survey finding that 51 per cent of male remands and 54 per cent of female remands reported drug dependency (Ref.24).

Recent developments in policy and practice

15. The policy agenda for addressing drug misuse problems has been developing rapidly in recent years and has led to stronger emphasis on drug treatment services [BOX B, overleaf]. The Government has given a high profile to its plans to tackle drug misuse, supported by the publication of a ten-year strategy in 1998. At the local level, drug action teams (DATs) in England and drug and alcohol action teams (DAATs) in Wales^I are responsible for ensuring co-ordination between key agencies and assessing whether local spending plans and initiatives are aligned to key Government targets on drugs. The teams are expected to include senior representatives from local authorities, health authorities, the police, and the prison and probation services. From April 2001, DAT boundaries in England became coterminous with those of local authorities^{II} to ensure more effective co-ordination with services such as housing, social services and education. Welsh DAATs are based on the five current Welsh health authority boundaries.



-
- I In Wales, there has been a long-standing policy of including alcohol within the substance misuse strategy and Welsh DAATs address both drug and alcohol issues. A significant proportion of DATs in England also address alcohol issues. For the purpose of this document, the term DAT includes teams that address either drug or drug and alcohol issues.
 - II DAT boundaries are based on either county shire, unitary, metropolitan district or, in the case of London, borough boundaries.

BOX B

Some recent key developments in policy and practice

1995

The Government's White Paper *Tackling Drugs Together* set out plans to tackle drug misuse over a three-year period (Ref.25). Multi-agency drug action teams (DATs) were established at a local level with the remit of taking an overview of drugs-related issues, co-ordinating service planning and delivery and developing local action plans.

1996

The Welsh Office published *Forward Together*, a substance misuse strategy to combat drug and alcohol misuse in Wales (Ref.26). Drug and alcohol action teams (DAATs) were established at a local level.

The National Treatment Outcome Research study (NTORs) tracking drug misusers in treatment reported interim results showing substantial reductions in the quantity and frequency of drug misuse and criminal behaviour (Ref.27).

The Task Force to Review Services for Drug Misusers set up by the Department of Health reported that there was clear evidence that treatment – embracing social care and support as well as clinical interventions – can be effective in reducing harm to individuals and society (Ref.8).

1997

The Department of Health issued guidance for health authorities and social services on the purchasing of effective treatment and care for drug misusers in England (Ref.28).

The Welsh Drug and Alcohol Unit (WDAU) issued guidance on purchasing treatment to Welsh health authorities and social services departments (Ref.29). Separate guidance was also produced for service providers managing drug and alcohol services in Wales (Ref.30).

1998

The White Paper *Tackling Drugs to Build A Better Britain* published in May 1998 set out the Government's ten-year strategy for tackling drug misuse (Ref.31). A key target aimed to increase participation of drug misusers in treatment by 66 per cent by 2005 and by 100 per cent by 2008.

The Government allocated an extra £217 million to tackle drug problems, spread over three years. The funding included new monies for treatment services and earmarked some funds to support the expansion of schemes for drug misusing offenders.

Drug services were identified for the first time in NHS Priorities and Planning Guidance.

A new *Prison Service Drug Strategy* was published, giving a commitment to set up a drug treatment service framework and develop rehabilitation programmes (Ref.32).

The Advisory Council on the Misuse of Drugs (ACMD) report *Drug Misuse and the Environment* concluded that deprivation made a significant causal contribution to the cause and intractability of damaging kinds of drug misuse (Ref.15).

1999

The Department of Health published new guidelines on the clinical management of drug misuse and dependence (Ref.33).

New commissioning standards for drug and alcohol treatment and care were published by the Substance Misuse Advisory Service (SMAS) (Ref.34).

Drugscope and Alcohol Concern published a joint publication, *Quality in Alcohol and Drug Services*, setting out quality standards for alcohol and drug treatment services (Ref.35).

In Wales, £4.5 million was made available over three years, as part of a package of measures included in a Social Inclusion Fund, to support drug and alcohol treatment services and improve access to treatment.

2000

The National Assembly for Wales published *Tackling Substance Misuse in Wales: A Partnership Approach*, a ten-year strategy covering the full range of substances that are misused in Wales, including alcohol and over-the-counter drugs, and volatile substances, such as solvents and glue (Ref.36).

The Government's Spending Review announced a further £167 million for drug treatment, spread over three years.

The ACMD report on reducing drug related deaths was published in June 2000. The report covered areas such as prescribing, drug services, surveillance and Hepatitis C. An action plan to monitor and reduce drug-related deaths will follow (Ref.3).

The United Kingdom Anti-Drugs Co-ordination Unit issued guidance on pooled treatment budgets to DATs (Ref.37). In England, DATs are required to prepare annual Treatment Plans indicating how money will be spent locally.

2001

A new National Treatment Agency (NTA) for England was established in April 2001. Set up as a special health authority, the NTA will play a lead role in setting and monitoring drug treatment standards and oversee a pooled national treatment budget.

The Government announced an extra £300 million to support their *Communities Against Drugs* strategy, spread over three years, and issued a circular setting out how these monies were to be used (Ref.38). £15 million will be made available to DATs to increase their involvement with local communities.

The Department for Work and Pensions allocated £40 million, spread over three years, to help drug misusers find employment in 31 pathfinder areas in England and Wales.

Occupational and functional maps of the drugs and alcohol sector were developed by the National Training Organisation, Healthwork UK, the Qualifications and Curriculum Authority and DoH (Ref.39). These will form the basis for new National Occupational Standards for specialist drug and alcohol workers to be developed by 2002.

A new Drugs Strategy Directorate based at the Home Office assumed responsibility for the previous UK Anti-Drugs Co-ordination Unit. It is now responsible for ensuring the delivery of all aspects of the drugs strategy in cooperation with other Government departments and key agencies.

A White Paper on police reform, *Policing a New Century*, outlines plans to bring together the work of DATs and Crime and Disorder Reduction Partnerships (CDRPs) (Ref.40).

2002

A *Models of Care* project commissioned by the Department of Health will set out guidance on the co-ordination of treatment and effective care management across substance misuse treatment services.

16. The changing organisation of primary care will also affect the commissioning and delivery of drug treatment services. The formation of Primary Care Trusts (PCTs) in England will be completed by April 2002, and in some areas PCTs will assume responsibility for commissioning drug treatment services. In others, this function may rest with Strategic Health Authorities.^I In Wales, local health groups (LHGs) will commission drug treatment services. New initiatives such as the introduction of salaried options for GPs in England, Local Development Schemes, GP commissioning pilots, the NHS Act 1999,^{II} the Health and Social Care Act 2001,^{III} and nurse prescribing also offer new ways of delivering and managing drug treatment services.

I Around 30 Strategic Health Authorities will be established from 1 April 2002. These replace the 95 existing health authorities in England, which will be abolished.

II The NHS Act 1999 allows pooled funds, 'lead commissioning' and integrated provision.

III The Health and Social Care Act 2001 contains clauses to introduce care trusts, which were first proposed in the NHS Plan (Ref.42), and which will provide integrated health and social care within one agency.

The amount of money spent on interventions to reduce drug problems in the first place...is relatively small...

Costs and resources

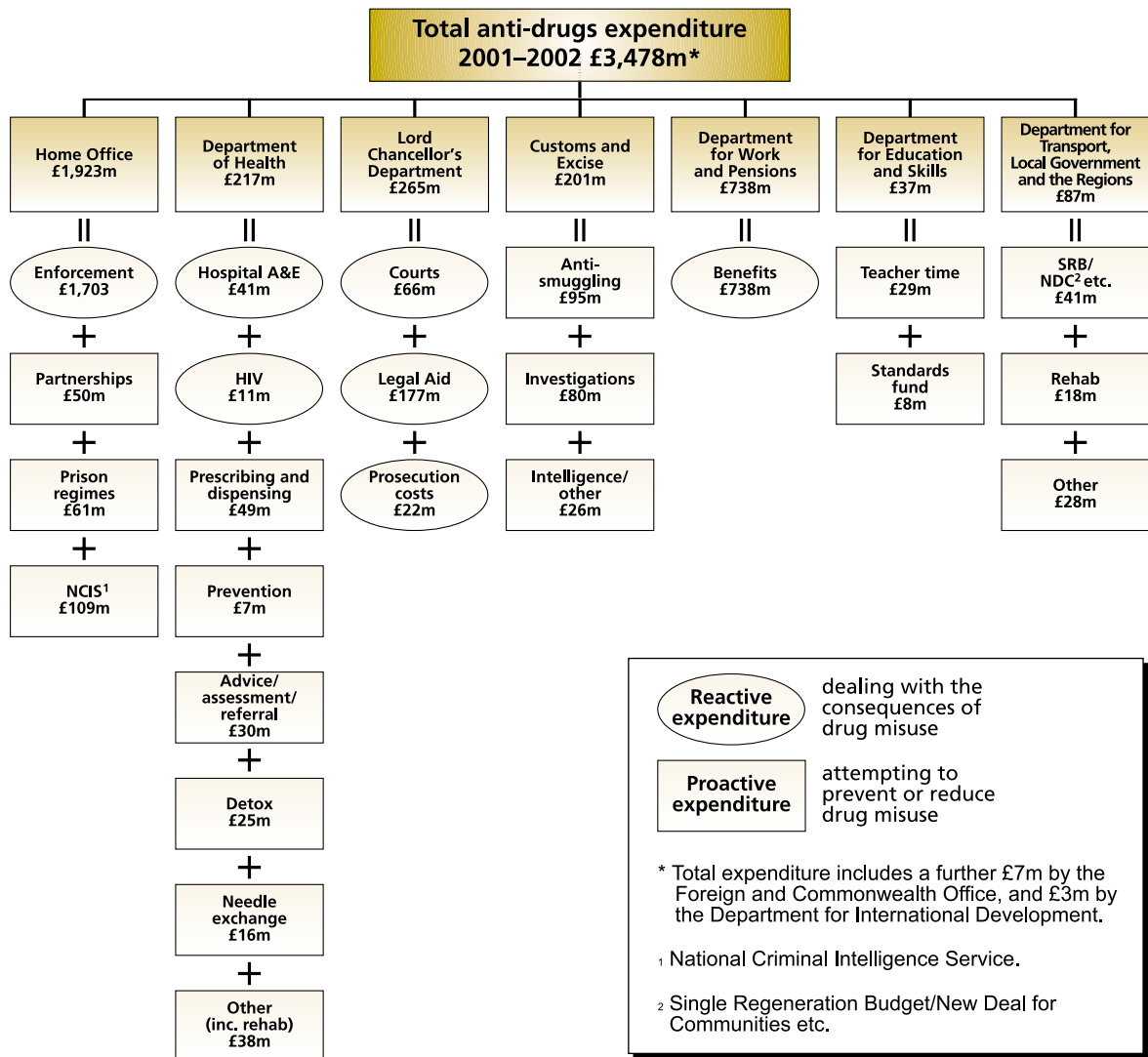
17. In 1998, the Government's Comprehensive Spending Review (CSR) estimated that around £3.5 billion pounds would be spent on the direct and indirect costs of drug misuse in 2001/02, channelled through a large number of Government departments [EXHIBIT 4]. Criminal justice system costs, covering police, prosecution, prisons and the courts, and social security payments to drug misusers who cannot work, account for a significant proportion of the total expenditure. The amount of money spent on interventions to reduce drug problems in the first place – notably treatment, education and prevention initiatives – is relatively small, accounting for less than 20 per cent of the total sum. A key objective of the Government's strategy is to reduce the amount of money spent addressing the consequences of drugs and direct more resources towards interventions that tackle the causes of drug problems.

18. The Government has allocated new resources to support the introduction of the strategy. Following the Comprehensive Spending Review in 1998, an additional £217 million was invested in the national drugs strategy, spread over three years (Ref.41). Further spending plans for the new Drug Treatment Budget and other anti-drug programmes were published in July 2000 following HM Treasury Spending Review 2000. There have been two main criteria for the allocation of resources – evidence of effectiveness and unmet need. As a result, investment in research and information, initiatives targeted at specific 'at risk' groups and drug treatment, has been prioritised. Investment in treatment will increase from £234m in 2000/01 to £401m in 2003/04 (Ref.41).

EXHIBIT 4

Government anti-drugs expenditure

In 1998, the Government estimated that around £3.5 billion a year would be spent on the direct and indirect costs of drugs in 2001/02. Of this expenditure, 80 per cent is classed as reactive – dealing with the consequences of drug misuse.



Source: Comprehensive Spending Review, 1998

About this study

19. In view of the rapidly developing policy agenda, higher levels of financial investment and growing emphasis on providing timely and appropriate support to people with drug misuse problems, effective drug treatment services are necessary at a local level. To this end, the Audit Commission has carried out a study of adult treatment services in 11 areas of England and Wales, based on DAT boundaries in England and DAAT boundaries in Wales. The report covers specialist community-based drug services provided by NHS trusts, social services departments and the independent sector. It also looks at the role that general practitioners play in supporting drug misusers, often by prescribing substitute drugs in partnership with a specialist service.

20. In addition to interviewing a wide range of staff, various techniques were used to collect data and provide comparative information [BOX C]. The study found wide variation in the availability of different services, working practices within services and how effectively local agencies worked together. Weak commissioning practices and the absence of management information and effective performance monitoring arrangements often contributed to the problems identified. In many cases, it was evident that people with drug misuse problems often struggle to get the help that they need, when they need it. The study describes how all agencies providing care and support need to work together to:

- strengthen partnership working and commissioning;
- review the quality and range of service provision;
- promote better care co-ordination and joint working;
- develop more flexible approaches to attract and support a wider range of drug misusers; and
- improve support to primary care.

21. Chapter Two outlines the historical development of drug treatment services, the current role and structure of community-based drug treatment services, and the features of effective drug treatment. Chapter Three explores how services currently respond to need and where and why problems arise. Chapter Four looks at possible ways forward that could help to improve the quality and delivery of local services at a local level. It also considers the steps that the new National Treatment Agency and other Government departments could take to promote improvements in policy and practice.

BOX C**Techniques used in this study**

Resource mapping: This was a summary of all the funding available for community-based drug treatment services, inpatient provision and residential services from health authorities, social services, police, probation and, where appropriate, Primary Care Trusts. Information about levels of activity and sources and level of funding was also collected directly from community-based services in both the statutory and independent sectors.

Case file analysis: This covered 52 individuals who had been referred to community drug services 12 months earlier. It looked at assessments carried out, the range of professions and agencies involved and the actions taken to ensure effective care management and throughcare. In total, 52 files were examined in 6 different service providers.

GP survey: This gauged GPs' attitudes to working with illicit opiate misusers, their views about local drug treatment services and the training and support they received. The survey was sent to all GPs (3,653) in 10 study sites. It was based on a national survey undertaken by the National Addiction Centre. 1,574 GPs responded to the survey – a response rate of 43 per cent.

User research: One-to-one interviews were held with 18 drugs misusers to gain qualitative information about their experiences of seeking and receiving help and views of local services. Individuals were contacted through independent community-based services. Three focus groups were also run. The groups included clients recruited from both residential and community-based services.

2



Drug Treatment Services

The current pattern of drug treatment services is complex and variable, reflecting both uneven growth and different philosophies of care. Although there are many gaps in understanding what sort of treatment works best for whom and why, there is growing evidence that a range of treatment interventions reduce drug misuse and the criminal activity and health risks associated with it. But failure to apply accepted good practice can reduce the chance of a successful outcome.

The historical development of drug treatment services – uneven growth, different philosophies of care

22. As the number of drug misusers has increased, a range of services and agencies has evolved to meet their needs. These aim:

- to reduce the harm which individuals cause to themselves, and others, including family and society;
- to stabilise and reduce the consumption of illicit drugs with the aim, where appropriate and possible, of achieving abstinence; and
- to rehabilitate the misuser into society (Ref.5).

23. The current pattern of service is complex and highly variable. The type of support available ranges from less intensive harm minimisation interventions, such as needle exchange schemes and information and advice, through to more structured community-based and specialist residential programmes. This report defines all these services as ‘drug treatment services’. This chapter explores:

- the historical development of drug treatment services;
- the structure of drug treatment services; and
- the features of effective treatment.

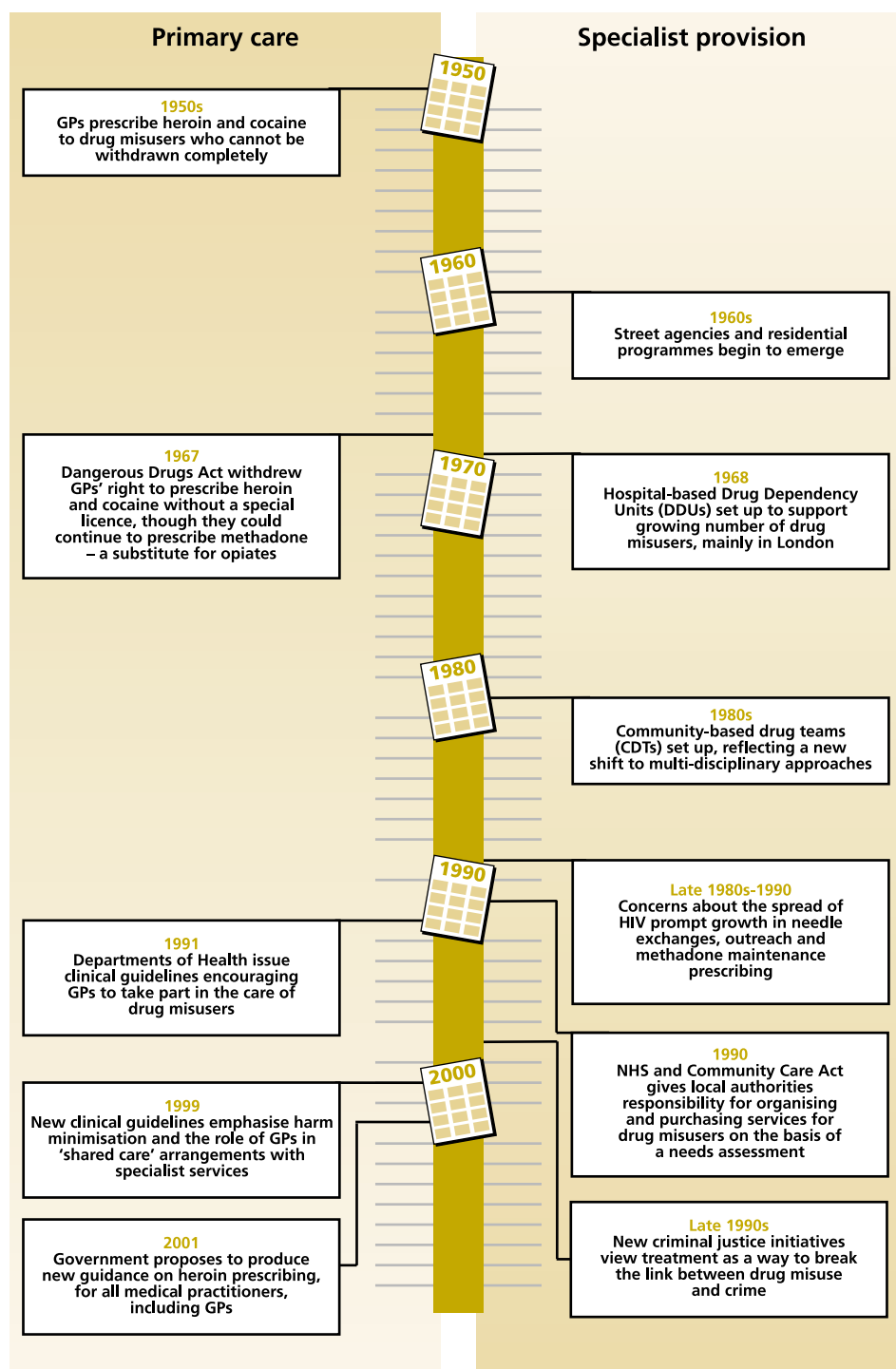
24. Until the 1960s, there were no specialist drug treatment services in the UK. Since then, a range of specialist services has developed and some GPs have continued to provide support in a primary care setting [EXHIBIT 5, overleaf]. Shifting political concerns and priorities have prompted different waves of service development. The growth of Drug Dependency Units (DDUs), for example, was a response to both the increasing numbers of drug misusers and concerns over the illicit trade of prescribed drugs among a few London doctors (Ref.43). The development of harm minimisation approaches, such as needle exchange schemes, was in turn driven by a recognition that HIV could be spread from one injecting drug user to another and further in to the wider community. This led to a stronger emphasis on attracting injecting drug misusers who were not engaged in treatment (Ref.44). Most recent service developments view treatment as a way of breaking the link between drug misuse and crime, reflecting the Government’s emphasis on crime reduction [BOX D, overleaf].

25. Contrasting approaches to the care of drug misusers are also evident, often reflecting different views about how people can best be treated. Many DDUs, for example, initially placed a strong emphasis on a medical model of care, focusing largely on the health needs of drug misusers. In contrast, Community Drug Teams (CDTs) attempted to promote a more ‘integrated’ approach (Ref.45), viewing drug misuse in a more social context and seeking to enlist the support of generic services, including housing, social services, GPs and criminal justice agencies. The service objectives of different providers also vary. While most residential programmes and self-help networks, such as Narcotics Anonymous, view abstinence from drugs as the key objective, many community-based services recognise ‘intermediate’ goals, such as reductions in the sharing of equipment or criminal behaviour, as equally valid (though abstinence often remains the ultimate objective).

EXHIBIT 5

Key developments in drug treatment provision

Specialist drug treatment services emerged in the 1960s, alongside primary care provision.



Source: Audit Commission

BOX D

Criminal justice drug treatment initiatives

A number of initiatives have been developed to extend drug treatment to those committing drug-related crime:

- **Arrest referral schemes:** are commissioned by the police and aim to encourage arrestees who are problem drug misusers to seek treatment. Arrest referral workers based in police custody suites refer people to appropriate treatment services. The national strategy aims to achieve schemes in all areas by 2002 (Ref.46).
- **Drug treatment and testing orders (DTTOs):** are designed to break the cycle of reoffending through rehabilitation. Offenders convicted of an imprisonable offence, and deemed suitable for an order, are given a community sentence, provided they agree to attend a drug treatment course for a minimum of 20 hours per week for between 6 months and 3 years, and to undergo regular drug testing. Courts regularly review offenders' progress. It was estimated that 3,425 orders would be made by 2001 (Ref. 47).
- **Drug abstinence orders (DAOs):** Under a new pilot scheme in Hackney, Nottingham and Staffordshire, courts are able to impose a new community sentence, the Drug Abstinence Order, and attach a Drug Abstinence Requirement (DAR) to existing sentences. New drug testing powers allow persons aged 18 and over who have been charged with a range of trigger offences, as well as those under probation supervision, to be tested for specific Class A drugs, to identify those misusing drugs and to monitor their progress. Prisoners who are released can also have a condition inserted into their licence requiring them to be drug-tested by the probation service.
- **CARATs:** every prison in England and Wales now provides counselling, assessment, referral, advice and throughcare (CARATs) for prisoners. By 2002, the Government aims to increase the CARATs caseload to 20,000, to establish 30 new prison-based rehabilitation programmes and put 5,000 prisoners a year through treatment programmes (Ref.46).

26. The role that GPs play in treating drug misusers has changed over time. Before specialist services were established, they prescribed drugs – mainly heroin and cocaine – to those who could not be withdrawn completely.¹ This role diminished as specialist services were established, but both the Department of Health and the ACMD have increasingly encouraged GPs to work with drug misusers and to participate in 'shared care' schemes. These are schemes defined by the Department of Health as 'the joint participation of specialists and GPs in the planned delivery of care for patients with a drug misuse problem, informed by enhanced information exchange, beyond routine discharge and referral letters' (Ref.33).

¹ The practice of maintaining addicts on maintenance doses, often over a fairly lengthy period, was known as 'the British system'.

The current structure of community-based drug treatment services

...different localities have evolved different combinations of services, often including both independent and statutory provision.

27. The absence of any agreed service model for drug treatment provision and variations in the scale and pattern of drug misuse from area to area mean that different localities have evolved different combinations of services, often including both independent and statutory provision. Similar services may offer different types of treatment. Some street agencies focus solely on drop-in services and information and advice, whereas others also offer structured interventions such as daycare and counselling programmes. The range of support offered by different types of services, such as community drug teams and street agencies, often overlaps [EXHIBIT 6].

Community-based drug services

28. A community drug service or 'addictions service' is usually provided by a local NHS Trust and may offer a range of support, including:

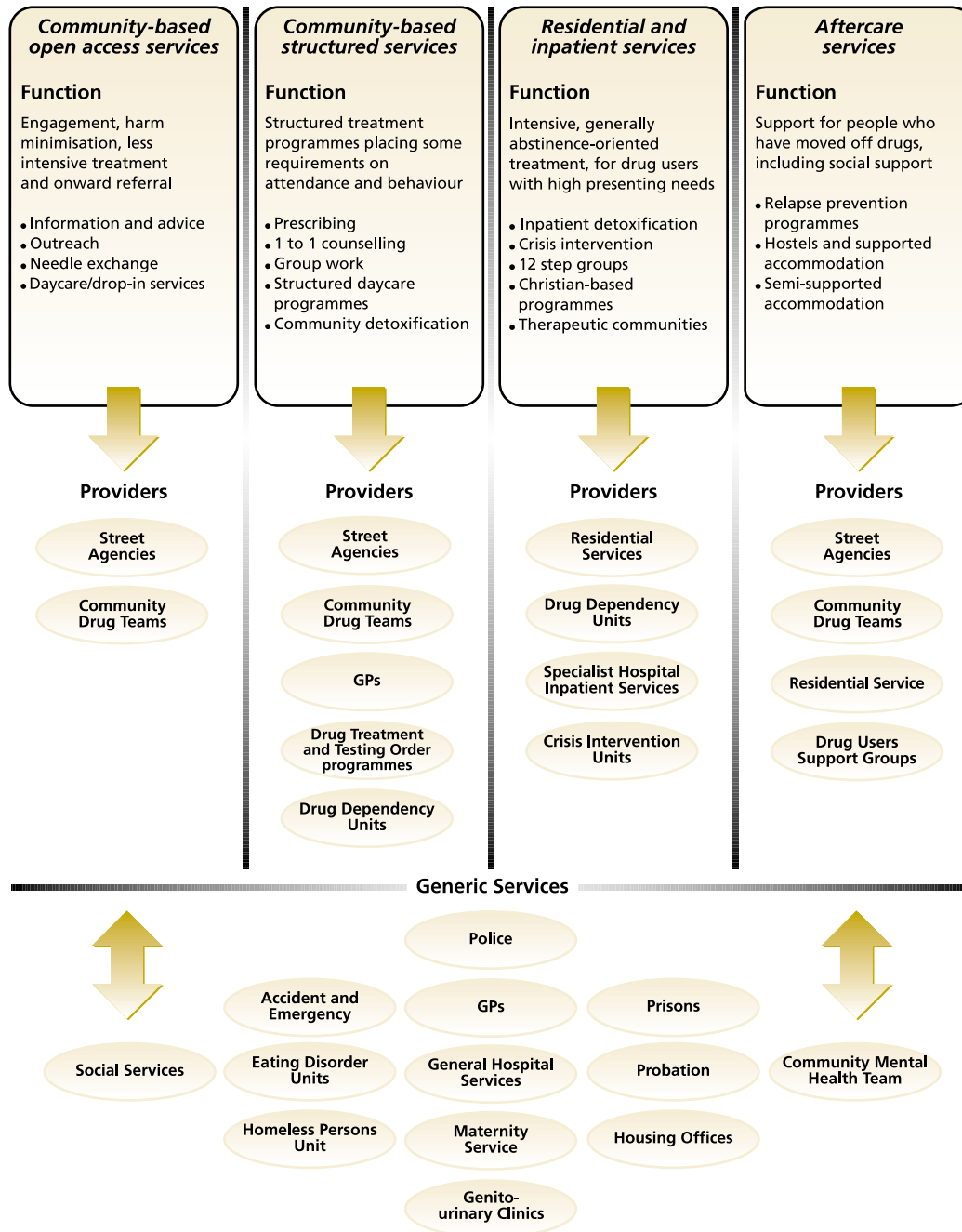
- general healthcare;
- counselling;
- alternative or complementary therapies;
- substitute prescribing, usually oral methadone for opiate dependent drug users;
- detoxification – as an inpatient and in the community;
- structured day care programmes; and
- relapse prevention programmes.

29. Each of the 11 areas visited in this study offered access to a community drug team (CDT) or 'addictions service', with some having as many as three separate services in their area. While most of these services were based in NHS Trusts, this was not universal. In one site, the health authority had commissioned an independent agency to provide drug treatment services. In another, a small social services substance misuse team had evolved into the main specialist service and was now commissioned by the health authority to provide a city-wide service. In both cases, medical staff were based within the teams. Out of the 16 CDTs covering DAT areas, 11 provided services for people with alcohol problems as well as drug problems. Around two-thirds of CDT expenditure in study sites was met by local health authorities.

EXHIBIT 6

Different types of drug treatment interventions

Most interventions are provided by the NHS and the independent sector.



Source: Audit Commission

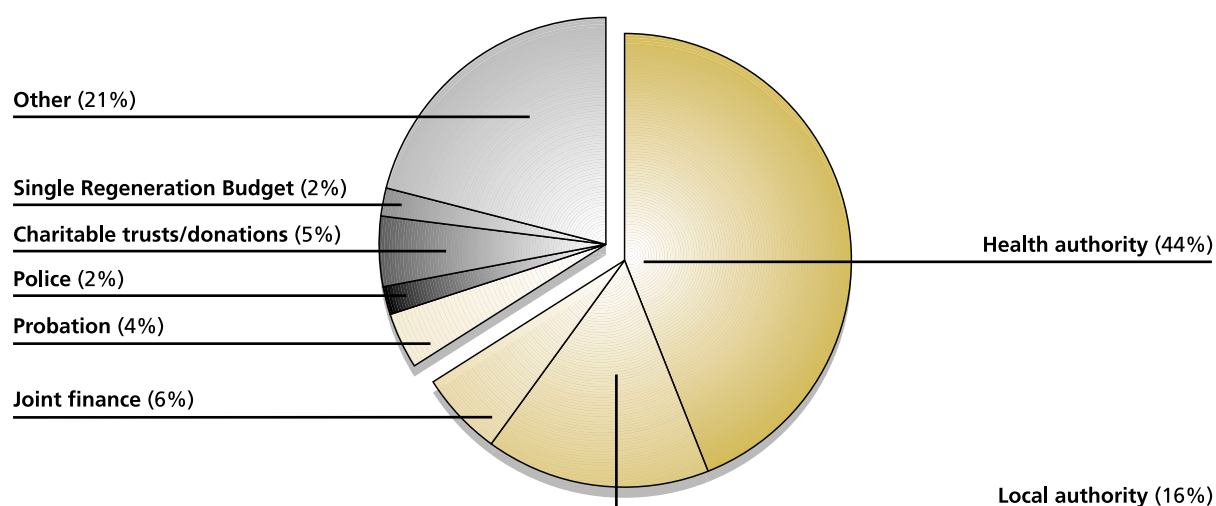
30. Street agencies often operate alongside CDTs and tend to offer low threshold, open access interventions, including drop-in services, information and advice, needle exchange services, counselling and support for the family and friends of drug misusers. These are generally run by the independent sector and have traditionally played an important role at the ‘front line’ in engaging drug misusers who are beginning to have major problems but who may not yet be ready to commit to more structured forms of treatment. They also have a key role in developing new approaches to emerging drug problems and are an important source of onward referral to other specialist treatment services.

31. In most cases, a rich mixture of funds is involved in supporting individual street agencies: charitable contributions are mixed with resources from local authorities and health authorities and funds from the Single Regeneration Budget (SRB), National Lottery and European funding schemes [EXHIBIT 7]. Many agencies have expanded in recent years after securing new funding. The total funding across the 22 street agencies covered by the Audit Commission study sites increased from around £5.8 million to £7 million between 1998/99 and 2000/01 – with an average funding increase of £52k. Additional resources had sometimes resulted in significant growth in the numbers employed; in one agency the number of staff employed had tripled in the last two years.

EXHIBIT 7

Funding sources for street agencies (2000/01)

Street agencies are funded by a wide variety of bodies, although around two-thirds of their budget is derived from health authorities and local authorities.



Source: Audit Commission data returns from 22 agencies in 11 study sites

GP surgeries are often the first port of call for help.

The role of GPs and primary care

32. GPs and primary care staff can play an important role in supporting drug misusers in the community. GP surgeries are often the first port of call for help. One survey of drug misusers found that 70 per cent of respondents who had contacted a service had first sought help from a GP (Ref.48). GPs can give information and advice as well as providing a number of services including general medical services, substitute prescribing, such as methadone, and guidance on harm reduction. Some GPs also work with specialist services in shared care schemes. These arrangements allow specialist treatment services to focus on more challenging clients and to use their resources more effectively. Many drug misusers also prefer to receive treatment through their GPs, often because it offers them a more accessible service and easier access to medical support, without the stigma of going to a specialist service (Ref.33).

Detoxification services

33. Detoxification services offer drug misusers help to eliminate physical dependence safely and provide support during withdrawal. Detoxification can be carried out on a supervised basis in a number of settings:¹

- as an outpatient or a day patient at either a general practice, street agency or community drug service (usually known as ‘community detoxification’);
- as a patient in hospital; and
- in a residential rehabilitation unit or crisis intervention service.

34. The Department of Health effectiveness review suggested that choice of setting should usually depend on the degree of motivation and preferences of the patient, the severity of dependence, the degree of multiple drug use, accompanying medical and psychological problems, as well as the accessibility of local services (Ref.8). Where people have relatively uncomplicated needs, they can usually be detoxified at home or in an outpatient setting so long as professional support is available. Those with a long history of addiction, or high levels of pre-treatment needs, or previous unsuccessful attempts at community detoxification, may require admission to an inpatient or residential setting (Ref.8).

¹ Some drug misusers may also try to detoxify themselves at home without medical supervision, usually by reducing their dose over a period of time.

Social services department substance misuse services

35. Local authority social services departments have a statutory duty to assess the community care needs of drug misusers and, where appropriate, purchase services on their behalf.^I These may include placements in residential rehabilitation services or structured daycare programmes. Different authorities have established different organisational arrangements to meet these responsibilities. Across the study sites, some social services departments had established substance misuse teams of between 5 and 20 staff, while others had rested responsibility with a single social worker, often based in a specialist mental health team. In two sites, the authority had formal arrangements with an independent provider to undertake assessments on their behalf.

Other services participating in treatment

36. A wide range of generic services come into contact with drug misusers, including accident and emergency departments, maternity services, mental health services and pharmacists. Many of these services can be a major source of referrals to specialist drug agencies. Increasingly, criminal justice services also play an important role both in referring drug misusers into treatment and providing treatment programmes themselves, usually in partnership with specialist treatment services.

Numbers in contact with treatment services

37. Recent figures estimate that in 2000/01 around 128,000 drug misusers were in contact with treatment services in England and Wales, with the majority attending community-based drug services^{II} [EXHIBIT 8]. About one-third of those reported were under 25 years of age. Routine data from the Regional Drug Misuse Databases for the period ending September 2000 show that in both England and Wales the ratio of males to females presenting to drug services was three to one (Ref.49). The proportion of people presenting for treatment by main drug of use varies across England and Wales. Heroin is the main drug of use for 64 per cent of clients in England, compared with only 45 per cent in Wales. Welsh services report larger proportions of users presenting with cannabis, amphetamines or benzodiazepines as their main drug of misuse [EXHIBIT 9].

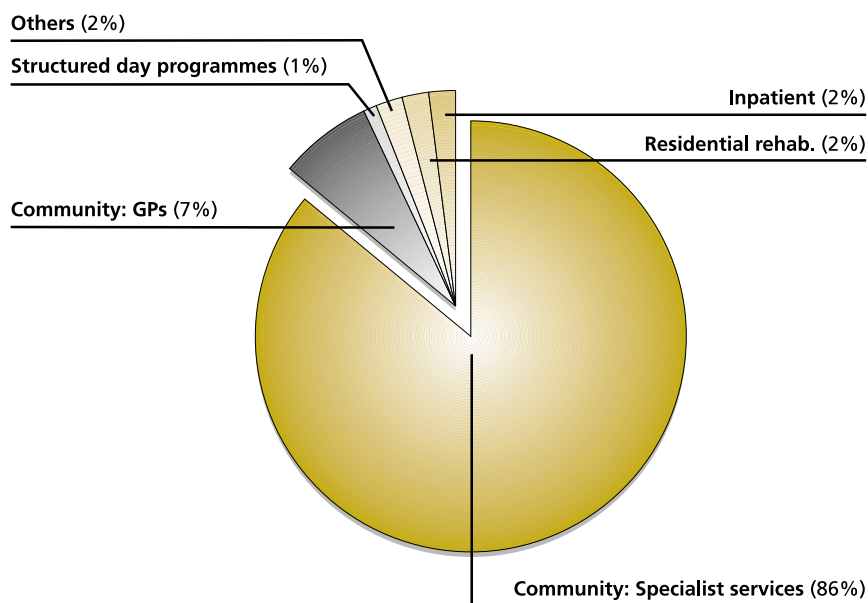
I Prior to the NHS and Community Care Act 1990 the costs of financing residential placements were often met by central government through social security payments.

II Three sources of information were used to provide an estimate of the number of drug misusers in contact with treatment services: censuses carried out of all drug misusers in treatment in England and Wales during April to September 2000 (Refs. 50, 51), and routine data from the Regional Drug Misuse Databases (RDMDs) for users presenting for treatment during the period October 2000 to March 2001. As reporting to the database is voluntary and some types of agencies are excluded (needle exchange schemes, social services, street outreach work), the figures underestimate those in treatment. It is also likely that community-based specialist services reported more completely than other groups – GP and residential service returns are probably far less complete.

EXHIBIT 8

Percentage of drug misusers in contact with drug agencies by type of service, 2000/01

The majority of users reported by the census (86 per cent) were attending community-based specialist services.

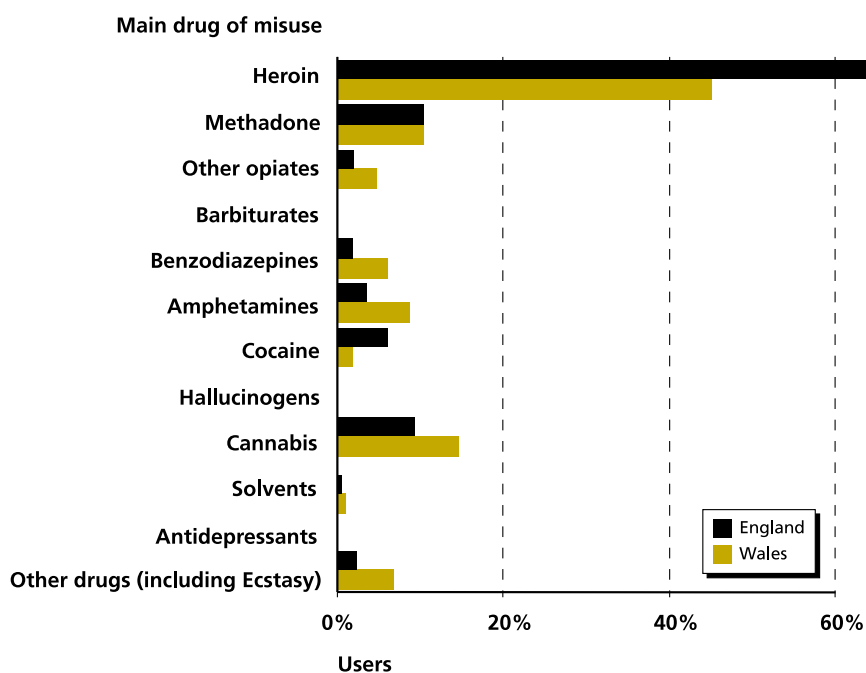


Source: Department of Health, Statistics from the Regional Drug Misuse Databases on drug misusers in treatment in England, 2000/01, Statistical Bulletin 2001/33 (Ref.51) Information from the Baseline Census, Welsh Drug and Alcohol Unit, 2001 (Ref.52)

EXHIBIT 9

Main drug of misuse for users starting agency episodes in the period ending 30 September 2000, in England and Wales

The proportion of clients presenting to drug agencies with heroin as their main drug of misuse is higher in England than in Wales.



Source: Department of Health, Statistics from the Regional Drug Misuse Databases for six months ending September 2000. London: Department of Health, Statistical Bulletin 2001/18 (Ref.49)

What is effective drug treatment?

...some agencies are achieving better treatment gains than others.

38. Over the last twenty years, research has demonstrated that a wide range of treatment interventions are effective in reducing drug use and the criminal activity and health risks that are often associated with it [APPENDIX 5, page 105]. NTORs reported improvements in the reduction in drug taking and in the physical and psychological health of many clients after one year^I (Ref.6). Abstinence rates for illicit opiate use increased from 22 per cent to 50 per cent in residential settings and from 5 per cent to 22 per cent in community settings. Significant reductions were recorded in injecting, sharing of equipment and frequency of drug use. Self-reported criminal activity also fell markedly. Shoplifting crimes fell by 67 per cent and burglary came down by 77 per cent. Improvements in drug use were largely maintained 4/5 years after treatment,^{II} with 47 per cent of residential clients and 35 per cent of those treated in community settings reporting abstinence from illicit opiate use (Ref.52).

39. Despite research such as this, there are still many gaps in understanding what interventions work best for whom, and why. This is largely because the outcome of treatment for any one individual is affected by their personal circumstances and motivation, as well as the severity of their problem. Some drug misusers may respond to a brief community-based intervention, such as a programme of counselling; others may require more intensive long-term treatment. Some people may be fully committed to achieving abstinence from all drugs from the start of treatment, while others may initially only be prepared to make more limited behavioural changes. The intervention and approach that works for one person will not necessarily work for another.

40. Nevertheless, some agencies are achieving better treatment gains than others. For example, the NTORs study found wide variations in the degree of improvement shown by clients receiving the same intervention at different agencies. Clients in the ‘best’ performing agencies showed reductions in heroin use which were three times greater than those of the ‘worst’ performing agencies (Ref.6). This may in part reflect a failure to apply accepted good practice. Although the evidence base for some types of intervention is weak, there is an emerging consensus about the factors most likely to lead to positive treatment outcomes [BOX E].

41. Using these factors as a starting point, the following chapter explores how well treatment services meet the needs of problem drug users.

I The study follows the progress of 1,075 clients (the majority of whom have been opiate dependent for many years) in treatment, in both residential and community settings. The community approaches are: methadone maintenance and methadone reduction programmes, largely with a harm reduction philosophy. The residential treatments are abstinence-based, specialist inpatient and rehabilitation programmes. One-year follow-up results were based on interviews with 769 clients (72 per cent of the sample).

II A randomly stratified sample of 650 clients (drawn from 894 clients who the research team had contacted during the first year of the study) were tracked at 2 and 4/5 year follow-up points. Results at 4/5 year follow-up are based upon interviews with 496 clients from the reduced sample (76 per cent).

BOX E

Factors promoting effective treatment

Research evidence suggests that a number of factors contribute to successful treatment outcomes:

Rapid access – Many drug misusers present to treatment services in crisis when they are extremely vulnerable. However, as they can quickly lose motivation to address their problems, services need to get clients into treatment without delay (Ref.8).

Systematic assessment and treatment matching – Treatment interventions must be carefully matched to the needs of individual clients. It is impossible to conclude that a drug misuser who improved in a residential setting would necessarily have made the same gains in a community-based programme (Ref.6). Good assessment procedures and access to a balanced range of treatment interventions are essential to ensure an optimum match between a client's needs, treatment settings and interventions.

A comprehensive approach to care management – In most cases, pharmacological interventions alone will not help to break a pattern of drug dependency. Drug problems are often closely associated with many other problems such as unemployment, family breakdown and crime. Although there is limited evidence in this area, the Department of Health effectiveness review concluded that failure to address wider life context issues *'may slow down or reverse progress in addressing drug misuse itself'* (Ref.8). This underlines the need for a comprehensive care management approach that attends to the individual's multiple needs.

Retention – Keeping drug misusers in treatment has been shown to increase their chances of success. NTORs found that clients in short-stay residential programmes who remained in treatment for 28 days, and those who remained in long-stay residential rehabilitation programmes for 90 days, achieved better outcomes than those who stayed for shorter periods (Ref.53). A number of factors contribute to poor retention, including prolonged assessment procedures, inflexible approaches to dosage policy in methadone programmes, the lack of ancillary services (such as counselling, legal support and general medical services) and poor rapport between clients and programme counsellors (Refs.54,55,56,57). Conversely, delivering treatment within a positive and supportive environment encourages people to stay in treatment.

Co-ordination – The complex nature of drug dependency means a client may require varying combinations of services and treatment interventions during the course of treatment and recovery. In practice, this may involve a wide range of specialist treatment services and generic services working together to support individual clients. Close interagency co-operation and an effective system of care management are crucial, in order to prevent clients falling between services, to avoid the duplication or omission of interventions and to ensure continuity of care.

3



Problems with Drug Treatment Services

Drug misusers need rapid access to treatment, with support carefully matched to their individual needs. But many drug misusers struggle to get timely and appropriate help.

A picture emerges of limited treatment options, lengthy delays and under-developed care management that allows too many people to 'fall through the net'. Some of the problems stem from constrained resources, but poor service planning, different views about 'what works' and poor collaboration between treatment services, GPs, mental health services and prisons do not help.

42. The complex nature of drug misuse and dependency means that drug misusers often require different combinations of treatment interventions over time and need to be supported along a ‘treatment pathway’. Many also have multiple needs. Some have a mental health or an alcohol problem and a proportion have difficulties with their social networks and accommodation. This means that treatment options and support must be carefully matched to different needs. It is crucial that different treatment services are effectively co-ordinated and appropriate support marshalled from a wide range of other agencies, such as housing and mental health services.

43. This chapter examines how well drug treatment services respond to these challenges at a local level. While Audit Commission fieldwork identified a number of innovative and effective approaches, it also found a common set of problems that can reduce the scope and quality of care for individual clients. These include:

- **Difficulties accessing drug treatment.** Weak assessment procedures, the uneven availability of treatment services and lengthy delays often make it hard for drug misusers to get the help they need.
- **Care often fails to meet individual needs.** Some clients receive a poor service because their care is not well managed and different treatment interventions are poorly co-ordinated. Joint working arrangements are underdeveloped.
- **Weaknesses in commissioning and resource allocation.** Poor service planning, low levels of commissioning expertise and the funding framework make it difficult to improve current performance and to ensure that local provision is ‘fit for purpose’.

Difficulties accessing drug treatment

Multiple referral routes, unco-ordinated assessment

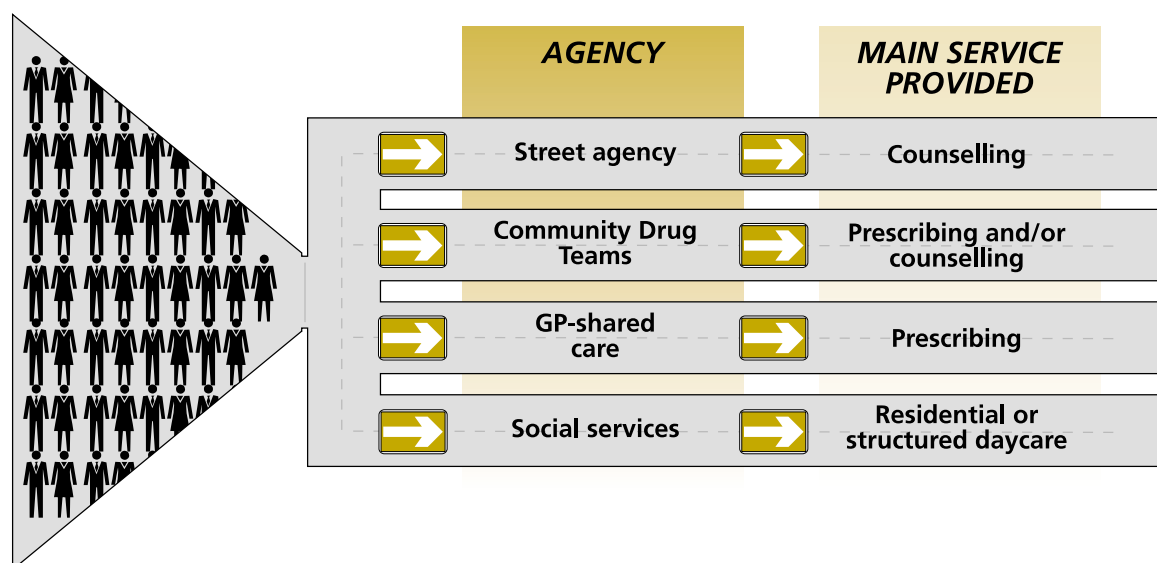
44. In most areas, there are many routes into treatment and lots of professionals involved in making onward referrals to specialist treatment services. People can usually refer themselves to street agencies, community drug services and social services departments or visit their GP. Each of these agencies may either provide or arrange a treatment intervention directly or make an onward referral to another service better placed to meet people’s needs. Potentially, this type of multiple entry system can allow rapid access to services and afford people a degree of choice over the type of agency they approach. However, to operate effectively, systematic screening and assessment systems need to be in place to ensure a client is placed with the most suitable provider, irrespective of their point of entry.

45. But current assessment practices often do little to secure either rapid access or appropriate treatment. Multiple assessment is common, as few areas have developed a common screening and assessment framework or arrangements for passing information between providers. This not only leads to increased costs and delays but also means that many clients face unnecessary repetition of a lengthy, and often personally distressing, process. In many cases, assessments are undertaken by a single member of staff and may be focused narrowly on a client's suitability for one specific intervention – such as maintenance prescribing or residential rehabilitation [EXHIBIT 10]. This means that the client's options may be limited by the personal preferences or treatment philosophy of the individual undertaking the assessment and/or the eligibility criteria for a particular type of service. For example, some social services departments will not consider a residential placement until a drug misuser has tried (and failed) treatment in the community.

EXHIBIT 10

Multiple routes into treatment

Point of entry may influence the type of service offered to clients.



Source: Audit Commission

46. Existing systems rarely have safeguards to prevent mismatches between clients' needs and the service offered. Few services use validated tools to diagnose the degree and severity of drug dependence,¹ and many lack clear eligibility criteria setting out the type of client who they are most likely to be able to help. In combination, these deficiencies increase the number of inappropriate referrals and reduce the likelihood that people's needs will be met effectively. Some psychiatrists interviewed for this study, for example, considered that some of their current clients would have benefited from earlier referral instead of receiving inappropriate treatments elsewhere in the meantime. Current systems may also fail to minimise risk, both to individuals and to the wider community, since there is little guarantee that those with high level needs receive more intensive support.

Limited treatment options

47. Strengthening referral and assessment procedures should help to reduce any mismatch between clients' needs and the services they receive. However, this would not in itself guarantee a suitable service – client choice in a particular locality may be limited to what is on offer rather than what is needed.

48. The availability of different services varies widely across England and Wales. For example, the numbers of street agencies – often the first port of call for someone seeking help – varied widely between fieldwork sites. While overall need in the underlying population makes direct comparisons difficult, three areas had no street agencies at all. Anyone seeking help in those areas would not have this option open to them. A similar pattern was visible in inpatient detoxification services [EXHIBIT 11, overleaf]. In one site, a county DAT straddled two health authorities; one had 16 beds for drug and alcohol misusers, while the other had none. This presented a problem where identified high level needs were not met by alternative services such as community detoxification.

The availability of different services varies widely across England and Wales.

1 There are two official international diagnostic classifications based on the consideration of both drug use (intoxication) and harmful use and dependence: the World Health Organisation's International Classification of Disease (ICD-10) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DMS-IV).

EXHIBIT 11

Inpatient provision in study sites

The level and type of inpatient provision varied from area to area.

	SITE										
	1	2	3	4	5	6	7	8	9	10	11*
Inpatient beds in specialist unit	✓	✗	✗	✗	✗	✓	✓	✗	✓	✗	✗
Dedicated inpatient beds within psychiatric hospitals in DAT area	✗	✗	✗	✓	✗	✓	✓	✓	✗	✓	✗
Inpatient contract with NHS Trust in another area	✗	✓	✓	✗	✓	✗	✗	✗	✗	✗	✗

* Inpatient provision in site 11 was spot-purchased on a bed-by-bed basis.

Source: Audit Commission fieldwork in 11 study sites

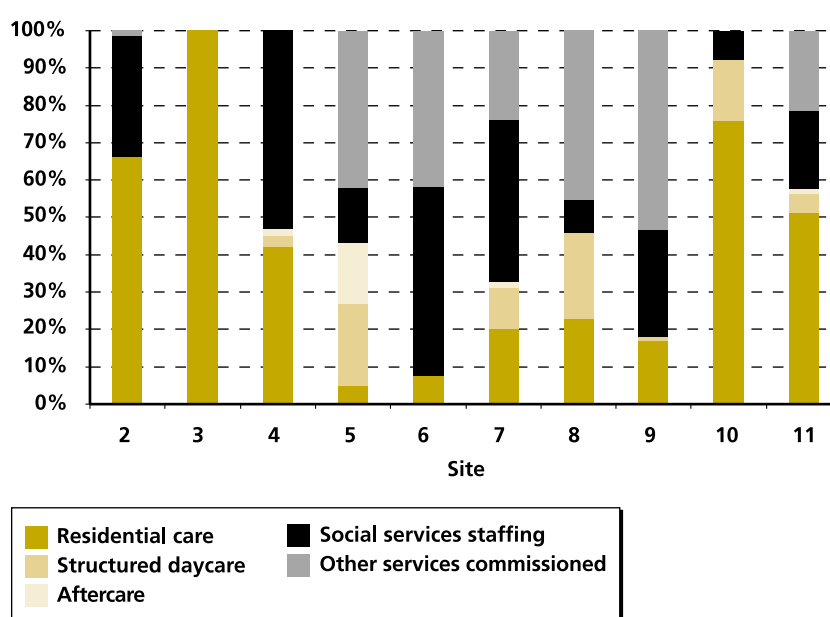
49. The range of interventions offered by the same type of services also varied. For example, some social services departments provided a wider range of support including structured daycare and home care, but others focused resources almost entirely on residential rehabilitation programmes – leaving gaps not filled by other agencies [EXHIBIT 12]. Some services were only provided in one area: one social services department had commissioned an independent agency to visit clients at home on a weekly or daily basis to provide a range of practical and social support.

EXHIBIT 12

Percentage of social services expenditure on different interventions (1999/2000)*

Analysis of social services expenditure shows marked variation in what is being purchased.

Total expenditure (1999–2000)



* Site 1 was unable to provide data.

Source: Audit Commission data returns from 11 study sites

50. Similarly, CDTs offered very different levels of support to drug misusers who had completed detoxification and stayed in the community. In one area, ex-users attended a structured daycare programme for up to seven weeks following detoxification and could join local relapse prevention groups, run by ex-users with the support of a local street agency. Elsewhere, daycare programmes following detoxification lasted just two weeks. In some cases, professionals felt such structured interventions offered clients very little. Consequently, no further support was offered after detoxification.

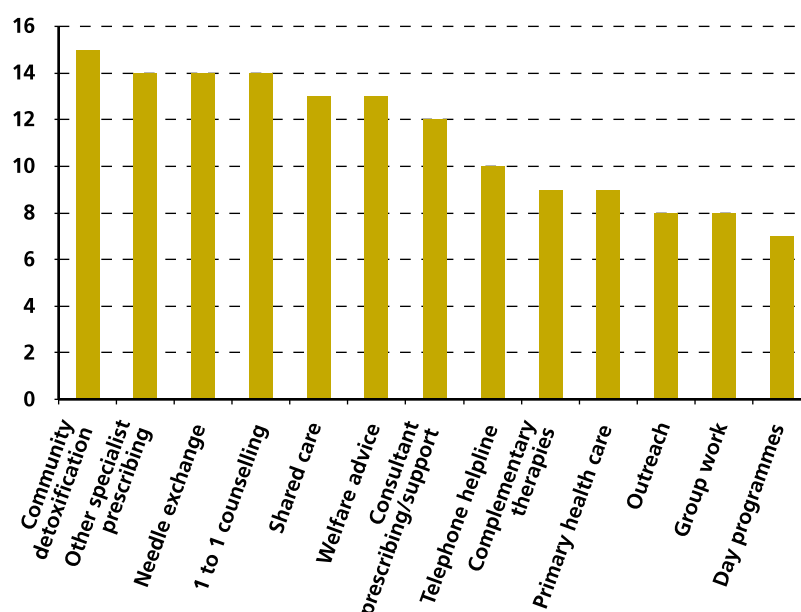
51. Generally, the type of support offered by community drug services reflected the staff mix. Some CDTs mainly employed medical staff and placed a strong emphasis on specialist substitute prescribing, general healthcare and needle exchange services. Other CDTs employed a broader range of staff, such as social workers, probation officers, counsellors and generic drug workers, and therefore offered a wider menu of options, including structured day programmes, aftercare programmes, counselling, complementary therapy and support groups, as well as clinical support [EXHIBIT 13]. The staff mix of some CDTs also influenced local shared care arrangements. Where consultant-led CDTs conformed to a medical model, access to shared care tended to be more limited. Conversely, nurse-led services relied on GPs to provide all necessary clinical support. Neither of these models appeared to be without its difficulties. Some GPs were reluctant to prescribe to drug misusers or manage complex cases without support from a local consultant. But areas that were heavily reliant on specialist support frequently struggled to meet demand.

EXHIBIT 13

Different services provided by community drug teams

Community drug teams provided a range of services in most fieldwork sites, though the range varied from place to place.

Number of community drug teams providing the service



Source: Audit Commission fieldwork in 16 CDTs in 11 study sites

...little emphasis has yet been placed on systematically reviewing the needs of crack users, black and ethnic users and women...

Special needs

52. Even where the right service exists in an area, the *style* of the service may fail to cater for groups with special needs. In most fieldwork areas, little emphasis has yet been placed on systematically reviewing the needs of crack users, black and ethnic users and women, or developing new services to promote their engagement more effectively. As most community drug services have evolved in response to the needs of white male opiate users, what they offer may be out of step with these groups' own perceptions of need. Research among crack users, for example, has shown that many fail to approach treatment services because what they want is a less formal, open access service, offering a broader range of psychosocial support and staffed in part by ex-users (Ref.58). Community drug services that operate rigid appointment systems, offer limited access to counselling, have little user involvement and continue to view prescribing of methadone to counter opiates as their core business are unlikely to meet this demand. Other research suggests that services do not always respond effectively to the needs of people with drug *and* alcohol problems. The NTORs study found that clients treated in community settings reported no change in drinking patterns after one year (Ref. 59).

Other access problems

53. Drug users in receipt of substitute prescriptions need to be able to get to dispensing facilities and their local clinic, sometimes on a daily basis. Some may also want to visit drop-in services or other unstructured services on a regular basis; or they may be required to attend structured day programmes, sometimes as part of a community sentence or DTTO programme. Yet getting there can be a problem. In some areas, services – such as structured daycare programmes – were only available to a small number of clients in the immediate catchment area, often due to lack of transport or tight geographical eligibility criteria. In other areas – especially large rural areas – access to prescribing services was limited, due to low levels of participation by GPs and community pharmacists. But the provision of special transport arrangements was rare and only one site issued bus passes to enable clients to reach local services.

54. Services must also be available at the right time. The Department of Health review of effectiveness stressed that '*any service that aims to provide 'low threshold' access to treatment must be available when its target population needs it*' (Ref.8). Yet few street agencies operated outside office hours. Only 7 of the 22 street agencies within the study sites opened outside 9 to 6pm and only 5 provided a service at weekends.

Lengthy waiting times

55. Users surveyed by the Commission reported how long waiting times and allocation processes which involved repeat appointments and further delays stopped them engaging with a service [BOX F]. But many areas struggled to respond quickly to new referrals. Among those CDTs able to provide information (and not all could), the median waiting time for prescribing services at 31 March 2000 was 35 days, although in three areas the average wait was over 100 days. There were also lengthy delays for community and inpatient detoxification services [EXHIBIT 14, overleaf]. Social services also took various amounts of time to respond to referrals: while most undertook assessments within 14 days, one site took almost 80 days to respond, partly because of staff shortages. There were also marked variations in the time taken to complete assessments and place people in residential services. Of the six sites that could supply these data, the average time taken ranged from 7 to 115 days, giving a median response time of around 8 weeks.

BOX F

User comments on assessment/treatment waiting times

They don't care. You're put on a list and then they'll call you up so many months later and what are you supposed to do in that time? When you want to come off drugs, it's then, not 4 or 5 months down the line.

Male, heroin user, aged 40

The only problem with drug services is the length of time you have to wait for a script...

Male, heroin and crack cocaine user, aged 21

They referred me to the service and I waited roughly 2 or 3 months for the appointment. So that morning I was really positive, I'd gone down, I'd had no gear, I thought, right I'm going to start my methadone script today and that's it. So I've gone in there and they've said, "You'll have a two hour interview and fill all these forms in," and I'm withdrawing at this time. So I thought I better do it. So long as I get my methadone at the end of it. And then he said, "When you've filled this in, we'll send you an appointment for the doctor." I went, "Eh? I thought this all happens today. This is why I've waited this long". And he goes, "No, we then refer you to the doctor, which can take anything from 2 to six weeks." So I said "You want me to sit here 2 hours after waiting 3 months, rattling, and then wait another 6 weeks in the same situation and then come in." I said, "Just stick it, forget it."

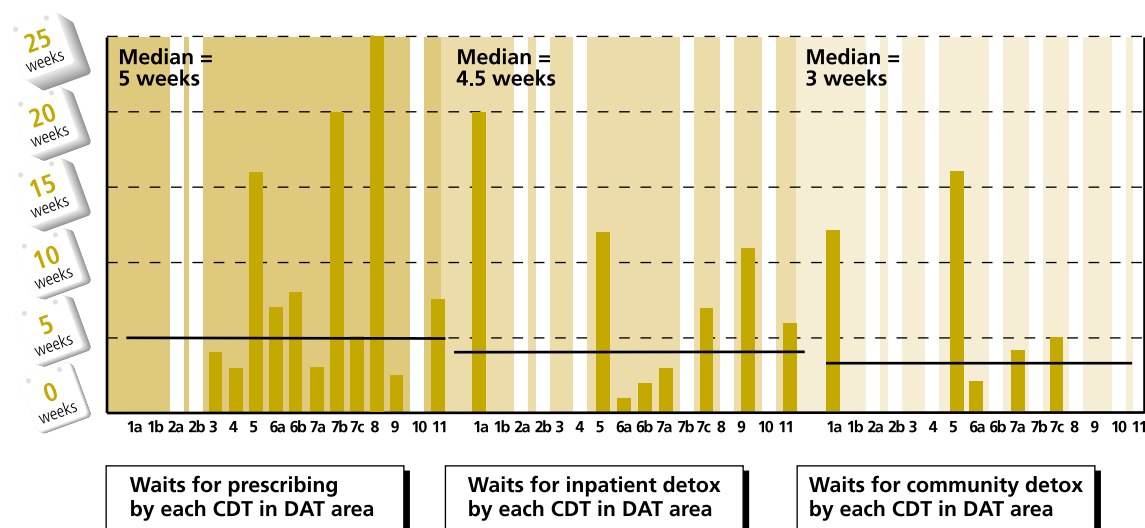
Male, heroin user, aged 38

Source: Audit Commission user research, 2001

EXHIBIT 14

Waiting times for prescribing and detoxification

Lengthy delays were evident in many CDTs for prescribing and detoxification services.

Average wait at March 2000**Notes:**

□ Blanks denote absence of data

1. The 2 CDTs in site 2, and the 1 CDT in site 10 could not provide any information about waiting times for prescribing and detoxification services.
2. The 1 CDT in site 4 and the 1 CDT in site 8 could not provide any information about waiting times for detoxification services.
3. The 1 CDT in site 11 could not provide any information about waiting times for community detoxification.
4. 1 CDT in site 7 did not offer any detoxification services; 1 CDT in site 6 did not offer community detoxification.

Source: Audit Commission data returns from 16 CDTs in 11 study sites

56. Lengthy waiting lists can drive clients away: in one area where prospective clients routinely waited five months for an appointment at the community drug service, only one in every three clients offered an appointment ever attended. But long waits also have other adverse consequences. They increase the risk that service choice will become driven by availability rather than need. For example, in one site, some users were encouraged to go for detoxification rather than wait for vacancies to arise for methadone maintenance. Local agencies can be deterred from making onward referrals, concealing unmet demand. A number of street agencies reported that they rarely referred people to prescribing services or social services departments because they knew they would simply be put on a waiting list. Lengthy waiting times also jeopardise the potential success of national drug initiatives, such as arrest referral schemes. Clients with lower priority health needs picked up by these schemes may have little chance of receiving a service quickly.

57. There are a number of reasons for lengthy waiting lists. The first is a national one – as drug problems have increased, mainstream services have not expanded quickly enough to keep pace. But there are two additional problems that community drug teams need to address: inefficient, bureaucratic procedures and inflexible, resource-intensive treatment regimes.

58. Inefficient, bureaucratic procedures. Many drug services fail to allocate people to services efficiently and effectively, leading to logjams and delays. In some cases, the allocation process is overly reliant on the involvement of senior clinical staff. For example, in one service, delays occurred partly because a consultant insisted upon personally prioritising every written referral before cases could be allocated to other team members. In another, the allocation process was lengthened by the involvement of many staff from different professional backgrounds, all of whom assessed each client individually at separately arranged appointments. As a result, clients seeking maintenance prescribing needed to attend three separate appointments on different days before a prescription could be issued.

59. Inflexible treatment regimes. Some services apply standard treatment ‘conditions’ to all clients irrespective of their needs and record of therapeutic compliance. For example, one service insisted that 95 per cent of all clients on substitute scripts should be on supervised consumption arrangements.¹ Another required each client to take a weekly urine test and receive fortnightly key worker sessions. These sorts of treatment ‘conditions’ may be appropriate for some clients. However, their blanket application increases the cost per client and hence reduces the number of clients who can be treated. If regular reviews are not carried out, provision may also become blocked by people whose needs are no longer urgent. Waiting lists grow and high priority clients struggle to get the support they need.

Care fails to meet individual needs

60. Once drug misusers have gained access to treatment, their care must be carefully managed. It should be adjusted as people’s needs and circumstances change. In some cases, care from a range of different services may need to be co-ordinated. However, fieldwork for this study found:

- some drug treatments were delivered poorly or not in accordance with the evidence base;
- some clients received inadequate support due to poor care management;
- services were often poorly co-ordinated – both drug treatment services and other services; and
- shared care arrangements were underdeveloped.

¹ To ensure compliance and minimise diversion, prescriptions of substitute drugs such as methadone are sometimes taken under the supervision of a pharmacist or a member of staff at the prescribing service. This is known as ‘supervised consumption’.

...where evidence does exist, it does not always influence practice.

Treatments delivered poorly or inconsistently

61. There are many gaps in understanding about the effectiveness of different types of treatment. But even where evidence does exist, it does not always influence practice. For example, research has shown that inpatient treatment in a psychiatric ward produces fewer positive outcomes than treatment in drug dependency units (Ref. 60). Users interviewed on behalf of the Commission also identified the problems of being accommodated in psychiatric beds [BOX G]. However, such beds were still used in some areas, often irrespective of CDT concerns about the limited expertise of ward staff, the poor quality of the treatment environment and the ready availability of illicit drugs hampering treatment outcomes. Some areas also opted for short inpatient stays of 10 days or less, despite research evidence showing better outcomes for those who remained in treatment for 28 days.

BOX G

User views of inpatient detoxification in psychiatric settings

It's soul destroying, being mixed with all those with a mental illness...it's like you have been labelled...

Male, cocaine user, aged 40

I had three detoxes an' each time I was sent to a psychiatric hospital and put on a psychiatric ward. It's hard enough to do a detox anyway, but when you are thrown in with patients who've got their own issues, it doesn't help when you're detoxing; it certainly doesn't help them either. Twice I walked out; I couldn't cope with the havoc that was going on around the ward. It was madness because people were ill at the time. You think – what am I doing here?

Female, heroin user, aged 29

Source: Audit Commission user research, 2001

62. Inconsistent approaches to substitute prescribing can pose further problems. While some areas placed a strong emphasis on tight control of methadone programmes – generally, involving supervised consumption, regular urine testing and the use of sanctions to address non-compliance – others ran ‘low threshold’ programmes with far fewer controls. Users confirmed the existence of variable approaches, with varying degrees of satisfaction (or dissatisfaction) [BOX H].

BOX H

User experience of prescribing

They wanted to refer me to a place in my area, but they said that my dose was too high. Therefore I’m stuck in a service quite a way from where I live, because the only place that will give me an adequate dose is the X hospital. The area I live in has a policy of never giving doses that high. I am very happy with the treatment I get from hospital, because they let me come every six weeks and they give me tablets rather than liquid which is more convenient for me to travel with. They don’t sanction people if they use on top, so you feel you can be honest with the people that you’re talking to.*
Male, long-term opiate user, aged 46

There was two lads that I can think of who gave positive samples, and they were on the three strikes and you’re out arrangement. One of the chaps I spoke to said that if they’d just given him a little longer on the dose he was on, he was just beginning to level out and get some sort of order. Then they were hitting him with a reduction, then they kicked him off.
Male, long-term opiate user, aged 46

I was under a large Drug Dependency Unit in London. I moved out of London two years ago and was referred to a Community Drug and Alcohol and Resource Centre in X. I immediately encountered problems. I was on a long-term maintenance script and had been for many years. They immediately forced me onto a reduction dose, which I was extremely unhappy about. I found it destabilising.
Male, long-term opiate user, early 40s

Everyone in this room has been told at some time during the course of their treatment ‘It’s against the rules’. But they never produce these rules, they never show these rules. They have nothing to do with the Orange Book (Clinical Guidelines). Its totally arbitrary.
Male long-term opiate user, early 40s

* The Advisory Council on the Misuse of Drugs has advised ‘absolutely against the prescription of methadone tablets to opioid misusers because of the potential dangers of tablets being ground up and injected. In our view any doctor who despite warnings persists in irresponsible practice should be reported to the GMC’. (Ref.3)

Source: Audit Commission user survey, 2001

63. Different approaches to prescribing in part reflect different (and quite appropriate) clinical judgements. But they also highlight very different views about the *purpose* of prescribing. Those running low threshold programmes often argue that it is the only way to attract more ‘hard to reach’ clients and minimise the harms caused by misuse. Others feel more structured programmes better motivate clients, promote change and reduce the risks of leakage into the wider community or of client overdose.

64. Clinical Guidelines produced by the Department of Health have done little to resolve these differences. Most practitioners claim the Guidelines support their approach irrespective of the rigidity or flexibility of their regime. There are also differences between the approach recommended by the Guidelines and the one recommended by the ACMD in their recent report on drug-related deaths (Ref. 3). For example, while the Guidelines suggest that most new patients should be on supervised doses for ‘*at least three months*’, the ACMD recommends daily supervision for ‘*at least six months and often longer*’ (Ref. 3). Other research has also pointed to wide variations in prescribing practice across the UK, largely because of its ‘*lack of formal structures or treatment protocols*’ (Ref. 61).

65. The quality of support offered by some treatment services can also be poor: community detoxification is a good example. An increasing number of community drug services and street agencies offer community detoxification, sometimes in partnership with a GP. But the support offered to clients can be variable. One community drug service arranged for a nurse to visit each client up to three times daily but others provided far less support. Lack of support emerged as an important issue among some users interviewed by the Commission [BOX I].

BOX I

Negative user experience of community detoxification

A small number of clients reported undertaking a home detoxification either via a GP or a community drug team. Several considered it to be a negative experience:

I just felt abandoned.

Female, heroin user, aged 31

After two days I went from having my methadone and my heroin as well to having nothing. I just couldn't move off the couch. I stuck it for 48 hours, which is a long time when you're withdrawing. They just gave me some tablets and that was it. Somebody came to see me once and that was it.

Female, heroin user, aged 32 with small child

Source: Audit Commission user research, 2001

Variable staff expertise

66. Some of the problems with the ‘delivery’ of treatment may reflect low levels of staff training and expertise. Staff in drug treatment services are drawn from a wide variety of professional backgrounds. A mapping exercise of the drug and alcohol sector undertaken by Healthworks UK^I in 2001 found many staff to be well qualified but *‘often their qualifications are not specifically relevant to the specialised substance misuse work they are undertaking’* (Ref.39). In the absence of any overall framework of training and qualifications for the sector as a whole, many workers in the field were also *‘still receiving little or no training relevant to their needs’* (Ref.39). The result is wide variations in practice and standards of service. For example, several agencies did not employ British Association of Counselling (BAC) accredited counsellors or provide staff with supervision and were essentially offering a service more akin to ‘advice and support’. Elsewhere, qualified counsellors offered a more structured service that aimed to achieve specific goals over a fixed period of time.

Recruiting and retaining staff with suitable experience is a national problem...

67. Recruiting and retaining staff with suitable experience is a national problem, largely due to overall shortages across the health and social care professions. This partially explained the absence of consultant support in some sites. But lack of key staff can hamper the development of new approaches to service delivery. Some fieldwork sites struggled to secure the participation of GPs in shared care arrangements due to the absence of consultant support. Others failed to meet new demands arising from arrest referral schemes because of the pressures faced by under-resourced community drug services.

68. The rapid development of the drug treatment sector – with new criminal justice interventions developing alongside the expansion of drugs commissioning and policy – has exacerbated these pressures. Many agencies reported difficulties retaining staff due to new opportunities elsewhere. Such pressures are unlikely to diminish. Youth offending teams, for example, are also now recruiting large numbers of drugs workers. Estimates suggest that the number of drug treatment specialists will need to increase by up to 50 per cent in the next five years to meet demand (Ref.39).

^I Healthworks UK, the National Training Organisation for the health sector, is currently developing national occupational standards for people working in the drugs and alcohol sector. As part of this work, it has produced a UK-wide occupational and functional map, which sets out the role of people working in this area and identifies their education and training requirements and existing qualifications.

Care management within community drug services

69. Good care planning increases the likelihood that drug misusers will remain in treatment and achieve a positive outcome. It also helps to ensure that individual clients receive an integrated package of care that offers a holistic response to their problems. Clear care plans can promote effective co-ordination between services, taking account of each client's changing needs over time. Ideally, the plan should reflect the contributions of all relevant agencies and copies of individual plans should be given to users. Clear treatment goals – both short-term and longer-term goals – should be included and reviewed on a regular basis at meetings with a key worker. However, a review of treatment case files showed that care planning within CDTs did not always reflect this good practice [EXHIBIT 15]. A review of 52 case files across six community drug teams found that around one-half of clients did not have a care plan and that only one-half of the reviews involved other agencies. User interviews also pointed to weaknesses in care management: *'Until recently, they'd kept me on 10mg methadone about 7 years, never speaking to me, never asking me anything'* (male, long-term opiate user, late 30s).

EXHIBIT 15

Review of case files

Of 52 case files examined by the Audit Commission, only half contained care plans.



Source: Audit Commission casefile review in 6 CDTs in 5 study sites

*...failure to balance
'policing' with the
achievement of wider
goals risks driving
clients away...*

70. Why is care management inconsistent? One explanation is that CDTs have differing views about the role of the service and the way drug treatment should be managed. Some CDTs interpret their role narrowly – simply as prescribing services – and therefore do not consider wider needs or actively organise contributions from other services. In one site, the CDT simply suggested clients visit another agency if they needed help with housing or benefits advice. Overemphasis on therapeutic compliance can also have an adverse impact on care management. For example, although some CDTs held regular care management meetings, these often focused exclusively on compliance rather than the achievement of any broader goals. Concerns about clients ‘topping up’ prescriptions with illicit drugs are understandable and do need to be addressed within care management arrangements. But failure to balance ‘policing’ with the achievement of wider goals risks driving clients away and generating an atmosphere of mistrust.

71. In other cases, effective care management can be impeded by negative views about the client’s ability to change. For example, one CDT manager argued that *‘we can’t set long-term goals for this group – they are too chaotic’*. Such negativity also appeared to lead to insufficient emphasis on follow-up. Non-attendance was simply assumed to reflect lack of motivation to change. Most CDTs made little attempt to follow up people who had dropped out or missed appointments. Often follow-up was limited to sending a letter offering a further appointment, although most services made more effort to chase those considered to be a risk to others or themselves. The existence of waiting lists was often used to justify this approach; why follow up a non-attender when there are more motivated clients waiting for the service?

72. Different views about the nature of ‘treatment’ can also lead to insufficient emphasis on moving a client along a treatment pathway. In some cases, substitute prescribing and retention are seen as *the* primary goals of treatment. This may be appropriate for some clients who need several years of support. But if retention becomes the overriding service philosophy, it risks holding back those who may be able to move on given other support, such as help to gain qualifications and skills or to develop new social networks. Conversely, if services define treatment to include a range of social support, when does treatment end? More carefully tailored care management approaches are required to secure a pathway approach. However, few CDTs routinely set long-term goals for clients that relate interventions to expected outcomes, or specify a treatment duration for those who want to ‘move on’. These factors may help to explain why clients in ‘methadone reduction’ and ‘methadone maintenance’ programmes appear to achieve very similar results. NTORs found that after one year there were *no* significant differences in doses, treatment retention rates, mean time in treatment or changes in substance misuse (Ref.62).

Poor co-ordination and joint working

73. Most drug misusers have complex problems that cannot be solved by one agency acting alone. However, many clients fail to receive a seamless service due to:

- lack of co-ordination between different treatment services; and
- poor joint working with other services, such as mental health.

74. Some clients need to move along a pathway between treatment services – in particular from detoxification to rehabilitation. Several sites reported difficulties achieving a seamless transition from inpatient detoxification to a residential placement. Some CDTs did not routinely contact social services before a client was admitted for inpatient detoxification. This resulted in them spending longer than necessary in hospital awaiting the outcome of their community care assessment. In some cases, there was no follow-up care for those leaving hospital. These problems occurred more frequently when budgets for inpatient treatment and residential care were held separately by CDTs and social services departments. Difficulties were not limited to inpatient care. Those undergoing detoxification in the community were not always linked into other services, increasing their chances of relapse. Continuity of care can also be poor where residential treatment is provided ‘out of area’. It is usually the responsibility of the service provider to support the clients following treatment, but if they do return ‘home’, local services rarely attempt to check their progress.

Co-ordination of care for ex-prisoners is particularly poor.

75. Co-ordination of care for ex-prisoners is particularly poor. Recent research, tracking 112 prisoners who had undergone some form of treatment in prison, found that only half were offered help to obtain treatment on release and only 11 per cent were fixed with an appointment at a drug agency. Four months after release, 86 per cent said that they had used some form of drugs and one-half were using daily. About one-half had nowhere to live and only 16 per cent were employed. The tracking project estimated that 8,000 people may be released each year with a serious dependency on drugs and that they account for five million crimes per year (Ref.63). High levels of Government investment in the CARATs programme have dramatically expanded prisoners’ access to treatment, but inadequate follow-up on release remains a problem. Many fieldwork sites reported that there was still little co-ordination between CARATs workers and local treatment services. This was partly because funding for aftercare included in CARAT contracts has often not been invested in follow-up services in the community and partly because many prisoners returned to a different geographical area on release, making co-ordination difficult to achieve. These failings undermine the value for money offered by CARATs.

76. Drug dependency is often closely associated with many other problems such as unemployment, family breakdown and crime. Clients of other agencies may also need help from drug treatment services. For example, recent studies of mental health team caseloads in inner city areas found that around a third of clients with some form of psychosis also had a substance misuse problem, giving them a ‘dual diagnosis’.

77. But, despite research that demonstrates the importance of good joint working across agencies, and the existence of local protocols in many areas, joint working remains patchy. In some cases, joint relations are good at a senior level but not translated into practice at an operational level (or vice versa). As a result, some clients fail to get the service they need. Drug misusers with mental health problems sometimes fall between services because the necessary agencies are not involved in their assessment and case review meetings, or agencies disagree on who should take the lead. Some of these clients present high levels of risk. For example, a review of 17 independent inquiries into homicides by mentally ill people between 1993 and 1996 found evidence of either problem drug or alcohol use in 13 cases (Ref.64). In around half it was thought to be a major cause of the homicide. Drug misusers with children can also experience problems. Interagency disputes about how the children should be cared for sometimes lead to delays in residential placement for the client.

78. Poor joint working tends to have two main causes: different philosophies or priorities across different services; and budgetary disputes. For example, in some study sites, mental health services felt unable to offer a diagnosis before a client was drug-free. Where diagnosis was given, clients with a substance misuse problem were often diagnosed as having a personality disorder – thus deeming them untreatable and beyond help. Conversely, some mental health services reported difficulties securing support for *their* clients from treatment services. Drug treatment services can be reluctant to treat people who do not appear motivated. But this can prove a formidable hurdle to people with ‘dual diagnosis’ who often have poor compliance and a chaotic lifestyle. Different views about what constitutes a ‘serious’ drug or mental health problem, high workloads and the absence of systematic joint training frequently compound these problems.

...housing departments are often unsure how best to house drug misusers.

79. For non-drug services, drug misusers are only one of many client groups – and one that presents particular challenges. For example, some housing departments – especially in the south east – face an overall shortage of stock for non-priority households and therefore struggle to house drug misusers who are single. Where they do manage to do so, they may face considerable pressure from other residents, concerned about anti-social behaviour such as discarded needles, threatening behaviour, and late night comings and goings. More generally, housing departments are often unsure how best to house drug misusers. Should they be offered accommodation in a familiar area, close to support from friends or family, or moved out of the area, away from drug-dependent friends? Should recovering misusers be housed together in close proximity so that they can offer each other mutual support, or will this increase the danger of ‘domino’ relapse or make them a target for dealers?

80. Joint working is also frequently hampered by arguments about who should pay for what. It is not uncommon for drug services and specialist mental health services to disagree on the proportion of treatment costs that each should meet. Disputes arise even within social services: for example about the proportion of funding to be met from the substance misuse and children’s services budgets when children need to be supported while a parent is in residential rehabilitation. Delays inevitably arise while these problems are resolved – some social services departments acknowledged that the assessment process can grind to a halt until agreement is reached. Interagency relationships may also be strained by confidentiality protocols. For example, while the police funded arrest referral schemes, some CDTs felt bound by client confidentiality not to reveal personal details of those subsequently receiving services.

Underdeveloped shared care arrangements

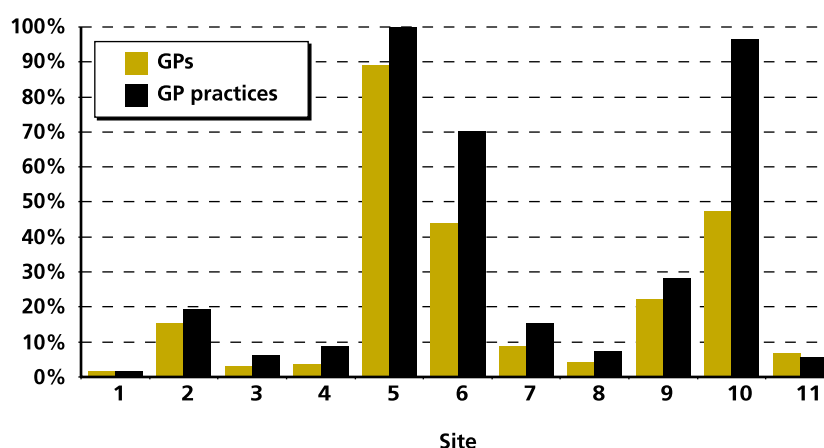
81. Good joint working between CDTs and GPs is critical. GPs can play an important role in the day-to-day management of a drug misuser’s medical needs and can help to reduce referrals to specialist services. Many clients also prefer to receive care in a primary care setting in the community wherever possible (Ref. 33). In response, some areas have developed ‘shared care’ arrangements, whereby GPs and specialist services work in partnership to support clients. But shared care is underdeveloped, meaning that most drug misusers continue to be heavily reliant upon specialist services. Only six of the eleven fieldwork sites visited by the Commission had a formal shared care arrangement in place. In around half of the areas fewer than 10 per cent of GPs were involved in local arrangements, below the Department of Health’s target of 20 per cent [EXHIBIT 16].

EXHIBIT 16

GP and GP practice involvement in shared care arrangements

Many areas had very low levels of participation in shared care arrangements.

Participation in shared care



Source: Audit Commission data returns from 11 study sites

82. The absence of any shared care arrangements sometimes reflects specialists' reluctance to encourage wider GP involvement, partly as they feel the quality of support may diminish. However, when local schemes are established, securing wider GP involvement is often a struggle. Some GPs have negative attitudes towards drug misusers and have concerns about client overdose, the potential impact on other patients and surgery staff or increases in their workload [BOX 1, overleaf]. Many still view activities such as prescribing and dose assessment as the preserve of specialist services. The results of an Audit Commission survey of GPs across 10 study sites confirmed this problem.^I Although the vast majority of respondents agreed that they should provide general medical services to opiate misusers, one-half did not consider prescribing methadone for maintenance to be an appropriate activity for general practice; 77 per cent felt it was inappropriate for them to perform dose assessment prior to prescribing. Lack of training and expertise may partly explain this response. Most GPs still receive very little training in drug misuse as part of their undergraduate and postgraduate medical education^{II} and few feel confident about meeting drug misusers' needs [EXHIBIT 17, overleaf].

I 1,574 GPs in ten of the eleven fieldwork sites responded to an Audit Commission survey focusing on the treatment of opiate users, a response rate of 43 per cent.

II In 1990 the Advisory Council on the Misuse of Drugs recommended that substance misuse should form a core part of undergraduate and postgraduate medical training for GP registrars. Although the recommendation was accepted by central Government, it was never acted upon.

BOX J

Negative GP attitudes to providing specialist support for drug misusers

Although around two-thirds of GPs who responded to the Commission survey felt that it was highly appropriate to provide general medical services to drug misusers, some expressed reservations about providing specialist support.

Treatment of drug misusers requires protected time. I cannot treat them within my contractual hours because they require three times the usual consultation time. They are also often violent, manipulative, rude and demanding.

[We need] specialist clinics for illicit opiate misusers, shorter waiting times, more support and counselling and easier accessibility in the community.

I feel methadone prescription is not part of services that could be provided from normal GP accommodation – GPs can provide these services sessionally outside their practice premises with training.

The key to successful detoxification and maintenance is a high level of monitoring and support, which GPs do not have time or resources to carry out. Their general medical care remains very much our responsibility.

Our practice does not prescribe methadone any more due to a receptionist and our practice manager being assaulted on two separate occasions.

Audit Commission survey of GPs, 2001

EXHIBIT 17

GP attitudes towards drug misusers

Only one-quarter of GPs felt confident working with opiate misusers.

* 1 per cent of respondents did not complete this section of the survey

Statement	Percentage of GPs who agree or disagree with the statement*		
	Agree	Uncertain	Disagree
I have received sufficient basic training and post qualifying training to help me manage patients with drug dependency problems	19%	14%	66%
I feel confident in my ability to work with opiate misusers	25%	23%	51%
Opiate misusers require forms of therapy beyond the competence of the ordinary GP	66%	13%	20%
The demands on a GPs' time which opiate misusers are likely to make are not manageable within the routine schedule of the surgery	71%	11%	17%

Source: Audit Commission survey of 3653 GPs, 2001

83. Poor support from specialist treatment services makes it difficult to address these barriers *or* guarantee that those GPs who work with drug misusers can offer a good quality service. Almost two-thirds of GPs who responded to the Commission survey did not feel they had easy access to specialist support when working with opiate misusers. Around a third of those who *prescribed* methadone for maintenance also felt they had not received sufficient training and did not have easy access to specialist services. In some cases, such findings may be explained by the absence of local shared care arrangements or GPs' own concerns about the quality of support in the absence of a local consultant. But some shared care arrangements also fail to address GPs' training and support needs adequately. Audit Commission fieldwork found that some areas did not provide training for those GPs participating in shared care and do not consider their training requirements or the dissemination of good practice within their local policy [EXHIBIT 18]. Without adequate training or support, the service that clients receive can be poor: *I don't think GPs know enough about heroin use. It's hard to explain to them what you're going through, how you feel. Their answer is diazepam, temazepam or 80ml of methadone – which makes you twice as worse at the end of the day* (male, heroin user, aged 34).

EXHIBIT 18

GP training

Some areas have yet to address GP training or the dissemination of good practice within shared care schemes.

	SITE										
	1	2	3	4	5	6	7	8	9	10	11
Shared care policy identifies GP training needs and proposes strategy to address them	X	✓	X	X	X	✓	X	X	X	X	✓
Shared care policy identifies arrangements for dissemination of good practice	X	✓	X	X	X	X	X	X	X	X	X
Training provided for GPs	X	✓	✓	X	✓	✓	✓	X	✓	X	✓
Training provided for pharmacy staff	X	✓	X	✓	✓	X	✓	X	✓	X	X

Source: Audit Commission fieldwork in 11 study sites

84. Another reason for low levels of GP expertise and involvement is the way in which shared care arrangements are set up and managed. Clinical Guidelines produced by the Department of Health recognise that ‘specialists’ and ‘generalists’ should play distinct roles relative to their degree of expertise [BOX K]. However, as there is no agreed model of ‘shared care’, many different models have evolved, each with their own strengths and weaknesses [BOX L].

BOX K

The role of medical practitioners in the treatment of drug misuse

Clinical guidelines produced by the Department of Health recognise three levels of expertise among medical practitioners involved in the treatment of drug misuse:

Level 1: The Generalist

Generalists are medical practitioners who may be involved in the treatment of drug misuse, although this is not their main area of work. They should be able to demonstrate

relevant competence to underpin their practice and care for a number of drug misusers, usually on a shared care basis. Services to be provided would be expected to

include the assessment of drug misusers and, where appropriate, the prescribing of substitute medication.

Level 2: The Specialised Generalist

A specialised generalist is a practitioner whose work is essentially generic or, if a specialist, is not primarily concerned with drug misuse treatment, but who has a special interest in treating drug misusers. Such practitioners would have expertise and competence to provide assessment of most cases with complex needs.

Examples of a specialised generalist would be a general practitioner or a prison medical officer who deals with large numbers of drug misusers in their practice and who, with other professionals and agencies, provides many of the services that are necessary. Their drug misuse practice would possibly involve the prescription of specialised drug

regimens. Additionally they can potentially act as an expert resource in shared care arrangements for general practitioners and professional staff operating at Level One.

Level 3: The Specialist

A specialist is a practitioner who provides expertise, training and competence in drug misuse treatment as their main clinical activity. Such a practitioner works in a specialist multidisciplinary team, can carry out assessment of any case with complex needs and provides a full range of treatment and access to rehabilitation options.

Most specialists would normally (but not always) be a consultant psychiatrist who holds a Certificate of Completion of Specialist Training (CCST) in psychiatry, and is therefore able to provide expertise, training and competence in drug misuse training as their main clinical activity. Their practice would probably involve prescription of

injectable and other specialised forms of prescribing, which will require Home Office licences. They can act as an expert resource in shared care arrangements for other practitioners, professionals and staff.

Source: Adapted from *Drug Misuse and Dependence – Guidelines on Clinical Management*, Department of Health (Ref.33)

BOX L

Different approaches to shared care

The balance of responsibilities between specialist services and GP practices varied immensely across different shared care schemes. However, three broad models could be identified, each with different strengths and weaknesses:

'Centralist' models	Strengths	Weaknesses
The specialist community drug service provides the majority of client support, including dose assessment and key worker sessions, and undertakes all urine testing. The GP role is limited to signing scripts, usually on the basis of guidance from the specialist service, following key worker sessions. Contact between GPs and clients is limited.	May encourage GP participation and offers clients access to support from specialists with expertise in drug misuse.	May do little to increase the confidence and expertise of the wider GP population or reduce pressures on specialist services and delays for drug misusers.
'Satellite' models	Strengths	Weaknesses
GPs with special interest and expertise in drug misuse run separate clinics for drug misusers, usually in parallel to a specialist service. They usually offer substitute prescribing, although a patient's own GP may address their general health needs. Alternatively, workers from the specialist service may hold regular clinics in local GP practices. Usually, the workers offer GPs guidance on dose assessment and prescribing. GP involvement with the patient varies. Some limit their involvement to signing scripts and addressing the patient's general healthcare needs. In others, they formally review the client's progress with the satellite service. Some schemes have introduced contracts, setting out the role and responsibilities of the patient, specialist service and GP.	Provides patient with more choice and can reduce pressures on specialist services.	Can evolve into another specialist service, which then 'sils up'. Some primary care-led models may have poor links with specialist services and/or only offer clients medical support. May discourage wider GP involvement.
'GP-led' models	Strengths	Weaknesses
GPs provide drug misusers with health and medical support, in partnership with a nurse-led specialist service. The specialist service assesses all patients and offers GPs advice on dose assessment and dispensing arrangements. GPs see clients regularly and are usually involved in case review meetings with the specialist service. Some schemes have introduced contracts, setting out the role and responsibilities of the patient, specialist service and GP.	GPs fully involved in patient care and support. Can reduce pressures on specialist services. In rural areas, patient access to prescribing services may be improved.	Some GPs are reluctant to provide services without access to consultant support. Where GPs are unwilling to prescribe, clients may be unable to access appropriate support.

Source: Audit Commission

85. In practice, few existing models seem to have achieved an effective balance between general and specialist care. For example, if one or two GPs in an area act as ‘specialised generalists’ but fail to engage the wider GP population, they may evolve into yet another specialist service, which then ‘silts up’. Similarly, some schemes continue to rely heavily on the involvement of specialists, limiting the GP role to the ‘rubber stamping’ of prescriptions. Such schemes do little to build the expertise and confidence of GPs working with drug misusers. One area, which had set up this sort of model, involved 89 per cent of local GPs, but only 37 per cent of GP respondents from this area felt confident about working with drug misusers. The bureaucratic nature of some central arrangements may also increase pressures on specialist services [BOX M].

BOX M

Bureaucratic, centralised, shared care arrangements

One consultant-led community drug service, with two specialist registrars and nursing staff, relies upon local GPs to undertake all prescribing for clients under its ‘shared care’ scheme. However, medical staff at the specialist service assess all clients and advise GPs on the type, and dose, of substitute drugs to prescribe. When GPs prescribe substitute drugs, all clients have a weekly or fortnightly session with their key worker in the specialist service. Urine testing is also undertaken weekly by the specialist service. Key workers recommend changes in dosage to GPs, notifying them of proposed changes by fax. Prescriptions are printed by the specialist service and sent to the GP for their signature each fortnight. Signed scripts are then returned to the drugs service and taken to the dispensing pharmacy by one of the staff.

On average, GPs see their clients every three months, unless complications arise. There is a five-month waiting list for appointments to the specialist service.

Source: Audit Commission fieldwork

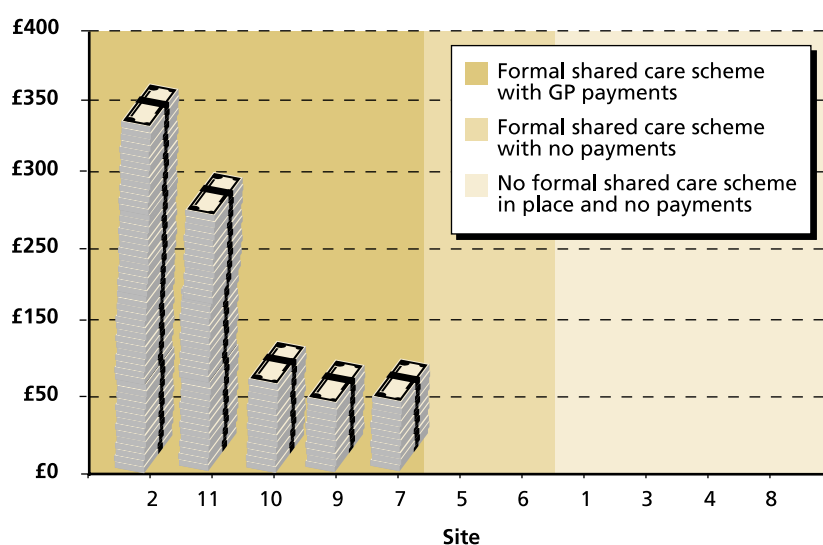
86. Lack of additional reimbursements is often felt to discourage participation in shared care. Two-thirds of GPs who responded to the Commission survey, for example, agreed that they should receive an enhanced capitation fee for prescribing methadone. However, while there is widespread recognition that treating drug misusers can be time-consuming and raise prescription costs, several areas offered no additional payments. Where payments were offered, rates varied [EXHIBIT 19]. The impact of payments as an incentive was also unclear, suggesting that small amounts of money *alone* did not greatly influence GP behaviour. The two areas with the highest levels of GP participation in shared care, for example, did not offer any separate payments. Some attempts to introduce new payment schemes had also been poorly managed. In one area, local GPs who had traditionally played an important role through well-established shared care arrangements without any additional payments became reluctant to continue once a new GP ‘satellite’ service was introduced and reimbursed to support drug misusers.

EXHIBIT 19

Patterns of reimbursement to GPs in shared care arrangements

In those sites where shared care arrangements are in place, payments to GPs vary widely.

Approximate payment per annum



- Site: 2 £100 per 10 appointments (based on maximum claim of up to 6 appointments per month for the first 3 months, thereafter 3 appointments per month)
- 11 £75 per quarter (plus £75 for initial appointments)
- 10 Approx. £110 per annum (varies according to total number of patients)
- 9 £100 per annum
- 7 £25 per quarter

Source: Audit Commission fieldwork in 11 study sites

Weaknesses in commissioning and resource allocation

87. If all of the problems described above are to be addressed systematically, services need to be commissioned carefully. Drug treatment services are purchased primarily by health authorities, but local authorities, probation and prison services and the police are also commissioners. Local authority social service departments may pay for services for drug misusers following community care assessments. The police and probation and prison services fund arrest referral schemes, drug treatment and testing order programmes and throughcare for ex-prisoners. Local commissioners therefore need to come together to address many of the problems with the management of drug treatment services identified in this chapter. However, they are often hampered by a lack of information about needs and services, and uncertainty about the relative effectiveness of different treatment interventions. Complex commissioning and funding arrangements compound these problems.

Poor service planning

88. To plan effectively, commissioners need good information about both the needs in their locality and also the level and nature of current services. However, in most cases, public health departments afford a low priority to any ongoing analyses of drug problems. As a result, local needs were identified from one-off studies, based largely on information about national prevalence and trends, rather than local data, and were often out of date. Attempts to identify latent demand or consider future trends in drug misuse and their impact upon demand for services were rare. Where commissioners adopted more systematic approaches, it was often unclear what difference they had made to purchasing decisions. One of the fieldwork sites had commissioned a needs assessment using ‘capture-recapture’ techniques, but the results had not been used to inform local service planning.

89. In addition to problems identifying ‘demand’ for drug treatment services, local commissioners often lack detailed knowledge of ‘supply’. This is partly because some health authorities do not have service agreements or contracts with providers that specify requirements for information about their levels of service or their performance. Moreover, many health authorities and social services departments struggle to identify precisely what they are spending on drug treatment or levels of activity. In many cases, expenditure is combined with alcohol treatment, and in some health authorities it is lost in the overall block contract for community mental health services. Simple disaggregation is rarely possible, raising questions about the validity of information that has so far been returned to central Government in DAT templates. Commissioners are also often unable to identify the costs of particular types of treatment interventions purchased from different services. Where monitoring does take place, the effort is usually inversely related to expenditure – large NHS trust contracts are often left to roll over year after year, whilst smaller agencies are scrutinised much more closely.

Even where drug treatment commissioners can identify the unit costs of different interventions, value for money is virtually impossible to determine.

90. Even where drug treatment commissioners can identify the unit costs of different interventions, value for money is virtually impossible to determine. This is mainly due to a lack of comparative data that can offer a benchmark for comparisons. Where services have attempted to monitor the effectiveness of their interventions, performance measurement is often a problem, not least because the interpretation of ‘success’ can be variable. One area, for example, decided to shift expenditure away from residential care on the grounds that 50 per cent of people dropped out, but struggled to explain why a success rate which was better than that achieved in the NTOR study was considered so poor. Statistical reliability of the information presents further difficulties. A common complaint is that it is meaningless to judge a service by the outcomes of a small number of individual clients. It is also not economically viable for small drug services to become ‘mini-research’ projects.

91. In the absence of good local information, commissioning decisions tend to be heavily influenced either by nationally determined priorities or by the judgement of local providers. While providers may have first-hand experience of drug misuse problems, there is a danger that existing patterns of service will be replicated unquestioningly or that local prejudices will determine purchasing priorities, rather than a sound appreciation of the evidence base. Alternatively, purchasing decisions can be driven solely by cost. For example, local commissioners in one study site had jointly agreed to reduce the use of residential placements in order to minimise costs and reinvest in community-based services that they felt offered better value for money. However, the shift to community-based provision left insufficient funds for those with higher needs. Another study site put an arbitrary ceiling of £500 per week on residential placements, making it difficult to place people with high needs.

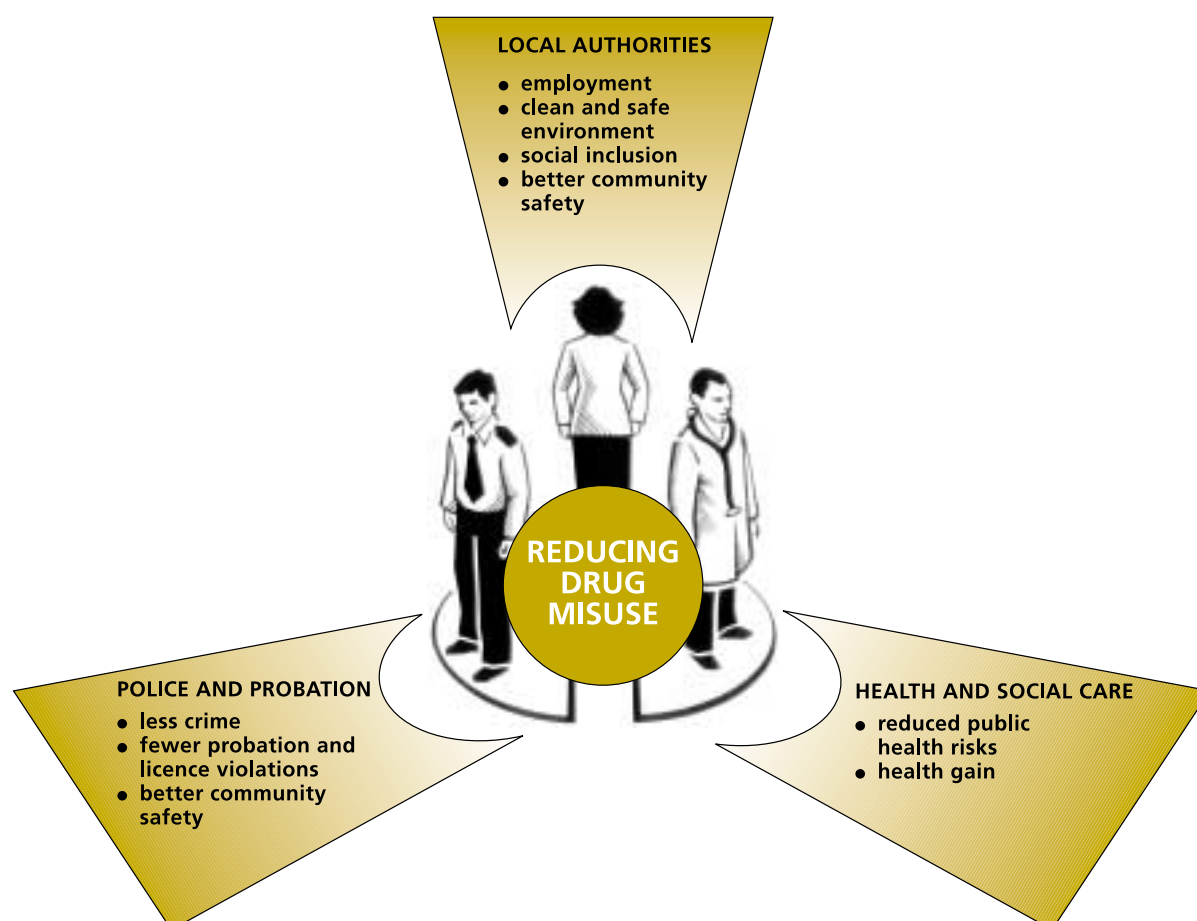
Disjointed commissioning and funding arrangements

92. Commissioning drug treatment services tends to be a low priority for each of the agencies involved. Drug treatment accounts for only 1-2 per cent of most health authority budgets and the ‘costs’ of drug problems fall largely on other agencies. As a result, most health authorities have insufficient drug treatment commissioning expertise. There is rarely a whole-time post dedicated to drugs and frequent structural changes in the NHS have shunted the responsibility from one person to another. The move to PCT commissioning presents new opportunities but, without careful management, risks exacerbating this problem. Attempts are being made to introduce joint approaches to commissioning, bringing together all funders to strengthen expertise and ensure effective co-ordination between specialist services and criminal justice initiatives. But, while many areas have already appointed joint commissioning managers and established joint commissioning groups, these developments have not yet had a significant influence upon purchasing decisions for mainstream services. Some joint arrangements also face difficulties balancing the differing priorities of different funders [EXHIBIT 20, overleaf].

EXHIBIT 20

Different treatment objectives

Commissioning agencies may have a number of different treatment objectives.



Source: Audit Commission

93. Certain aspects of the funding framework for drug treatment services also hamper effective commissioning (and therefore service delivery), with most criticism being directed at the way the introduction of new criminal justice initiatives had been managed. For example, in some areas, arrest referral schemes and CARATs increased the numbers of drug misusers referred for treatment *before* commissioners were able to increase service capacity. As a result, some local treatment providers struggled to meet new demands. These problems, which often fuelled friction between local partners, are partly rooted in the national funding framework. Since the introduction of the new drugs strategy, the bulk of new funding has been targeted at criminal justice initiatives while investment in mainstream drug treatment services has been much smaller.

One DAT co-ordinator...pointed to the difficulty of developing a coherent approach when individual agencies bid for funds opportunistically...

94. Many providers were also highly critical of funding regimes that promoted 'new initiatives' but failed to address the ongoing difficulties in securing finance for core activities, such as drop-in centres, which can play a vital role in attracting new clients (but are hard to evaluate). In Wales, new monies allocated for drug and alcohol treatment and vulnerable young people as part of a package of measures in a Social Inclusion Fund were primarily targeted at new schemes, leaving commissioners little scope to address shortfalls in mainstream services. Problems presented by multiple funding streams were another source of complaint, with many providers reporting difficulties due to the short-term nature of the funding and the increased administrative burden that resulted from their management. Long-term strategic planning can also suffer. One DAT co-ordinator, for example, pointed to the difficulty of developing a coherent approach when individual agencies bid for funds opportunistically, resulting in duplication of services or new initiatives that were not highly prioritised by the DAT. The need for health authorities to spend monies allocated within a single year equally increased the risk that money was allocated to areas where it could be spent, rather than where it was needed

95. DATs should have a key role in the development and commissioning of services. But their wide strategic agenda, combined with limited specialist expertise, means that some have not yet grappled with the more complex aspects of treatment. Their focus has tended to be on new money and specific funding schemes rather than the effectiveness of current performance. For example, one DAT had spent several meetings discussing how to allocate £100,000 from a Health Action Zone initiative, but had never reviewed the performance of mainstream drug services costing around £2.4 million. National planning and reporting arrangements for DATs also encourage a short-term planning horizon. At present, DATs report details of activity in templates and treatment plans on an annual basis, focusing primarily on actions in the last year and identified priorities for the year ahead. This does little to encourage the development of a strategic approach, which is usually characterised by long-term goals and objectives, with actions implemented incrementally according to a clear plan. Treatment plans appear to recognise the need for a longer-term approach.

Conclusion

96. Drug misusers face a number of problems accessing treatment services and getting the type of help they need. They may experience long waits to get treatment, which is often insufficiently comprehensive or poorly co-ordinated. This may contribute to higher than necessary drop-out rates, causing problems for the client and increasing costs for the wider community. But although drug problems are inherently difficult to unravel and treat, some treatment services are performing better than others. Drawing upon Audit Commission fieldwork, the next chapter suggests how services could be improved, using case studies.

4



Improving Performance

Increased funding offers local agencies new opportunities to review the quality and range of drug treatment services. The starting point is better intelligence about local needs and the performance of existing services. Developing more flexible approaches and improving care co-ordination and joint working are likely to be priorities in many areas. The efforts of local agencies need to be supported by parallel improvements in the national framework. Raising the standard of support could prove difficult without a better understanding of 'what works' and a national focus on performance measurement and staff training and development.

97. Commissioners, DATs and service providers need to work together to improve drug treatment services. As already outlined, extra funds are being provided, and these offer an ideal opportunity for areas to start to tackle the problems described in the previous chapter. These findings – along with the factors promoting effective treatment identified in Box E – suggest that the efforts of local agencies will need to focus on five key tasks:

- **Strengthening partnership working and commissioning** – DATs need to establish a joint infrastructure to undertake commissioning and ensure that key decisions are reflected in partners' own policies and resource allocation processes.
- **Reviewing the quality and range of treatment services** – Commissioners and service managers need better intelligence about their target population and the resources, activity and performance of drug treatment services. Working together, they can assess how well resources are currently being deployed and consider options for change.
- **Promoting better care co-ordination and joint working** – Commissioners should ensure that care pathways across these services are well managed and promote good continuity of care as drug misusers move between services and agencies.
- **Developing more flexible approaches** – Many areas need to promote more integrated approaches that marshal the support of other key agencies effectively, including housing and mental health.
- **Improving support to primary care** – Areas need to review local shared care arrangements and ensure that GPs have access to appropriate support.

98. As some of the problems that local areas encounter in the successful delivery of treatment must be addressed at a national level, the new National Treatment Agency in England should help local stakeholders to tackle this agenda. With a remit to improve '*the capacity, quality and effectiveness of drug treatment services*' (Ref.65), it is now well placed to promote parallel improvements in the national framework and develop a more coherent model of service standards and good practice. In Wales, the new Substance Misuse Intervention Branch (SMIB) in the National Assembly should play a similar role. Accordingly, this chapter sets out some initial proposals for both local and national action.

Strengthening partnership working and commissioning: local action

99. Promoting an effective strategy to secure improvements in drug treatment services will depend upon an effective partnership between local agencies with commissioning responsibilities. In practice, this means that local DATs should aim to:

- establish a joint infrastructure to undertake commissioning of local services;
- ensure that there are effective links with other partnerships and agencies, such as housing authorities and employment services; and
- link the work of the group to partners' mainstream activities and budget making processes.

100. Setting up a joint group to oversee the commissioning of drug treatment services can promote better co-ordination and many DATs have already established such groups: those that have not should do so. The membership of such groups should be comprehensive and their remit should include *all* investment in drug treatment services, rather than simply the new pooled budget. Support for such groups will be key. As treatment services are not the sole priority of any one member, there is a danger that the development of a coherent purchasing strategy will be lost amongst competing priorities. To avoid this, local areas should consider appointing a joint commissioning officer to take forward key areas of work, such as the development of key contracts and service specifications.

101. Good links between commissioning groups and other local partnerships will help to prevent duplication and ensure a coherent approach to what are often overlapping problems. The development of Local Strategic Partnerships (LSPs) and recent proposals¹ to bring together the work of DATs and Crime and Disorder Reduction Partnerships (CDRPs) provide a new opportunity to review local arrangements. But achieving effective co-ordination is not easy and new arrangements will need to be closely tailored to local circumstances. One county DAT, for instance, covers 16 district councils, each of which has a CDRP and a Youth Offending Team. A number of DATs have already experimented with ways to achieve better co-ordination. In one area with coterminous boundaries, the same person chairs the drugs, crime and youth offending partnerships, making it easier to recognise links between the three agendas. In two-tier areas, some DATs have set up district-level drug reference groups to plan tactical action and work with CDRPs to implement the *Communities Against Drugs* initiative, leaving DATs to focus on strategic matters (Ref.66).

¹ The White Paper on Police Reform, '*Policing a New Century*', published in December 2001, outlines plans to create a new community-based partnership by bringing together the work of Drug Action Teams (DATs) and Crime and Disorder Reduction Partnerships (CDRPs) (Ref.40).

Strengthening partnership working and commissioning: national action

102. Joint commissioning groups must also be linked to each partner's mainstream activities and budget processes. Strengthening service delivery and realigning mainstream budgets, for example, will require strong links between each agency at all levels of their organisation: strategic, managerial and operational. Careful planning of proposed changes will be key. In practice, the complexity of getting different organisations to agree on a common change of direction can be a cumbersome process, requiring each agency to go through their own decision-making processes and canvass broader support. However, the involvement and support of strategic players within the DAT – who have the authority to commit their organisations and to endorse new models of service – can help this process run more smoothly. Equally, an effective Chair can help to build trust and commitment between local partners and encourage individual agencies to consider changes in spending priorities.

103. While effective partnership working at a local level can help to drive through change, the Government could usefully review certain aspects of the national framework to promote a stronger emphasis on *long-term funding and planning* for treatment services and ensure better continuity in service development. More flexibility in the funding framework could equally afford DATs more opportunity to respond to local needs. Some areas, for example, need to make substantial investment in mainstream treatment services and follow-up support, to fully realise the benefits of new criminal justice initiatives. But although some DATs may ideally have chosen to prioritise resources in this way, the initial ringfencing of new treatment monies for drug treatment and testing orders militated against this approach.

104. A number of existing models could provide the basis for allowing DATs greater discretion over the use of funds. The move towards Public Service Agreements (PSAs) with local authorities, for example, is indicative of a longer-term approach, with funding tied to agreed performance measures that reflect local objectives. A similar model could be used to allocate pooled treatment monies, though the Government may be understandably reluctant to do so until the weaknesses in performance measurement highlighted in this report are addressed. Other types of funding and planning flexibilities could also be explored. These could include:

- allowing DATs more flexibility to set local targets and develop initiatives that respond to local circumstances;
- relaxation of NHS rules which require annual allocations of treatment monies to be spent within the year for which they are allocated; and
- a greater emphasis on long-term planning and funding cycles that allow greater synergy with other partnership activities.

Reviewing the quality and range of treatment services: local action

105. The Government could further assist local areas by ensuring that the future management of drugs policy is well co-ordinated. A number of Government departments play a key role in policy development and the NTA has already put together an ambitious business plan to guide the further development of drug treatment services. However, without careful management, there is a danger that local stakeholders will be overwhelmed by the pace of change and could struggle to prioritise their local agenda. Clarity around expectations and a clear statement of the responsibilities and priorities of each department would be welcomed by all working in the drug treatment sector and ensure more effective service delivery. Ensuring that new Government initiatives have been allocated sufficient time to deliver results (and are properly evaluated) would also help.

106. DATs need to develop a clear strategy to guide the development of treatment services. This should reflect the needs of current and emergent problem drug misusers within their area. More fundamental service reviews will also be needed to improve the quality of local provision and determine local priorities.

Assessing local needs

107. To be effective, local strategies for drug treatment services should be informed by up-to-date information on:

- drug-using patterns and the socio-demographic characteristics of drug misusers identified in the area;
- different patterns of use by age, gender and ethnicity; and
- any distinct geographical patterns or ‘hotspots’.

108. A number of sophisticated approaches have been proposed, based on epidemiological models. But few areas have the capacity to use these approaches successfully, at least in the short term. However, qualitative approaches can be used locally to build up a picture quickly, and at little cost.

109. Current service providers and key agencies – such as the police and probation – will all have views on the accessibility and quality of existing provision and can help to identify any shortfalls and unmet needs. Gathering information about existing clients’ satisfaction with the content and impact of the treatment they receive can also be helpful, perhaps through the establishment of service user forums. A drug misuse treatment satisfaction questionnaire recently developed in the UK for the drug misuse population could be used to solicit views (Ref.67). Feedback from outreach workers and street agencies can provide early indications of new trends, possibly supplemented by the insights of key staff brought together in more formal monitoring groups [CASE STUDY 1].

CASE STUDY 1

Leicestershire illegal drug monitoring group

In Leicestershire DAT a group consisting of representatives from the LEA, two drug agencies, the health service, the police and other services meets three times a year to report on recent developments and observations from the perspective of service providers. Police report on seizures and arrests, agency workers on the profile of their clients. To provide a basis for comparison, the group strives to provide information on the availability of particular drugs (up or down) and the prices of key drugs. This information allows the DAT to get an updated picture of drug related trends in the area, and to build up trends and target interventions accordingly.

Source: 'Local Drug Action Team Information Systems', Drugscope, 2001 (Ref.68)

110. Where new problems are identified, local research can be commissioned to find out more about their scale and nature and the way that services will need to adapt to meet emergent needs. As gaining access to 'hidden' populations of drug misusers can prove difficult, some areas have employed drug misusers known to services to carry out research on their behalf and used the results to shape future patterns of provision [CASE STUDY 2, overleaf].



CASE STUDY 2

Peer research to identify the needs of crack cocaine users, Trafford Probation Service and Trafford Substance Misuse Services

In 1994 Trafford Probation Service funded a research project that aimed to gauge the extent of crack cocaine use in their district and to find out about the needs of users. A detached drug worker at Trafford Community Drug Team managed the project.

Drug users with recent experience of using crack cocaine were employed as fieldworkers, with volunteers recruited on the basis that they had credibility and access to the target group. Fieldworkers made contact with drug misusers by 'snowballing'. To help penetrate 'hidden' populations, initial contacts were asked if they knew other crack cocaine users who would be prepared to be interviewed. A total of 231 crack users were interviewed during March and April 1994.

The research found that almost half (48 per cent) of those interviewed had *never* been in contact with a treatment service. And the vast majority of those who had contacted a service had sought help with a co-existent heroin dependency rather than their use of crack cocaine. Those who had contacted a service specifically for their crack cocaine use (13 per cent) were often disappointed with the service they received, with over half of this group rating it as 'useless' or of 'little use'. Many of those who had never contacted a service felt treatment providers offered very little to meet their needs or were unaware of local services.

A clearer picture of the 'style' of service that crack users wanted emerged from the research: essentially an informal drop-in service, staffed partly by ex-users, and targeted specifically at crack cocaine users. Confidentiality, rapid access and better information about crack cocaine were also identified as key issues. The results of the research have helped to shape Trafford's approach to service development. A crack cocaine project – *The Piper Project* – now provides an informal drop-in service for crack cocaine users and has succeeded in attracting a broader range of clients, including cannabis users and alcohol users.

Source: Adapted from Bottomley et al, 'Crack cocaine users – tailoring services to user need' (Ref.58), with support from the Piper Project, Trafford.

...better information about costs and performance should be collected routinely to inform local reviews...

Reviewing existing provision

111. Alongside needs analysis, a review of existing provision will give DATs a clearer picture of the capacity of services to meet local demands and, equally importantly, help to identify pressure points and shortfalls. Information contained in DAT treatment plans provides a starting point for such reviews, providing information on current capacity, waiting lists and estimates of projected demand. Such information is useful but needs strengthening to provide a firm basis for judging how services should be adjusted.

112. Initially, better information about costs and performance should be collected routinely to inform local reviews and provide sound management information for service providers and commissioners. For some health authorities, the first steps will be to identify their expenditure on specialist treatment services, clarify the range of interventions provided and set out current practices in separate service agreements or contracts. These should include some meaningful reporting requirements to identify the levels of activity and outcomes achieved within existing resources. Social services should also review their information systems, ensuring that any provision commissioned is carefully monitored. Where services are commissioned jointly, a standard framework for performance monitoring can help to reduce pressures on providers.

113. For trusts, this is likely to require a shift away from current opaque reporting methods (which tend to focus on input data such as occupied bed days, outpatient attendances and finished consultant episodes) towards a more client-centred approach. A number of ‘process’ measures based on those factors known to influence treatment outcome – such as retention, treatment completions and effective care planning – potentially offer commissioners more useful insights into service performance [BOX N, overleaf].

114. Any new information systems designed locally must fit with the National Drug Treatment Monitoring System (NDTMS), not least to reduce the burden on staff within reporting agencies. Under new reporting arrangements, the NDTMS can potentially provide profiles of all clients in treatment, identify those registered with more than one agency and the type of treatment interventions provided. However, under-reporting reduces the value of this information and continues to be a serious problem, especially among GPs. The most effective way to get people to return accurate figures is to use the information locally for management purposes. At a local level, commissioners could help by including compliance requirements in local contracts, service specifications and formal shared care arrangements.

BOX N**Measuring activity and performance of drug treatment services**

As the range of interventions provided by different services will vary, activity and performance measures need to be carefully tailored to each agency. However, the following ideas would help commissioners to begin to gauge how well community drug services and street agencies are performing:

Waiting times

- Average waiting time for assessment.
- Average waiting time for a service (for example, methadone treatment slot, residential placement).
- The number of people waiting to begin treatment at the end of the reporting period.

Referrals

- The number of new referrals seen by each service, by source, age, gender, ethnicity and main problem drugs.
- Percentage of new referrals completing assessment process.
- Percentage of new referrals admitted to service and interventions provided.
- Percentage of new referrals referred to other agencies.

Care management

- Percentage of clients with a care plan.
- Percentage of missed appointments and key worker sessions.
- Percentage of clients re-contacted after missed appointments and key worker sessions.
- Percentage of clients jointly managed with other agencies.
- Percentage of clients completing treatment and leaving the service.
- Percentage of clients leaving treatment early/dropping out.
- Percentage of clients asked to leave the service.

GP registration and shared care

- Percentage of clients registered with a GP.
- Percentage of GPs and GP practices participating in shared care arrangements.

Hepatitis B vaccinations

- Percentage of clients offered Hepatitis B vaccinations.
- Percentage of Hepatitis B vaccinations completed.

Source: Audit Commission

115. Outcome monitoring can be undertaken to supplement routine information collection. Increased pressure from commissioners has led to a proliferation of different approaches including customer satisfaction questionnaires and the use of instruments like the Maudsley Addiction Profile (MAP) and the Christo Inventory for Substance Misuse Services (CISS) [BOX 0]. However, commissioners need to consider carefully the added value of such exercises and the reporting burden placed on provider agencies. They should also be alert to potential problems. Where sample sizes are small, changes in the severity of clients admitted to a service can lead to large random variations in the apparent ‘performance’ of individual agencies. Equally, the reliability of information collected by some instruments may be variable. For example, the CISS depends upon workers’ own assessment of the ‘severity’ of clients’ problems so interpretations may differ. Self-report data can also be questionable, especially where clients may fear that some information may jeopardise their treatment.

BOX 0

Outcome monitoring tools

Two outcome monitoring tools are increasingly used to assess the impact of treatment interventions in local services:

Maudsley Addiction Profile (MAP)

The MAP is a brief 12-minute administered questionnaire for assessing treatment outcome. It contains 60 items across 4 domains: substance use, injection and sexual risk behaviour; physical and psychological health; relationship problems, employment and crime involvement. The recall period is the past 30 days (Ref.69).

Christo Inventory for Substance Misuse Services (CISS)

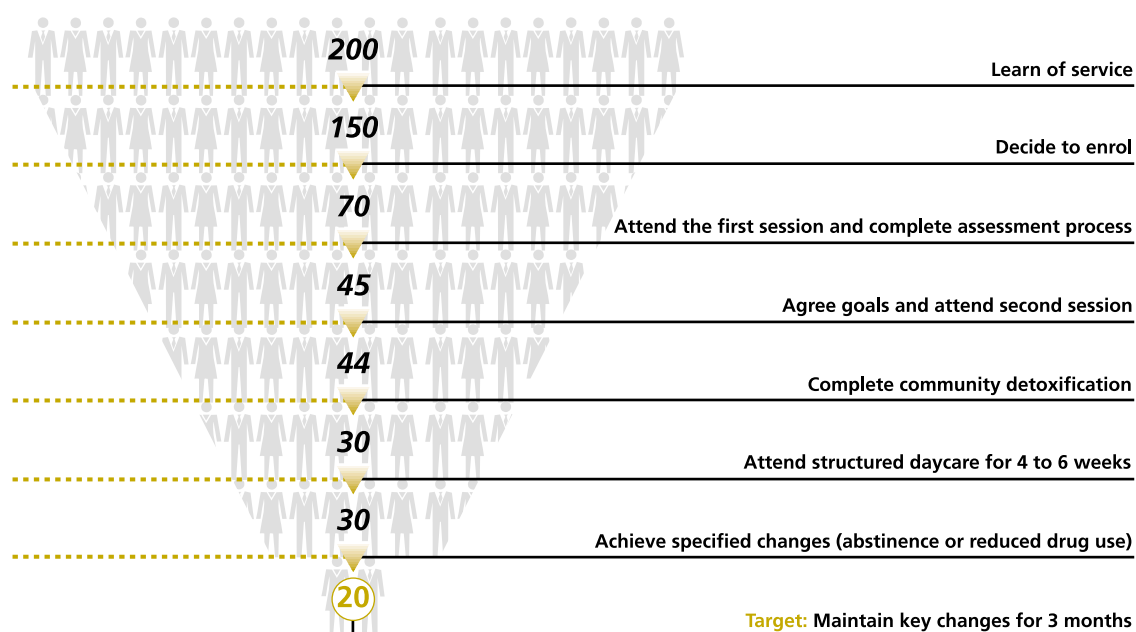
The CISS was designed to elicit workers’ impressions of their clients in a quick and standard way. Outcome areas are scored on a 3-point scale of problem severity, each illustrated with examples. The 10 outcome areas are: drug/alcohol use, social functioning, health, HIV risk behaviour, psychological well-being, occupational status, crime, ongoing support, treatment compliance and the worker/client relationship. Total scores range from 0 to 20, with scores of 13 and above indicating ‘high problem severity’ (Ref.70).

116. Outcome or milestone management can be used alongside clinical outcome tools to encourage both commissioners and providers to focus on results rather than activities and to promote continuous improvement. The approach involves commissioners and providers agreeing the outcomes that their services are expected to achieve. Milestones are then identified, showing the different stages that clients should pass through to get results [EXHIBIT 21]. Throughput targets are then set for the numbers of clients expected to pass through each milestone. Providers monitor how far these targets have been met. On the basis of the monitoring data collected, commissioners and providers may modify the contract or change the ways that services currently work. This sort of approach can allow workers to see if what they are doing is having a positive effect and offer clients concrete evidence of their progress (Ref.71). It can also help to ensure that services avoid pursuing ineffective activities. However, its success depends upon commissioners and providers allocating sufficient time to review activities and set meaningful targets: without this, there is a danger that provision will ossify and fail to meet emerging needs.

EXHIBIT 21

Outcome management approaches

A street agency working with drug users might agree the following client milestones with commissioners.



Source: Audit Commission, adapted from 'Outcome Funding: An overview and early experience for commissioners and providers of health and social care', Dr Chrissie Pickin, Salford and Trafford Health Authority (Ref.72)

117. Another approach is to encourage services to conduct self-assessment procedures and monitor and improve their own services. Some areas have already developed peer audit projects that have led to local improvements, using both the *Quality in Alcohol and Drug Services* (QuADS) improvement standards and locally determined standards as a benchmark [CASE STUDY 3]. Such approaches can be an effective way of encouraging local agencies to learn from each other and build ownership for change. However, such a step requires strong partnerships in which the commissioner trusts the provider (and vice versa). Equally, providers need to trust each other and manage the process in a way that promotes (rather than damages) good interagency relations. In an environment where agencies routinely compete for resources, this can be a tall order.

CASE STUDY 3

The South West Drug Services Audit Project

The South West Drug Services Audit Project was set up in 1991 and is currently managed with the Regional Drug Advisory Service. Its aim is to help improve the quality of local drug treatment services using both local and national standards to inform an annual cycle of peer audit. It is currently funded by 6 health authorities and carries out regular reviews across 19 statutory and independent agencies in the south west of England.

A full-time Project Co-ordinator has responsibility for organising audits and ensuring consistency across the various audits. But the services themselves are largely responsible for steering the project on behalf of their health authority funders. The Project follows an audit methodology that encourages drug service staff from both sectors to work together to:

- reflect upon their work systematically, critically and openly;
- set new 'South West Audit Project standards' of good practice;
- agree on improvements that need to be made;
- check that improvements occur; and
- work towards compliance with national standards (QuADS).

Teams of three experienced workers from the field plus the Project Co-ordinator conduct the audits. A user group representative has also been included on an audit team on a trial basis and the Project hopes to develop this role in the future. Each audit lasts one day and covers one compulsory standard agreed by Project members, and two optional standards nominated by the service itself from an agreed list of South West Audit Project standards and QuADS standards.

Currently, audit reports and any follow-up reports are confidential to the individual services, with only the overall results being reported in the Project's annual report. From April 2002, Drug Action Teams will also choose one standard for the audit and will receive a copy of the audit report. Failure to meet the agreed standards will result in an action plan with action points and timescales both for the service and, where appropriate, the Drug Action Team. These additional measures are being introduced by the Project in response to changes in the commissioning structure and to make the audit approach more rigorous.

As a measure of success, between 1999/2000 and 2000/01 compliance with standards has steadily increased from 36 per cent to 81 per cent. The Project has also built up a directory of over 300 good practice examples identified in the audits, allowing local agencies to learn from each other.

Source: Audit Commission fieldwork

...an incremental approach to change, concentrating first on key blockages, such as long waiting times, is likely to be the best way forward.

Strategic choice and priorities

118. On the basis of the information assembled, DATs and commissioners should be in a better position to identify the priorities for addressing unmet needs and for developing services. The indicators of needs and service patterns identified through service review should start to trigger discussions between agencies on key topics:

- Is the right range of services and interventions being provided to meet the needs and tackle the risk situations?
- How do unit costs, take-up and retention compare between different agencies? Can lessons be learned about more efficient methods of delivery?
- Do funding and contracting mechanisms encourage high quality services? For instance, is it a key objective to secure rapid access to high quality residential provision? If so, the development of some block or volume contracts may yield cost savings and reduce the uncertainties many providers face, thereby allowing them to develop more high quality services.
- Are the right numbers and type of staff employed in each agency? For example, do their skills match the problems being tackled?
- Are services being provided in a timely and acceptable manner?
- Are there specific barriers to access, and how could these be tackled? For example, is there scope to improve signposting and develop new links with mainstream services?
- What role should specialist services play in supporting other agencies in a more skilled and responsive approach?

119. For the most part, an incremental approach to change, concentrating first on key blockages, such as long waiting times, is likely to be the best way forward. But some areas have taken a more radical approach and chosen to recommission all drug treatment services within their locality [CASE STUDY 4]. Such approaches need to be carefully managed and evaluated. For example, changing providers can be disruptive, and continuity of service to existing clients must be assured. Potential disadvantages – such as lack of GP support for emerging models, difficulties securing new premises and the views of existing clients and key stakeholders – must all be considered.

CASE STUDY 4

Recommissioning drug treatment services in a London health authority

Prior to 1997, a London health authority contracted with a single mental health NHS Trust to provide community drug treatment. However, despite expenditure of almost £0.5m, the service was unable to meet local demands and was placing additional pressures on local GPs, some of whom were increasingly dealing with complex clients with Hepatitis B and C. The service was also poorly located, offered no outreach provision for crack cocaine users, and was unwilling to develop shared care arrangements.

Despite resistance from the specialist service, the health authority decided to re-tender its whole range of drug and alcohol services. In partnership with social services, new service specifications were developed to support the tendering process, based on a tiered range of services. Shared care arrangements were developed in advance, partly as a means of securing the wider support of the GP population.

Following a high profile and independent tendering exercise, which included a consultant psychiatrist from another service on the selection panel, a community-based independent agency was awarded the contract, with specialised generalist GPs providing medical input.

Over a period of 6 months leading up to the cessation of the contract with the specialist service, 110 clients were transferred to the new community agency. Research into the characteristics of 103 members of this group found that:

- Their ethnic breakdown did not reflect the local population, with an under-representation of black and asian clients. In contrast, the new agency had successfully attracted a much higher percentage of these groups.
- Over 80 per cent of those on oral prescriptions at the time of transfer reported continued injection of illicit drugs, with close to half admitting to using heroin.
- 47 reported no discussion with their former specialist worker concerning Hepatitis and HIV, 28 not having been screened for either Hepatitis B, Hepatitis C or HIV.
- The rate of GP registration for general medical services was low at 32 per cent, with over three-quarters of the sample reporting there had been no discussion with their former specialist worker concerning the value of GP registration.

- A high percentage (82.5 per cent) had not discussed the possibility of transferring their care into the primary sector.

Following the establishment of the new agency, around half of the clients who were transferred were passed on to GPs and the number of Hepatitis B vaccinations has increased. The service has also attracted a new cohort of clients – young asian male heroin smokers – and has introduced new services for crack users.

Source: Audit Commission fieldwork

120. Adopting new strategies to attract ‘hard to reach’ groups is likely to emerge as a priority in many areas, and a number of services have already adopted approaches that others could follow. Some have already attracted more crack cocaine users through the development of a targeted recruitment strategy [CASE STUDY 5]. Others have sought to make services more accessible to women. The Oasis Project in Brighton, for example, is a women-only service offering crèche facilities for users. It also provides a drug liaison midwife service, offering pregnant drug misusers more intensive support. Post-natal support lasts up to six months as opposed to the ten days usually offered by mainstream midwifery services. The worker also accompanies service users to ante-natal appointments, sometimes to ensure that more chaotic users actually attend and get the support they need. Outreach support and personal safety courses are provided for sex workers using drugs; potential clients are contacted via their cards in telephone boxes or through local saunas and massage parlours.

CASE STUDY 5

Working with Black crack users in a crisis setting, City Roads, London

City Roads has provided a residential crisis intervention service in London since 1978. Due to increasing numbers of crack cocaine users and black drug users in the capital, it secured a specific grant from the Department of Health in 1994 to develop new responses to the needs of this group.

The new project placed a strong emphasis on making contact with black crack cocaine users and developed a recruitment strategy with three components:

- a 24-hour crack telephone helpline offering information, advice, support and assessment for users;
- advertising the service to existing referrers to City Roads; and
- advertising the service in a wide range of outlets frequented by the target group people, including shops, newsagents, solicitors’ offices, fast food outlets, launderettes, barbers and minicab firms.

In total, 20,000 cards and 8,000 leaflets advertising the crack helpline were distributed to both professional agencies and commercial and other outlets.

The service also employed two black crack-specific workers and made two beds available solely for crack cocaine users. Following assessment, users could be admitted for up to three weeks and receive a package of care including medication and support through the withdrawal period, complementary therapies, recreation and exercise and key worker support. Workers also helped users to consider options open to them following discharge and, where possible, organised appropriate support.

In the 34 months of its operation, the project recorded a number of positive outcomes:

- around 1034 calls were taken on the crack helpline, around one-half of which were from clients in crisis;

- 248 individuals were admitted to City Roads via the crack line. 219 of these used crack as their drug of first choice and 70 per cent were black. In contrast, only 69 primary crack users were admitted through other admission routes over the same period and only 28 per cent of these were black; and
- on discharge, 44 per cent of crack users were discharged to residential or day programmes offering intensive, structured follow-up treatment. Only five per cent left without an onward referral to another agency.

This service has been subsequently integrated into City Roads’ mainstream crisis service. In this way it has continued to develop the service and deliver successful outcomes to black clients, including those using crack-cocaine.

Reviewing the quality and range of treatment services: national action

121. The efforts of local agencies must be supported by national action to raise the quality of drug treatment services. While more rigorous reviews can help local areas to provide the right services and deliver the interventions in the right way, the NTA and SMIB could make an important contribution by:

- improving the national collection of drugs data;
- developing a national framework for performance measurement;
- increasing understanding of ‘what works’; and
- building the capacity and skills of staff within the drug treatment sector.

Improving the collection of drugs data

122. Local quantitative estimates of prevalence and forecasts of future trends could help DATs to respond more rapidly to emerging problems and gauge the overall impact of their local drugs strategy. However, when managed locally, such exercises take time and effort and their success can easily be hampered by a lack of appropriate (often statistical) expertise and concerns about confidentiality and data protection issues. Delays in the release of key national data sets – such as drugs enforcement, seizures and mortality statistics – can further reduce the value of such local analyses.

123. An alternative option would be to strengthen national arrangements to quantify and transmit accurate and more up-to-date local drugs data. The Department of Health, for example, could examine the feasibility of extending the role of the National Drug Treatment Monitoring System (NDTMS) to provide estimates and forecasts for each DAT. This sort of arrangement is normal practice in surveillance of communicable diseases, such as HIV, where local health authorities receive estimates produced nationally. Options need to be considered in parallel with new studies that are being funded by the Home Office’s Drug and Alcohol Research Unit to assist in providing new estimates of problem drug misusers and to assess the feasibility of estimating prevalence at DAT level.

Developing a national framework for performance measurement

124. While local areas could do more to ensure that the performance of services is measured effectively, the NTA and SMIB could take a lead in developing a core national data set to capture key information in a standard way. Ideally, this should move away from the current focus on *capacity* and aim to include:

- input measures which show how resources are allocated in different areas and by different agencies;

...meaningful cost comparisons would depend on local arrangements for disaggregating drug and alcohol expenditure and activity across services...

- indicators of take up, timeliness and activity, which show the extent to which services and interventions are accessed by target groups, the speed of response and the effectiveness of care pathway management;
- indicators of cost efficiency which judge the unit cost of an intervention, such as cost per counselling hour delivered, or the annual cost of a methadone maintenance treatment slot; and
- indicators of effectiveness and cost-effectiveness, which assess the achievement of individual outcomes, and the unit costs involved.

125. Such an approach would be dependent upon appropriate investment in computer support at a local level to facilitate data collection and analysis. However, over time the data would provide a firmer basis for assessing the performance of different agencies and enable comparison and learning across different areas. Meaningful comparisons would be dependent upon the identification of some standard categorisation of interventions, such as structured day programmes and residential programmes, many of which vary in length and content. Equally, meaningful cost comparisons would depend on local arrangements for disaggregating drug and alcohol expenditure and activity across services, as well as the development of accounting rules which require treatment costs in trusts to be managed consistently.

126. Whatever information system is devised should seek to address the information requirements of all relevant Government departments (DoH, HO, HMT) and exclude re-reporting of any information already available nationally. The Department of Health should also promote the potential benefits of the new NDTMS system more widely and clarify issues that may lead to under-reporting or incomplete data. Confusion about 'informed consent', for example, has recently led some psychiatrists to refuse to provide patients' initials to NDTMS, making it impossible to identify where drug misusers are in contact with several agencies.

Increasing understanding of 'what works'

127. Many major difficulties within the drug treatment field stem from uncertainty about 'what works'. Although a growing body of research has shown that many types of treatment interventions deliver positive benefits, there remain some important gaps in knowledge. There is still no strong evidence base for the treatment of stimulant dependency, or for interventions such as outreach programmes, counselling or complementary therapies. Moreover, while the effectiveness review concluded that purchasers should have access 'to a full range of well-organised, properly monitored services', little is known about the client and organisational characteristics that reduce or prevent improvement. Such gaps, combined with the lack of nationally agreed standards for the delivery of key interventions and the absence of agreed service models or accreditation schemes for community drug programmes, can mean that local purchasers often struggle to address key issues:



- Should they restrict investment to more proven interventions or experiment with less proven approaches, such as structured daycare programmes or new prescribing options, such as naltrexone?
- What criteria should govern access to different types of interventions?
- What staff mix and interventions should community drug services offer? What role should medical specialists play in local arrangements?

128. The NTA must help local areas to answer these sorts of questions. This requires action on a number of fronts. One priority is to begin to address research gaps around the effectiveness of specific interventions and the treatment of non-opiate drug problems. In this context, recent Government announcements to set up a group of key experts to tackle the treatment of crack cocaine dependency and develop new guidance around heroin prescribing, provide an important step forward. To guide purchasing decisions, more research is also needed to accumulate evidence about the cost-effectiveness of different interventions and the type of services and staffing mixes that appear to work best. In the longer term, the development of an accreditation scheme for community drug programmes should also be considered.

129. Ensuring that partnerships and commissioners can understand and interpret the existing research base, learn from each other and critically appraise any new local approaches is also important. This will require the NTA to continue to support change on the following fronts to support a ‘learning culture’:

- ensuring that staff on the ground have the time and appropriate skills to draw on research to inform strategic choices about drug treatment;
- promoting research findings in an accessible format that increases local understanding of why and in what settings different approaches can be most effective; and
- allowing local work to inform national level decision making by giving partnerships scope to learn and experiment and feed back results to the ‘centre’.

130. Steps must also be taken to promote greater agreement about the best way to deliver interventions with a strong evidence base, such as methadone prescribing. Learning from other clinical areas that have sought to secure rapid improvements in practice and promote agreement on the best way to provide care, may prove the best way forward. Collaborative improvement approaches, for example, have already been successfully used to promote improvements in both primary care and cancer services. They have also helped to strengthen multidisciplinary working, promote enthusiasm for change and, most importantly, improve the patient’s experience of care [CASE STUDY 6, overleaf]. Critical success factors include a central team with experience of collaborative approaches, performance measurement and redesign skills, as well as a clinical excellence team bringing together individuals with substantial experience of promoting improvements in the topic area.

CASE STUDY 6

The Collaborative Improvement Model

The collaborative approach is based on the premise that:

- A substantial gap exists between knowledge and practice in healthcare.
- Broad variation in practice is pervasive.
- Examples of improved practices and outcomes exist, but they need to be described and disseminated to other organisations.
- Collaboration between professionals working toward clear aims enables improvement.
- Healthcare outcomes are the results of processes / systems
- Understanding the science of rapid cycle improvement can accelerate demonstrable improvement.

It relies on spread and adaptation of best practice through multi-disciplinary teams to accomplish a common aim. The key ingredients of the approach are:

- A practical review of current processes, identifying key constraints, delays and bottlenecks.
- Permission to redesign and streamline the current process.
- A flexible improvement model for testing, and implementing changes.
- Packaging of specific evidence-based subject matter knowledge (best practice).
- Small-scale testing to create momentum for making big changes to the system.
- Effective use of data for learning.
- Collaboration with other teams and experts in the subject matter to share learning.

At the start of the project, three key questions are addressed:

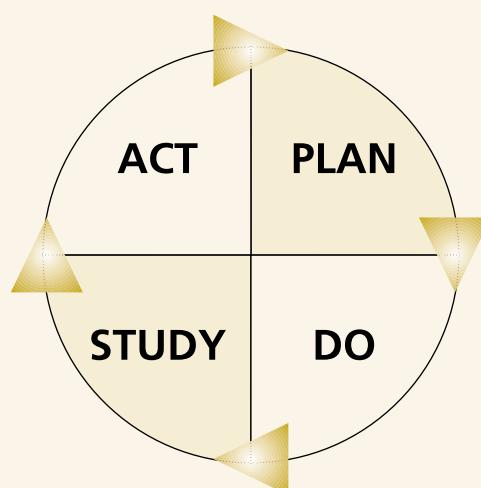
- What are we trying to accomplish?
- How will we know that a change is an improvement?

- What changes can we make that will result in improvement?

A Plan, Do, Study, Act cycle (PDSA) is used to test existing systems. The cycle begins with a plan and ends with action being taken based on the learning gained from the Plan, Do, and Study steps of the cycle. The four steps in the cycle consist of planning the details of the test and making predictions about the outcomes (*Plan*), conducting the test and collecting data (*Do*), comparing the predictions to the results of the test (*Study*), and taking action based on the new knowledge (*Act*).

- What changes are to be made?
- Next cycle?

- Complete the analysis of the data
- Compare data to predictions
- Summarise what was learned



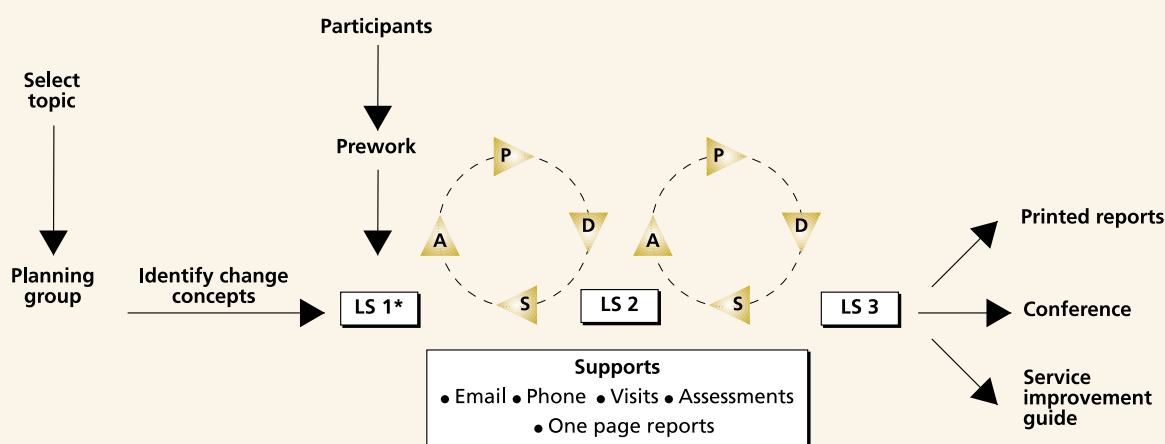
- Objective
- Questions and predictions
- Plan to answer the questions (who, what, where, when)
- Data collection to answer the questions

- Carry out the plan
- Collect the data
- Begin analysis of the data

Based on the results of the test, a change, or some part of a change, could be implemented, or it could be modified and re-tested, or

abandoned. When the overall desired improvements are achieved, details are presented as good practice to other services through a

combination of national conferences, Service Improvement Guides, conference calls and links to professional bodies.



* LS = Learning session

The Cancer Collaborative

The Cancer Services Collaborative (CSC) is a national programme that seeks to improve the experience and outcomes of care for people with cancer. Phase one of the CSC established 51 dedicated teams within 9 cancer networks to improve services over a 2-year period (1999-2001), using a simple change framework developed by Professor Don Berwick at Harvard's Institute for Healthcare Improvement.¹

Each network undertook a series of projects with each project focusing on patients with a specific cancer: bowel, breast, lung, ovarian, and prostate. The ideas for change were developed from expert meetings, discussions with leading practitioners, and literature reviews.

During the CSC, doctors, nurses, managers, clerical staff, porters, technicians and staff from every part of the healthcare system worked

together to examine the service that they provide, to consider what could be made better, and to make improvements for patients. During the term of the project many teams achieved improvement rates of up to 80 per cent against key targets. These included:

- reducing the time from patient referral for cancer to the first definitive treatment;
- improving access to investigations eg, a 13-week wait for barium enemas cut to 1 week;
- increasing the capacity in out-patient clinics eg. 3 visits over 4 weeks to get a diagnosis reduced to 1 week and a single visit; and
- procedural changes as a result of new methods of canvassing patient views and levels of satisfaction.

A major strength of the CSC was that it provided an important forum for clinical teams from across the country to come together and to share how they deliver services. Teams tested ideas out with each other, learned from each other's failures, and developed mechanisms to adopt the changes that worked. Many of the improvements that have been made are not due to inventing new ideas but are due to applying an existing idea that has already been shown to work well.

This, coupled with the fact that the collaborative change framework is a practical approach which places great emphasis on doing rather than reviewing, and with timescales leading to improvement measured in days and weeks rather than months and years, created widespread enthusiasm and an extremely positive environment for change.

¹ The collaborative improvement model is described in detail in an article entitled 'A Framework for Collaborative Improvement: Lessons from the Institute for Healthcare Improvement's Breakthrough Series' written by Charles M Kilo and presented in 'Quality Management in Health Care' 1998, 6(4), 1-13 © 1998 Aspen Publishers, Inc.

131. Applying such a model to the delivery of methadone treatment may lead to clearer standards for prescribing services. But much variation currently stems from different interpretations of risk. Some stakeholders adopt a relatively narrow, clinical approach – focusing on the risks arising from leakage and the danger of methadone-related deaths – which points to the need for close supervision and compliance. Others take a broader approach – taking into account other ‘risks’ associated with continued use of illicit, and often contaminated, substances and the wider impact on crime levels – leading to more emphasis on engagement. Less variable practice may consequently hinge upon clearer agreement about the appropriate balance of risk to adopt.

Building the capacity and skills of staff

132. Many drug misusers interviewed by the Commission reported that staff in the drug treatment sector were supportive, highly motivated and provided them with a lifeline:

I have a good relationship – I tell him everything – and honestly!

Female, heroin user, aged 31.

They really care, really, really wanted to help, you could see how motivated people are...how caring they are!

Female, heroin user, aged 28.

My support worker is marvellous, she would bend over backwards for you!

Male, heroin user, aged 21

But lack of appropriate staff or the absence of appropriate skills among the existing workforce must be managed by the NTA and SMIB. The current development of occupational standards for the drug treatment sector, and a new qualifications and curriculum framework, are important starting points and should increase professional status and career development opportunities within the field. However, the introduction of these new arrangements will take time. In the short term, emphasis needs to be placed on the development of initiatives to:

- strengthen the knowledge base and expertise of those involved in the commissioning of local services;
- develop the leadership and management skills of service managers;
- promote the development of effective team working within multidisciplinary services; and
- improve workforce planning to address shortfalls in key staff and identify short-term measures that commissioners and service managers can take to bridge gaps.

lack of appropriate staff or the absence of appropriate skills among the existing workforce must be managed by the NTA and SMIB.

Promoting better care co-ordination and joint working: local action

133. A critical area for improvement is the capacity to offer drug misusers well co-ordinated, tailored packages of care that can bring together appropriate support from a range of agencies. At present there is little guarantee that the services provided will match a client's level of need or that they will be provided in a 'seamless' way. This increases the risk of a 'revolving door' syndrome, as those people who 'fall' between different providers, or fail to get appropriate help after treatment, resume their habit and re-enter services a number of times. The nature of drug misuse means that such cases cannot always be avoided. However, better management of the initial referral process and the subsequent care pathway offers an opportunity to achieve better results.

134. The recent development of the Department of Health Models of Care (MOC) Project has already begun to examine how these issues will be addressed. This recognises that in most DAT areas better pathway management will depend on the establishment of more systematic processes of care for:

- screening and assessing to identify the actions required in a care plan agreed with the user;
- managing and organising care, in accordance with the goals identified in the care plan;
- ensuring continuity of care; and
- promoting ongoing monitoring and review.

135. This agenda provides a significant challenge for the drug treatment sector. First, it requires the development of a common screening and assessment framework and care management practices to underpin effective co-ordination across local agencies: many have evolved, and are committed to, their own procedures and practices. Different services also have different philosophies of care. Some CDTs see their role largely in clinical terms – with an emphasis on treating a specific condition, rather than on managing care. Equally, some social services departments have placed strong emphasis on providing continuity of care, while others see themselves primarily as 'local purchasers'. A further challenge stems from the need to manage care co-ordination and pathways across a large number of agencies. Some DATs in England, for example, rely on services from up to three CDTs, while DAATs in Wales may cover up to six separate social services departments. Concerns over the resource implications of new arrangements and the proposed timescale for implementation may pose further barriers to change, especially during a period of rapid change within the NHS.

136. These sorts of difficulties underline the need for an incremental, well-planned approach. In most areas, the first step will be to identify who will take lead responsibility for driving forward the introduction of new care-planning arrangements and build ownership for proposed changes.

Working together, commissioners and local providers will then need to:

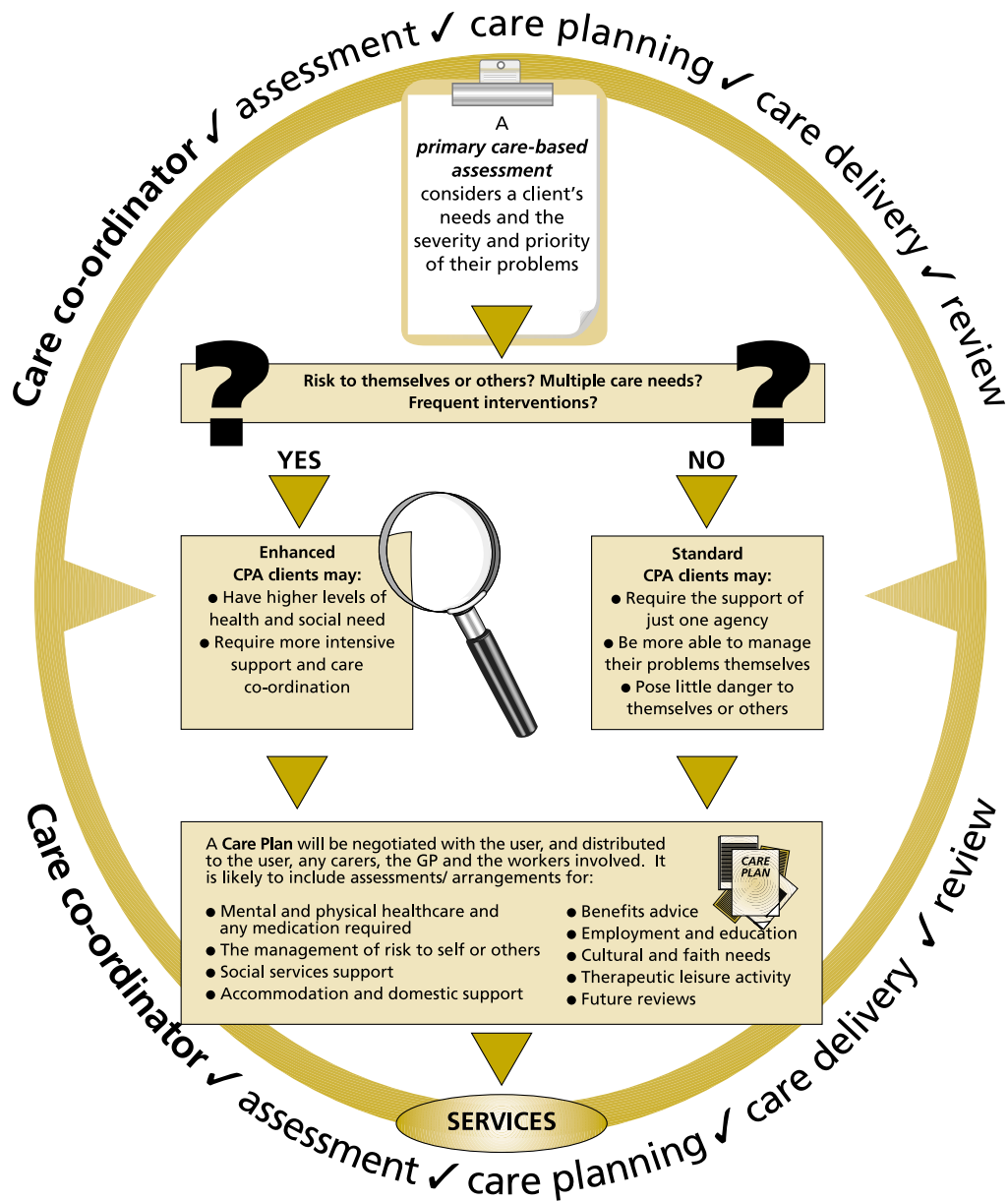
- better define the roles and responsibilities of different services and their objectives;
- develop a shared understanding of what needs to be done locally to improve care management and co-ordination;
- establish and agree clear criteria for referrals between services and how they will be dealt with;
- agree clear criteria and common procedures for assessment to ensure that the plans for future care reflect a multidisciplinary, integrated approach;
- agree how training and development needs arising from the introduction of new arrangements will be addressed; and
- consider how users could be involved in developing the new approach.

137. More effective care co-ordination will be the cornerstone of successful approaches, addressing many of the difficulties clients currently face in finding their way through a maze of local services. In recent years, a range of approaches has emerged in related fields that can provide models to follow. The Care Programme Approach (CPA), for example, is used in mental health to achieve better co-ordination, with specialist mental health teams, including both health and social service staff, taking the lead [EXHIBIT 22]. A single plan is devised which sets out the contributions from each service and a single worker keeps in touch with the client and makes sure that all the necessary elements of care are delivered. Clear criteria are established to determine those who are entitled to receive a care programme; where resources are very limited, those with severe mental illness are the first to receive care programmes. When care management programmes are operating fully, users have said how much they value access to a named worker who knows them and can be contacted about their needs, regardless of which agency is involved (Ref.73).

EXHIBIT 22

The care programme approach in practice

Recent proposals to modernise the Care Programme Approach emphasise the role of the care co-ordinator.



Source: Adapted from: 'Modernising the Care Programme Approach: A Policy Booklet', London: Department of Health (Ref.74)

...a team that brings together social and health professionals may prove to be the best option, allowing both medical and social care needs to be addressed together...

Promoting better care co-ordination and joint working: national action

138. Each local area will need to decide how such systematic approaches to care co-ordination can best be implemented in their area and identify which agency should take the lead. Decisions will need to take into account the skills and capacity of existing agencies, as well as their ability to marshal support from a wide range of statutory and independent providers. In practice, a team that brings together social and health professionals may prove to be the best option, allowing both medical and social care needs to be addressed together in multidisciplinary assessment and care planning processes. Such teams offer clients a more streamlined service, with one person responsible for driving their case through. In some areas, teams could be built around existing CDT structures, especially where these already include a broad mix of different professional groups within local teams. However, such teams would need to be carefully managed to ensure that different professional disciplines made a full contribution to patient-centred care.

139. Where CDTs are unwilling (or felt to be unsuitable) to take on a broader role, other options could be considered. The care co-ordination function could be located with either a well-established street agency or social services, given the latter's growing experience of care management. However, in most cases, medical input would be lacking and the problems of multiple assessment would persist. A more radical approach could be to locate the care management function outside the provider network altogether. In some parts of America, for example, separate care management projects provide a single point of referral for people with drug misuse problems who are on welfare. Projects, which generally include a mix of treatment professionals, undertake assessments, refer people to other services and manage their progress until they are ready to return to work. Such arrangements help to ensure that assessment is standardised and could provide an incentive for quality outcomes, as care co-ordinators can choose which providers to use. On the other hand, developing effective relationships with providers can prove problematic. Doctors providing treatment would need to make their own assessments.

140. In the longer term, the NTA and the Home Office Drugs Strategy Directorate should consider giving clear guidance to local agencies on effective care management models, based upon the outcomes of the Enhancing Treatment Outcomes initiative (which is piloting arrangements for improving care co-ordination in eight DAT areas in line with the Models of Care Project) and an evaluation of approaches adopted outside the UK.

Developing more flexible approaches: local action

141. Whatever local models are developed to improve care co-ordination, developing more flexible approaches that are closely tailored to the needs of individual clients will be key. Many areas need to strengthen the support they provide to people following treatment, particularly those with more complex ongoing problems and ex-prisoners. Some agencies have already started to develop imaginative approaches to support ex-prisoners using link workers based in voluntary agencies [CASE STUDY 7]. Others have recognised that the need for assistance with housing and other practical support is often not time-limited and developed long-term projects to help drug misusers with complex needs [CASE STUDY 8, overleaf].

CASE STUDY 7

Revolving Doors – providing link workers for ex-prisoners with complex needs

Revolving Doors Agency is the UK's only charity concerned exclusively with mental health and the criminal justice system. It runs practical schemes in police stations, prisons and courts to support people with mental illness, multiple needs and a history of offending. This is a vulnerable and often chaotic group who have 'fallen through the net' of mainstream service provision and have little or no support in gaining access to the services they need.

Since March 1993, Revolving Doors has worked in partnership with the police, health, housing, probation and social services in London to research the needs of this group. Having identified the demand for a service, it set up experimental Link Worker schemes to offer support and to identify new ways of improving access to housing, health and social care.

There are now four teams operating in Ealing, Tower Hamlets, Islington and southern Buckinghamshire. The teams work across the criminal justice system, with people leaving Wormwood Scrubs, Pentonville,

Holloway and Woodhill prisons as well as those in local police stations and courts. The service was extended to prisons in October 2000 and received 332 referrals in the first six months of operation. It is expected that the four schemes will receive 1000 new referrals from across the criminal justice system.

Substance misuse is a common problem for the client group, with 75 per cent having a drug or alcohol dependency, rising to 95 per cent of long-term clients leaving prison. Many are some way off being able to benefit from specialist substance misuse services. Harm reduction is the top priority in the short term, together with social and practical support.

The teams tackle substance misuse within a multidisciplinary framework. They help clients to link into a range of other services to improve related aspects of their lives, such as gaining meaningful daytime activities and a secure tenancy. The aim of the approach is to increase stability and support for clients with a view to engaging with

specialist services later and with greater success. Recent measures of the impact that the Ealing scheme has had on its long-term clients have shown that:

- 30 per cent experienced improved access to detoxification services, with access being declined to just 6 per cent of cases;
- 23 per cent gained improved access to mental health services, with less than 2 per cent being refused; and
- 34 per cent experienced improved access to a GP either through permanent or temporary registration with just 5 per cent refused.

The prevalence of substance misuse among the client group requires Link Workers to be trained to deal with both drug and alcohol dependency as well as mental health problems. The composition of the team also enables them to work across boundaries to pursue multidisciplinary solutions to problems. Link Worker teams comprise nurses, probation officers,

voluntary sector workers, social workers and occupational therapists, ensuring a range of skills are available to meet clients' needs. Each scheme has successfully brought together expertise from other sectors through multi-agency advisory groups that monitor and advise on the development of their work.

The Link Worker approach is based on the findings of thorough research. Anonymised records are kept of drug and alcohol dependency, tenancy arrangements, conviction history and other relevant factors, while outcomes such as registration with a GP or receipt of benefits are analysed to assess where the schemes are most successful and where they can improve. The aim is to use the evidence collected to establish a successful model for supporting this group effectively – and within budget – so that other agencies can develop and run schemes in their local areas.

Of central importance is the training of prison, court and police officers on mental health issues – particularly where mental illness can be masked by the effects of drugs and alcohol. Link Workers run a rolling training programme to help officers identify and refer prisoners with mental health problems and to improve their knowledge of what is available in the community.

Case History

Bill is a 35-year-old man of Irish descent with a long history of drug and alcohol use. Between the ages of 21 and 30, Bill was unemployed, spending long periods sleeping rough and committing petty offences to fund his growing drug habit. During this time, Bill was involved in a series of abusive relationships and was charged several times with assault. On his 30th birthday, Bill took an overdose following the breakdown of his long-term relationship, and was found face down in a pub car park. He continued to sleep rough and take drugs. Aged 33, he was arrested for assault following a fight in a pub and served one-half of an 8-month sentence.

While in prison, he completed a 10-day detox programme. When he self-harmed on the Wing he was referred to the Revolving Doors Link Worker Team. Bill had no fixed abode, and the vast majority of hostels were barred to him because of his drug problem. He was not registered with a GP and was still dependent on drugs.

Before his release, the Team and Bill planned how to link him into the services that he would require on release. He identified housing as a priority. Without accommodation, he told Link Workers that he felt his only option was to squat with friends where drugs were easily available. However, he wanted to stop using drugs and was enthusiastic about getting a place on a drug-detox programme.

Prior to release, Link Workers liaised with the Community Drugs Team (CDT) and arranged for an assessment of need for Bill which took place on the day of his release. Following his assessment he saw the CDT frequently for 4 weeks. Also before release, the Team referred him to a local direct-access hostel. He was successfully assessed and accepted for a place. This meant that he had accommodation during the 4-week period before joining the detox programme.

Throughout this time, Bill maintained contact with the Link Worker Team who were able to support him with his depression and other mental health issues. This included registering him with a GP who prescribed him some antidepressants. He completed the detox programme and then went into rehabilitation, which lasted 18 months. Bill no longer uses the Link Worker service but he is free to re-access the service at any point because the Team do not operate a system of case closure.

Source: Revolving Doors

CASE STUDY 8

Intensive support programmes for high needs clients, Focus Housing Group, Birmingham

This supported accommodation project is aimed at men in the age group 25–45 who are homeless and who have a history of serial exclusion from all other direct access hostels in Birmingham. It has provision for fifteen individuals to reside at the project for up to four years in purpose-built flats. Annual revenue costs of £297,000 (2000/01) are funded by the health authority (35 per cent), Social Housing Management Grant (4 per cent), and rents made up of housing benefit and personal contributions (61 per cent).

Many of the residents have combinations of mental health, self-harm, behavioural, alcohol misuse and substance misuse problems. The project works with these issues to a greater degree than in standard provision and provides:

- support on a 24-hour basis;
- intensive housing support;
- welfare rights advice;
- help in accessing primary healthcare and specialist services; and
- advice and support with basic life skills.

All the support services are intended to enable individuals to stabilise their lifestyle and maintain accommodation and there is an emphasis on joint working with other agencies so that this can be achieved successfully.

Referrals to the project are identified by the Community Homeless Mental Health Team, the Rough Sleeper's Initiative Contact and Assessment Team, and by local authority departments involved in mental health and homeless services. Every referral has to be submitted for approval by an allocations panel and the project manager. The project does not accommodate people whose behaviour/lifestyle is such that they should be dealt with through the criminal justice service or as an inpatient in community care services.

Source: Audit Commission fieldwork

142. The current development of *Supporting People*, the new policy framework for supported housing, provides new opportunities for DATs and commissioners to extend these types of schemes and establish (or review) policies in relation to drugs and homeless drug misusers. Policies should recognise that poor housing, or lack of access to housing, is often a contributory factor in drug misuse and try to avoid concentrating drug misusers in particular areas. Proposals for dealing with any 'nuisance' arising from a drug misuser's behaviour should also seek to minimise the revolving door syndrome by treating eviction as a last resort. Taking steps to avert tenancy crises through practical support, 'early warning systems' and resettlement services are likely to prove more cost effective in the long run.

143. In many cases, flexible support will only be achieved where partners in key services areas – such as housing, social services, mental health *and* substance misuse – work closely together. This requires a clear understanding of each agency’s respective responsibilities and scope of involvement in assessing care and support needs. Distinctive statutory remits, cultures and accountability procedures can make this difficult to achieve. But shared guidelines, protocols and procedures can help to clarify who is to do what. Other approaches include changing the way that services are organised and the style of operation to allow for a more preventive, multidisciplinary approach. In one authority, for example, local panels have brought together key professionals to promote a more co-ordinated approach to the care management of high risk clients with complex needs [CASE STUDY 9]. More effective liaison could also be secured through joint training, allowing different agencies to develop shared knowledge and skills, agree common objectives and establish regular communication channels.

CASE STUDY 9

Jointly managing high risk clients with complex needs, Surrey Social Services

Surrey Social Services recognises that substance misusers with personality disorders or mental health problems (‘dual diagnosis’ clients) can represent a very high risk group. In order to protect both individual clients and the community, it has agreed that rehabilitation should be easily available to this group and that social services has a responsibility to re-engage high risk clients as soon as possible. Two main measures have been introduced to achieve this:

- Five specialist substance misuse social work/care managers, attached to local substance misuse teams, are employed to assess and manage clients and refer more complex cases to a local ‘substance misuse panel’.

- Two localised ‘substance misuse panels’ have been introduced to oversee and co-ordinate the care of identified individuals.

Membership of the substance misuse panels includes social services, NHS mental health trusts, criminal justice and housing representatives. The relevant substance misuse social work/care manager also attends. Managers from the assertive outreach team and a local assessment centre (which provides respite beds for drug misusers) attend in an advisory capacity.

Workers from partner agencies who are involved in cases coming before the panel are also invited to attend for discussion of their client. The structure ensures:

- long-term, co-ordinated oversight of contact and engagement with identified high risk/vulnerable clients;
- co-ordinated care of clients with dual diagnosis to avoid barriers between mental health and substance misuse services;
- information exchange about these clients with relevant agencies; and
- reduction and containment of risky behaviours through co-ordinated community support and assertive outreach.

Source: Audit Commission fieldwork

Improving support to primary care: local action

144. *'I'm confident that my GP is doing the best for me...My doctor doesn't speak down to me, doesn't think she's better than me and she's always willing to help and when you go back to see her she remembers what happened last time...not all the doctors have been like that.'*

Male heroin user, aged 21

Irrespective of the configuration and focus of specialist services, GPs will continue to be a key resource in the treatment of drug misuse. The current shift towards primary care and many drug misusers' preference for treatment in a primary care setting mean that new partnerships with specialist services make good sense. And while not all GPs are willing to play a more active role, some may be prepared to do more [BOX P]. The Audit Commission survey of GPs, for example, found that 27 per cent of respondents would be prepared to work with more opiate users if they had access to specialist support. Results from NTORs also show that treatment in a GP setting can be successful, finding no differences in rates of improvement between clients receiving methadone treatment in specialist clinics and general practice settings (Ref.75).

BOX P

Positive GP attitudes to working with drug misusers

Some GPs reported that they found working with drug misusers a positive experience and some would do more if training and support were available:

No protocols or training have been offered at all. I could only make an informed choice of treating, or not, after that.

Willing GPs should get protected time for proper training, and updating their skills in managing this group of patients. They should be remunerated appropriately.

Locally agreed guidance is needed for a consistent approach to management, and closer liaison with local GP services.

When I have got involved it has actually been very rewarding.

Difficult, interesting, challenging and worthwhile!

145. Shared care arrangements that focus on those GPs who are willing to participate, build up their expertise, and ensure an effective balance between the roles of specialists and generalists, are likely to be the most promising approach [CASE STUDY 10, overleaf]. However, the strengths and weaknesses of different models need to be carefully considered, with options carefully matched to local circumstances and agreed with local medical committees and primary care trusts. Dorset Health Authority, for example, has sought to address local GPs' concerns about the lack of consultant support in West Dorset by purchasing a specialist consultant service from an adjacent NHS Trust. Under a 12-month fixed-price contract, the neighbouring Trust agrees to provide the local nurse-led specialist service and local GPs with:

- specialist consultant outpatient sessions for five clients with complex needs (up to three appointments per client);
- up to four ‘surgeries’ at the drug service offices for GPs who need advice on how to manage patients with complex substance misuse needs;
- input to the local GP training programme; and
- a weekday telephone helpline service for GPs within the West Dorset area.

CASE STUDY 10

The Consultancy Liaison Addiction Service – an integrated, primary care-based community drug and alcohol team

The Consultancy Liaison Addiction Service (CLAS) has been operating in south-east London since 1995. The service comprises a team of three drug and alcohol community psychiatric nurses, supported and managed by a principal in general practice. All staff in the CLAS team have specialist training in addictions, with the GP consultant having psychiatric training to senior registrar level. As the service is approved to provide the psychiatric component for general practice vocational training, a Senior House Officer is also attached to the team.

The key aims of the service are to:

- **enable drug and alcohol misusers to access primary healthcare services.** The team works with 72 neighbouring general practices and local street agencies, supporting the treatment of alcohol misusing and drug misusing patients. A menu of possible services is offered to each practice, including the provision of a weekly or bimonthly

consultation and assessment service, one-off advice, brief intervention therapies, establishment of a practice-controlled drug register, community detoxification and liaison with other services where appropriate.

- **improve the skills of GPs and primary care nurses in identifying and managing patients with alcohol and drug-related problems.** In-house training is offered to practice receptionists, managers and administrators in all local practices and specific courses have been organised for primary care nurses. To date, 17 different training sessions have been run, involving 123 practice staff. The team also provides training to all GPs on local vocational training schemes, following this up with a session during their GP practice attachment.

- **enhance the quality of care these patients receive by developing clinical guidelines, practice protocols and policies.** The team is closely integrated into the secondary specialist addiction service based at the South London and Maudsley Trust. CLAS offers specialist primary care expertise and advice to the specialist provider and health authority and has been actively involved in drawing up local shared care guidelines and payment schemes for GPs involved in the care of drug misusers.

Since the service was established, the number of local GPs prepared to see alcohol and drug misusing patients has increased, although the majority of patients are still seen by a minority of GPs. Over the years, the team has tended to focus its efforts on those GPs willing to work with substance misusing patients, while encouraging others to take on some patients and countering their reluctance.

Source: Audit Commission fieldwork

The appointment of a shared care facilitator, who can oversee the development and management of local arrangements...may also be helpful.

146. Whatever model is agreed, critical success factors will include:

- the production of locally agreed management guidelines that define the roles and responsibilities of both GPs and the specialist service;
- good joint working relations between specialist and primary care services;
- a comprehensive training strategy for GPs, preferably supported by locum cover that will help to release GPs from their surgeries; and
- clear arrangements for monitoring and evaluation.

The appointment of a shared care facilitator, who can oversee the development and management of local arrangements and provide a point of contact for GPs, may also be helpful. Camden drug action team, for example, appointed a facilitator to increase the number of GPs participating in shared care arrangements and to ensure they work within the clinical guidelines.

147. Local schemes should also address the needs of other primary care staff, many of whom have high levels of day-to-day contact with drug misusers. Community pharmacists, for example, can play an important role in the management of drug misusers, including dispensing drugs as part of supervised consumption arrangements and offering needle exchange services. However, research has shown that many are an underused point of contact for the drug misusing population and would benefit from a closer relationship with prescribing services and improved training (Ref.76).

148. Funding flexibilities introduced by section 36 of the NHS Primary Care Act 1997 provide opportunities to offer GPs additional payments to recognise increases in workload and expertise. Drug misusers generally consult their GP more than other patients, they require more prescribed items and generate specific costs related to methadone prescribing, such as toxicology charges. One study estimated these costs at around £2,030 per year in 1994 [BOX Q, overleaf], though others have put the cost closer to £1,000 per annum. The financing of individual GPs would need to be considered carefully to reflect the extent of their responsibilities and should only be considered alongside other measures that seek to enhance support to GPs – payments alone are unlikely to secure greater participation. The development of Personal Medical Services pilots also gives health authorities scope to negotiate new salaried contracts with GPs to meet specific local needs, such as providing care for drug misusers.

BOX Q

Estimated annual costs of methadone prescribing

Research based on 46 drug misusers receiving methadone maintenance during an 18-month period at clinics run by general practitioners in Glasgow identified the following estimated annual costs, based on 60mg dispensed daily at a local pharmacy:

	Cost per patient (£) *
General practitioner and practice time (3 minutes weekly)	208
Counsellor time (20 minutes weekly)	173
Dispensing fees	806
Methadone	323
Toxicology (fortnightly urine analysis)	520
Total	2030

* Based on prices in 1994

Source: Philip Wilson et al 'Methadone Maintenance in General Practice: Patients, Workload, and Outcomes', 1994 (Ref.77)

Improving support to primary care: national action

149. The Department of Health has already taken steps to improve training and support to GPs, in partnership with the Royal College of General Practitioners (RCGP). An accredited Certificate course has already been developed for those GPs with a special interest in drug misuse and a Diploma-level qualification is under development. However, there is currently no training scheme or accredited qualification for the increasing number of GPs who lead multidisciplinary drug teams and often act as the local 'expert' in the absence of a more traditional specialist service. This gap needs to be addressed and will require clarification of the core skills and competencies of GPs working in this capacity, as well as agreement on remuneration and clinical governance arrangements. Developing an undergraduate curriculum designed to promote training in drug misuse in nursing, medical and pharmacy schools and considering the role that emerging 'nurse consultants' could play in supporting drug misusers could equally lead to an expansion of expertise and clinical resources within the sector. Key stakeholders, including the relevant Royal Colleges, RCGP, NTA and Department of Health, should work together to oversee this agenda.

The way forward

'I can see the future and it looks bright'.

Male, crack cocaine user, aged 32.

150. People who become problem drug misusers often face myriad problems; for Government, local agencies and communities, the problems caused by drug misuse in turn pose a significant challenge. Effective treatment services provide a major way of helping drug misusers return to a healthier life in the community and can help to reduce drug-related crime and social exclusion. Many of the weaknesses in current provision can be remedied where local agencies strive to make services more accessible and responsive to the needs of the user, improve care co-ordination and joint working, and develop more effective links with primary care. Better strategic planning, bringing together information on local needs and service performance, must also underpin new ways of working.

151. The time is ripe for change in drug treatment services:

- New proposals to bring together the work of DATs and CDRPs provide a new impetus to strengthen joint working.
- The NTA in England and SMIB in Wales can improve the national framework – providing better guidance on service models, strengthening the research base and promoting agreement upon best practice.
- New investment can be used to expand and improve local services.

Securing improvement will take time, but the potential gains are immense. If the opportunity is missed, the losers will be some of the most vulnerable people and communities in the country.



RECOMMENDATIONS



Changing Habits

Recommendations for drug action teams and key local agencies

- 1 Establish clear arrangements for joint commissioning drug treatment services within the DAT area, ensuring that any joint arrangements are linked to each partner's mainstream activities and budget processes [paragraphs 100-102].
- 2 Promote effective links between DATs, key local partnerships (Crime and Disorder Reduction Partnerships, Youth Offending Teams and Local Strategic Partnerships) and other mainstream services to ensure a coherent approach to drug-related problems [paragraph 101].
- 3 Identify the needs and profile of all problem drug misusers within the DAT area, taking into account existing clients' satisfaction with the content and impact of the treatment that they receive [paragraphs 107-110].
- 4 Establish information systems to collect better information about the costs and performance of drug treatment services in order to inform purchasing decisions and more fundamental service reviews [paragraphs 112-117].
- 5 Consider the development of new strategies to promote the engagement of 'hard to reach' groups and improve access where problems are apparent, for example, through new recruitment strategies or women-only services [paragraph 120].
- 6 Develop more effective assessment, care planning and co-ordination arrangements to ensure that the services provided match a client's level of need, promote a multidisciplinary approach and minimise the risk of 'revolving door' syndrome [paragraphs 133-139].
- 7 Improve the quality of support provided to drug misusers following treatment, especially for ex-prisoners and those with complex, ongoing problems [paragraph 141].
- 8 Establish (or review) policies in relation to drugs and homeless drug misusers and consider new opportunities to strengthen joint working arising from the development of the *Supporting People* policy [paragraphs 142-143].
- 9 Review the effectiveness of shared care arrangements, taking into account the strengths and weaknesses of different models, new funding flexibilities and the views of key stakeholders (GPs and practice staff, community pharmacists, primary care trusts and local medical committees) [paragraphs 145-148].

RECOMMENDATIONS



Changing Habits

Recommendations for central Government

- 10 The Home Office Drugs Strategy Directorate (DSD) should review the funding framework for drug treatment services to promote a stronger emphasis on *long-term* funding and review [paragraphs 103-104].
- 11 The Home Office DSD should consider whether new funding flexibilities identified for the public sector (such as Public Service Agreements) could be extended to the drug treatment sector [paragraph 104].
- 12 The Home Office DSD should ensure that drug treatment policy is well co-ordinated and that the responsibilities and priorities of each Government department are clearly stated [paragraph 105].
- 13 The Department of Health/NTA/SMIB/Home Office DSD should examine the feasibility of using national drug treatment monitoring systems to provide forecasts and estimates of drug trends for each DAT [paragraphs 122-123].
- 14 The Home Office/Department of Health/NTA/SMIB should address key research gaps around the effectiveness of specific treatment interventions and their cost effectiveness [paragraphs 127-128].
- 15 The NTA/SMIB should promote existing research findings in an accessible format to increase understanding of 'what treatment works' [paragraph 129].
- 16 The Department of Health/NTA/SMIB should assess the feasibility of using collaborative improvement approaches to promote improvements and greater consistency in the quality of treatment offered by specialist treatment services, focusing initially on community prescribing services [paragraphs 130-131].
- 17 The Department of Health/NTA/SMIB should improve workforce planning to address shortfalls in key staff and build the expertise of all those working in the drug treatment field [paragraph 132].
- 18 The Home Office DSD and the NTA should give clear guidance to local agencies on effective care management models, based on the Enhancing Treatment Outcomes initiative and approaches adopted overseas [paragraph 140].
- 19 The Department of Health/NTA/SMIB should agree the core skills and competencies of specialist or consultant GPs and develop an accredited qualification and training scheme for practitioners working in this capacity [paragraph 149].
- 20 The Department of Health/NTA/SMIB should develop an undergraduate curriculum for medical, pharmacy and nursing schools, in partnership with the Royal College of General Practitioners (RCGP) and relevant Royal Colleges, and consider the role that nurse consultants could play in supporting drug misusers [paragraph 149].

Appendix 1

Checklist for action: Improving services at a local level

	Drug action teams	Joint commissioning groups	Service providers
Strengthening partnership working and commissioning			
• Set up an inter-agency group to oversee the commissioning of drug treatment services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Make an officer responsible for developing key treatment contracts and specifications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Ensure joint commissioning arrangements are linked to each partner's mainstream activities and budget processes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Establish effective links between the DAT, joint commissioning group and other key strategic partnerships	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Reviewing the quality and range of treatment services			
• Canvass the views of current service providers, commissioners and key staff on the quality and accessibility of existing provision and new trends	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Gather information about existing clients' satisfaction with the content and impact of the treatment they receive	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Identify expenditure on specialist drug treatment services and clarify the range of interventions provided by each service	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Develop separate contracts or service level agreements with each treatment provider	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Ensure that performance monitoring arrangements collect robust information on costs and performance of services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Consider the use of outcome monitoring and outcome funding models to promote continuous improvement	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Review current provision using information collected on needs and service patterns to identify service priorities and options for change	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Consider new strategies to attract 'hard to reach' groups, such as women drug misusers and crack cocaine misusers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Promoting better care co-ordination and joint working			
• Develop a shared understanding of what needs to be done to improve care co-ordination locally	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Define the roles and responsibilities of the different services and identify who will take the lead in driving forward new care planning arrangements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Establish and agree clear criteria for referrals between services and how they will be dealt with	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Set clear criteria and common procedures for assessment to reflect a multi-disciplinary, integrated approach	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Agree how training and development needs arising from the introduction of new arrangements will be addressed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Consider how users could be involved in developing the new approach	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Developing more flexible approaches			
• Strengthen support provided to people following treatment particularly those with more complex problems and ex-prisoners	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
• Introduce shared guidelines, protocols and procedures with partners in housing, children's services and mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Improving support to primary care			
• Assess the strengths and weaknesses of the different shared care models and match the options to local circumstances	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Take account of the views of GPs and stakeholders, including the LMC and PCT, on the introduction of a shared care scheme	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Introduce a local shared care policy in line with Departments of Health guidelines	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
• Consider including care for drug misusers in any new salaried contracts with GPs and offering additional payments to other GPs supporting drug misusers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Checklist for action: Improving the national framework

	Home Office Drugs Strategy Directorate	Department of Health	National Treatment Agency
Strengthening partnership working and commissioning			
● Promote greater emphasis on long-term planning and funding cycles to promote better continuity in local service development	✓		
● Allow DATs more flexibility to set local targets and develop initiatives that respond to local circumstances	✓		
● Consider a relaxation of NHS rules that require treatment monies to be spent within the year for which they are allocated		✓	
● Provide clarity around expectations and a clear statement of the responsibilities and priorities of each Government department	✓		
● Ensure that all new Government initiatives to strengthen and expand treatment services are properly evaluated	✓	✓	✓
Reviewing the quality and range of treatment services			
● Strengthen national arrangements to quantify and transmit accurate and more up-to-date local drugs data on both prevalence and future trends		✓	
● Promote the potential benefits of the new NDTMS reporting arrangements more widely and issue guidance on issues that lead to under-reporting		✓	
● Develop a core national database to capture information on the cost and performance of drug services more effectively	✓	✓	✓
● Address research gaps around the effectiveness of specific interventions and the treatment of non-opiate drug problems		✓	✓
● Promote research findings in an accessible format that increases local understanding of what works and why		✓	✓
● Accumulate evidence about the cost-effectiveness of different interventions and types of service		✓	✓
● Consider a collaborative improvement approach to promote agreement on the best way to deliver key interventions such as community prescribing			✓
● Consider the development of an accreditation scheme for community drug programmes			✓
● Strengthen the knowledge base and expertise of both commissioners and service managers through training and development			✓
● Promote the development of effective team working within multi-disciplinary services			✓
● Improve workforce planning to address shortfalls in key staff and identify short-term measures to bridge any gaps			✓
Promoting better care co-ordination and joint working			
● Give clear guidance to local agencies on effective care management models, based on the outcomes of local pilot projects and approaches adopted overseas		✓	✓
Improving support to primary care			
● Develop an accredited qualification for those GPs who act as 'the local expert' and often lead multi-disciplinary drug teams		✓	✓
● Develop an undergraduate curriculum to promote training in drug misuse in nursing, medical and pharmacy schools		✓	✓
● Consider the role that emerging 'nurse consultants' could play in supporting drug misusers		✓	✓

Appendix 2

Main types of illicit drugs

DRUG NAME	STREET NAMES	WHAT DOES IT LOOK LIKE AND HOW IS IT TAKEN?
Amphetamines	<ul style="list-style-type: none"> • speed, whizz, uppers, amph, billy, sulphate 	<ul style="list-style-type: none"> • grey or white powder that can be snorted, swallowed, smoked, injected or dissolved in a drink • tablets that are swallowed
Benzodiazepines	<ul style="list-style-type: none"> • includes drugs such as Valium, Mogadon ('moggies') and temazepam ('mazzies') 	<ul style="list-style-type: none"> • tablets or capsules that are swallowed
Cannabis	<ul style="list-style-type: none"> • marijuana, draw, blow, weed, puff, shit, hash, ganja, spliff, wacky backy 	<ul style="list-style-type: none"> • a solid, dark 'resin' • leaves, stalks and seeds ('grass') • a sticky dark oil • can be rolled (usually with tobacco) in a spliff or joint, smoked on its own in a special pipe, or cooked and eaten in food
Cocaine	<ul style="list-style-type: none"> • coke, charlie, snow, C 	<ul style="list-style-type: none"> • white powder that is snorted up the nose; sometimes dissolved and injected
Crack	<ul style="list-style-type: none"> • rock wash, stone 	<ul style="list-style-type: none"> • small raisin-sized crystals that are smoked
Ecstasy (MDMA)	<ul style="list-style-type: none"> • E, doves, XTC, disco biscuits, echoes, hug drug, burgers, fantasy 	<ul style="list-style-type: none"> • tablets of different shapes, sizes and colours (but often white) that are swallowed
Heroin	<ul style="list-style-type: none"> • smack, brown, horse, gear, junk, H, jack, scag 	<ul style="list-style-type: none"> • brownish-white powder that is smoked, snorted or dissolved and injected
LSD	<ul style="list-style-type: none"> • acid, trips, tabs, blotters, microdots, dots 	<ul style="list-style-type: none"> • ¼ inch squares of paper, often with a picture on one side, that are swallowed. Microdots and dots are tiny tablets
Methadone	<ul style="list-style-type: none"> • Physeptone is the most common brand name 	<ul style="list-style-type: none"> • white crystalline powder that is dissolved in fluid and swallowed • also available in tablets, that can be swallowed, or crushed and injected • methadone in ampoule form can be injected

WHAT ARE THE EFFECTS?	WHAT ARE THE RISKS?
<ul style="list-style-type: none"> gives the user a 'buzz' of extra alertness, energy and confidence 	<ul style="list-style-type: none"> can impair judgement and concentration may lead to depression and anxiety after use long-term use places strain on the heart and can lead to mental illness
<ul style="list-style-type: none"> calms user and slows them down mentally relieves tension and anxiety high doses can make user drowsy and forgetful 	<ul style="list-style-type: none"> physical dependence can develop with withdrawal leading to nausea, headaches and irritability overdoses can cause coma and impaired breathing
<ul style="list-style-type: none"> user feels relaxed and talkative may bring on a craving for food ('the munchies') 	<ul style="list-style-type: none"> smoking cannabis with tobacco may lead to users becoming addicted to cigarettes can leave user tired and lacking energy can make user paranoid and anxious smoking joints over a long period can lead to respiratory disorders, including lung cancer
<ul style="list-style-type: none"> sense of well-being, alertness, confidence effects last roughly 30 minutes user is often left craving more 	<ul style="list-style-type: none"> cocaine is addictive; regular use can be expensive and hard to control leaves user feeling tired and depressed for a couple of days can cause chest pain and heart problems that can be fatal
<ul style="list-style-type: none"> crack has the same effects as cocaine, but causes a more intense and shorter 'high' 	<ul style="list-style-type: none"> crack and cocaine carry the same risks, but crack use can be even harder to control
<ul style="list-style-type: none"> users experience enhanced feelings of alertness, well-being and sociability sound, colour and emotions seem more intense users may dance for hours 	<ul style="list-style-type: none"> users can feel tired and depressed for days risks of overheating and dehydration if user dances excessively without taking breaks or drinking enough fluids has been linked to liver and kidney problems some suggest use may be linked to brain damage, causing depression in later life
<ul style="list-style-type: none"> produces euphoria and pain relief, and gives the user a sense of warmth and well-being larger doses may make the user relaxed and drowsy 	<ul style="list-style-type: none"> heroin is highly addictive, and requires increasing amounts to achieve the same high sudden withdrawal produces symptoms of nausea, muscle pains, diarrhoea and goose flesh overdose can cause coma and in some cases death injecting can damage veins, and sharing injecting equipment puts users at risk of blood-borne infections
<ul style="list-style-type: none"> effects (a 'trip') can last for 8 to 12 hours users will experience their environment in a different way objects, colours and sounds may be distorted 	<ul style="list-style-type: none"> users may experience a 'bad trip' 'flashbacks' may be experienced where parts of a 'trip' are re-lived some time after the event use can complicate mental health problems
<ul style="list-style-type: none"> commonly prescribed as a substitute for heroin causes a high/mood change that is less intense but longer lasting than with heroin may cause drowsiness 	<ul style="list-style-type: none"> can cause unpleasant side effects such as itching, constipation or reduced sexual desire overdose can result in over-sedation or death using heroin, alcohol or other sedatives on top of methadone can easily cause overdose can cause vein damage if tablets or concentrated ampoules are injected

Source: © Health Education Authority, 1998.

Appendix 3

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Appendix 4

The legal framework

For most of the nineteenth century, drugs such as opium and cocaine could be bought over the counter in local pharmacies. The first serious restrictive framework for regulating the sale of opium and other substances was introduced under the **Poisons and Pharmacy Act 1868**. Possession of cocaine and opiates first became an offence under the **Defence of the Realm Act 1916**.

Through the twentieth century most British drug law has been passed to meet obligations arising from United Nation Conventions. For example, the **1920 Dangerous Drugs Act** was passed in order to ratify the Hague Convention of 1912. The Convention required states to limit the manufacture, trade and use of opiates for medical purposes; to close opium dens; to penalise unauthorised possession of opiates; and to prohibit their sale to unauthorised persons. The Act also placed controls on the importation, exportation and manufacture of tincture of cannabis and preparations containing dihydrocodeine. Between 1925 and 1967 the Dangerous Drugs Act was amended a number of times, both to extend the range of controlled substances and to implement Convention protocol.

Today, the main legislation controlling the misuse of drugs in Britain is the **Misuse of Drugs Act 1971**. This replaced earlier Acts and brought all controlled drugs under the same statutory framework. It also incorporated: the relatively new system of licensing doctors to prescribe heroin and cocaine to addicts; the requirement for all doctors to notify addicts to the Home Office; regulations on the safe custody of drugs; and national stop and search powers for the police. It also established the first statutory advisory body, the Advisory Council on the Misuse of Drugs (ACMD).¹

The Misuse of Drugs Act 1971 divides controlled drugs into three Classes, which are linked to maximum penalties in a descending order of severity, from A to C. This three-tier classification was designed to make it possible to control particular drugs according to their comparative harmfulness, either to individuals or to society as a whole. For the offence of possession, penalties for Class A drugs range from six months imprisonment and/or a fine of £5,000, to 7 years in jail. For the same offence with Class C drugs, the maximum penalty is 2 years in jail or an unlimited fine.

¹ *Drugs and the Law, Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, The Police Foundation, 2000.

Current classifications, which incorporate changes and additions since 1971, are as follows:

- *Class A* includes cannabinal and cannabinal derivatives, cocaine (including ‘crack’), dipipanone, ecstasy and related compounds, heroin, LSD, magic mushrooms, methadone, morphine, opium, pethidine and phenylcyclidine.

Class B drugs which are prepared for injection are classed as Class A.

- *Class B* includes amphetamines, barbiturates, cannabis (herbal), cannabis (resin), codeine, dihydrocodeine and methylamphetamine.
- *Class C* includes anabolic steroids, benzodiazepines, buprenorphine, diethylpropion, mazindol, pemoline and phentermine.

Between 1997 and 2000 the Police Foundation Inquiry into the Misuse of Drugs Act 1971 reviewed current drug laws in the UK. The inquiry made 81 recommendations, including a number of proposed changes to the classifications of drugs that they argued would better reflect up-to-date medical and scientific knowledge. The report also recommended that the penalties for possession of Class B and C drugs should not include prison, and that the maximum sentence for possession of Class A drugs should be reduced and imposed only when a community sentence and treatment have failed or been rejected.

The Government’s official response to the Police Foundation Inquiry in November 2000 rejected all the proposed reclassifications of drugs. The only major recommendation of the report to be accepted was the suggestion that charges of supplying drugs might be avoided if offenders proved the drugs were only for use by a small group of friends. However, in October 2001, the Home Secretary announced the reclassification of cannabis from a Class B to a Class C drug, subject to evidence from the Advisory Council on the Misuse of Drugs.

Appendix 5

Research on what works to reduce illegal drug misuse¹

Evaluating treatment outcomes

Any evaluation of what works in reducing illegal drug misuse must focus on what each specified treatment is designed to achieve. For most people presenting to a service, tackling problem drug misuse is the main goal and stopping or reducing use is the obvious indicator of success (*Ref. 1*). There are also expectations that treatment will lead to reductions in health problems and improvements in the patient's personal and social situation. Consequently, most research studies evaluate treatment on four problem 'domains':

- drug use involvement;
- injection and sexual risk behaviours for blood-borne infections;
- physical and psychological health problems; and
- personal and social functioning (a broad set of problems spanning family and relationships, accommodation, employment, criminal involvement and other public safety issues).

It is important to recognise that treatment outcome expectations and priorities may differ across individual, family, community, service-related and criminal justice perspectives.

The majority of people who have difficulties with their use of illegal drugs encounter relatively mild and self-limiting problems usually during their adolescence and early adulthood. However, those presenting to specialist treatment services tend to have chronic problems in several areas and these are often characterised by remissions and relapses. The treatment of drug misuse can therefore be compared with other chronic health conditions – such as adult onset diabetes, hypertension and asthma. Treatment outcomes for drug misuse are as good or better than those achieved for these 'mainstream' debilitating conditions (*Ref. 2*).

The nature of the evidence

Most of the evidence for the effectiveness of treatment for drug misuse comes from two types of research study:

- (i) **Naturalistic or 'observational' studies** contrast patients who access studied treatments on outcome measures at one or more points following a baseline intake assessment. These studies are very useful for the evaluation of treatment systems where patients often engage in different types of service over time. There have been several major multi-site studies of this kind, including the Drug Abuse Treatment Outcome Study (DATOS) in the United States and the National Treatment Outcome Research study (NTORs), a cohort study of 1075 patients conducted in England and funded by the Department of Health. These studies can show if outcome expectations are achieved and how changes observed vary across services and with the amount or type of treatment that patients receive. These research designs cannot unequivocally attribute improvements to treatment in the absence of a control group of patients randomly assigned to receive no treatment. It is possible that patients would have changed significantly over the same period without treatment.

¹ This appendix is based on a review of the evidence base commissioned by the Audit Commission. The review, undertaken by Dr John Marsden and Dr Michael Farrell from the National Addiction Centre, Institute of Psychiatry at the Maudsley Hospital, focuses on research from the UK, as well as the USA, Australia and a small number of other countries. All of the summarised studies have been published in peer-reviewed academic journals. References cited in this appendix are given on pages 109–12.

(ii) **Experimental, controlled trials** usually involve random assignment of patients to specific treatment interventions and to comparison interventions. No-treatment control conditions are rarely used in this healthcare area. Where they are feasible to conduct, experimental designs offer the most convincing evidence on treatment efficacy, but these sorts of study need to be carefully conceived to maximise their usefulness in treatment systems. Randomised trial studies of treatment for young people and adults in the pharmacotherapy and counselling arenas have been recently commissioned in the UK.

Although much can be learned from overseas research studies, it is sometimes difficult to judge whether the findings can be fully applied to the UK culture and service delivery context. There are often marked differences in the types of people who take part in outcome studies and the structure and operation of the services studied.

The effectiveness of key treatment interventions

In the UK, there are four main types of treatment for drug misuse:

- inpatient programmes;
- community prescribing;
- care planned counselling, including structured day programmes; and
- residential rehabilitation.

The characteristics and evidence base for each of these interventions are summarised below.

Inpatient programmes

Currently, most UK inpatient programmes care for patients who are primarily dependent on heroin, and many also have concurrent problems with use of psychostimulants and benzodiazepines. The main goal of hospital inpatient programmes is to help the patient detoxify in as safe and as comfortable a manner as possible. For heroin there is a choice from several medications, including methadone, buprenorphine and other drugs such as lofexidine or clonidine. On its own, the detoxification phase of treatment may not be effective in helping patients achieve lasting recovery.

Rather, detoxification is better seen as an important first phase of those treatment programmes aimed at abstinence (Ref. 3).

Completion of detoxification in an inpatient setting is the main outcome indicator. Average completion rates are generally good, being 75 per cent when methadone is used, and 72 per cent when using non-opioid drugs (mainly lofexidine) (Ref. 4). While methadone remains the most commonly used withdrawal medication, several randomised controlled trials have contrasted between buprenorphine and clonidine. These suggest that buprenorphine is better at reducing the severity of withdrawal symptoms and leads to fewer adverse effects (Ref. 5).

There is evidence that patient treatment acceptability, completion and post-discharge outcomes are better among those treated in specialist rather than general psychiatry inpatient settings (Ref. 6). NTORs has reported on the follow-up outcomes from inpatient treatment in a sample of 95 patients interviewed six months after discharge. The proportion using heroin dropped from 70 per cent at intake to 40 per cent at follow-up, while injecting reduced from 66 per cent to 39 per cent (Ref. 7). These improvements were maintained at a one-year follow-up (Ref. 8).

Community prescribing

Two broad types of community substitution prescribing programme are available for heroin users. In **maintenance programmes**, a substitute (usually oral methadone) is administered at a suitable and stable level for a period of several months and sometimes years. In **reduction programmes**, patients are first stabilised on the substitute and then gradually withdrawn over a period ranging from several weeks to many months. Internationally, there is a well-established research and clinical evidence-base for oral methadone maintenance treatment (MMT). On average, patients report a substantial reduction in heroin use and improvements across the four problem domains (Refs. 9, 10). NTORs results at six months, one year and two years describe sustained patient improvements across these follow-up points (Refs. 7, 12, 13). At four to five year follow-up, 35 per cent of the NTORs participants who had entered methadone treatment reported being abstinent from heroin (Ref. 14). Several studies have shown a dose

response effect in MMT, with patients receiving doses at 50mg per day and above being more likely to be retained in treatment and less likely to continue to use heroin (*Refs. 15, 16, 17*).

Outside of the specialist clinics, NTORs has also reported on six-month follow-up outcomes for 155 patients treated in seven primary healthcare settings (of which five had shared care arrangements with specialist services). These GP-treated patients were contrasted with a cohort of 297 patients treated in specialist services and achieved comparable improvements (*Ref. 18*).

Buprenorphine maintenance is generally as effective as methadone maintenance in reducing illegal heroin use and retaining patients in treatment, and also has a better safety profile in overdose (*Refs. 19, 20, 21*). Further research and development work may be needed in the UK to assess the patient groups and delivery arrangements best suited to buprenorphine maintenance. Levo alpha acetyl methadol (LAAM), a longer acting form of methadone, has currently been withdrawn in Europe due to concern about cardiovascular complications.

Since methadone reduction treatment programmes in the UK contain a stabilisation or maintenance phase prior to dose reduction, researchers have evaluated outcomes using the same criteria as for MMT. In the US, studies of shorter-term reduction programmes have generally been negative, reporting high patient attrition and poor rates of abstinence (*Ref. 22*). NTORs has reported on the two-year follow-up outcomes from reduction programmes. On average, patients reported using heroin on 23 days in the previous three months at this point (a reduction of 61 per cent on pre-admission levels) (*Ref. 12*). However, the reduction services had poorer retention rates than the MMT programmes although this was still at reasonable levels, with half of the patients sampled still receiving a reduction programme after one year, and almost a third remaining in treatment after two years. While this suggests good retention, the study highlights a need to review the operational goals and clinical practices of UK reduction prescribing.

Other forms of community prescribing include:

- **Relapse prevention prescribing**

Drugs such as naltrexone may be used to speed up withdrawal and can help patients avoid relapse after detoxification. A single maintenance dose of naltrexone blocks the effects of any heroin taken for the next day and this may also reduce heroin cravings. However, the evaluation literature points to considerable problems with naltrexone compliance and high levels of patient dropout (*Ref. 23*). A recent review of 11 evaluations noted that in four studies only 3–49 per cent of subjects actually commenced treatment. In a further five studies, 23–58 per cent of participants left within the first week, and in another four studies 39–74 per cent of participants left treatment by the end of the second week (*Ref. 24*). Collectively, patient retention in treatment varied from 43–240 days. However, among highly motivated or compliant patients, naltrexone effectiveness is generally high, suggesting a patient-treatment assessment and matching effect (*Refs. 25, 26*).

- **Community detoxification**

In contrast to inpatient treatment, average completion rates for community detoxification treatment are less impressive, being 35 per cent for tapered methadone, and 53 per cent for other drugs, such as lofexidine (*Ref. 3*). The reason for lower performance appears to be due to patients being unable to endure withdrawal symptoms or losing their resolve to continue with detoxification. This does not mean that all heroin dependent patients seeking detoxification should be treated in an inpatient programme, as there is some evidence that patients with a stable, supportive home environment are able to succeed in community settings (*Ref. 27*). However, the literature points to a considerable need to strengthen support and aftercare arrangements for community detoxification services.

Care planned counselling

Most UK counsellors working with drug misusers follow a client-centred, cognitive behavioural framework. Treatment goals tend to be individually determined and are developed from a motivational interviewing style intended to help the patient to increase understanding of their drug use behaviour and encourage changes in harmful drug taking patterns.

Care planned counselling services usually offer a planned programme of individual psychotherapy, with treatment varying in duration from a few sessions to several months. In some parts of the UK, structured day programmes have been established that provide fairly intensive individual and sometimes group counselling. Patients may attend four or five days a week, for several hours each day and for between two and eight weeks. To date, there have been no observational or experimental studies of counselling and structured day services published in the UK. However, there is a substantial international literature on counselling and psychotherapy approaches in drug misuse treatment and this has relevance for the delivery of counselling programmes in this country.

There is some outcome evidence for the impact of motivational interviewing with drug users (*Ref. 28*). Positive evaluations of interpersonal problem solving approaches have also been reported (*Refs. 29, 30*). In the US, brief and intensive cognitive behavioural coping skills treatments have achieved positive results for adults with cocaine dependence, as have behavioural psychotherapies which use contingency reinforcement methods to help patients maintain abstinence (*Refs. 31, 32, 33, 34*).

Generalised counselling has been evaluated in a variety of studies and as part of the US multi-site observation studies. Results suggest that abstinence-based counselling is associated with reductions in drug use and crime involvement and improvements in health and well-being (*Refs. 36, 37*). In DATOS, for example, weekly or more frequent cocaine use among patients attending outpatient drug-free counselling services reduced from 41–18 per cent at one-year follow-up while weekly heroin use fell from 6 to 3 per cent (*Ref. 38*).

Residential rehabilitation

While the origins and underlying philosophy of residential rehabilitation services differ, these services share common features, including: communal living with other drug users in recovery; group and individual relapse prevention counselling; individual key working; improved skills for daily living; training and vocational experience; housing and resettlement services, and aftercare support. Programmes can be grouped by duration: **short-term residential (STR) programmes** include a detoxification programme as

the first stage of a programme that lasts for six to 12 weeks; **long-term residential (LTR) programmes** generally do not provide medically supervised withdrawal and last for 12–52 weeks.

Residential rehabilitation programmes have been evaluated in terms of completion rates and reductions across the four problem domains. There is a strong body of international research showing good outcomes for patients treated (*Refs. 39, 40, 41*). However, early drop-out appears to be a problem and studies commonly show that 25 per cent of patients leave within two weeks and 40 per cent by three months (*Ref. 42*).

NTORs has reported on one-year follow-up outcomes from patients admitted to 4 STR and 12 LTR programmes. Reductions in rates of illegal drug use between the 90 days before intake and follow-up were as follows: heroin (75–50 per cent); crack cocaine (37–18 per cent); other stimulants (71–32 per cent) and benzodiazepines (57–28 per cent) (*Ref. 43*). Some 38 per cent of the patients treated in residential programmes were abstinent from illegal drugs at 4–5 year follow-up and 47 per cent were abstinent from heroin (*Ref. 13*).

Factors influencing treatment effectiveness

Although the evidence base suggests that a wide range of treatments can be effective, there is often substantial variability in the outcomes achieved by different patients. A number of factors may account for this:

- **Programme variation**

Treatment agencies operating within the same modality can vary quite widely in their operating characteristics and specific therapeutic methods and support services used (*Refs. 44, 45*). Treatment agencies operating programmes of the same modality are not equally effective and multi-site evaluations of methadone prescribing, for example, have pointed to marked differences in effectiveness in heroin use outcomes between agencies (*Refs. 15, 59*). These differences are likely to arise from a complex interaction of patient differences and operational efficiency and quality aspects of the programme itself. For methadone prescribing, for example, the most

effective types of programme use substitution prescribing as a platform to deliver individual or group counselling together with the provision of medical and other support services (*Ref. 46*).

- **Mental health problems**

Many problem drug misusers have co-existing mental health problems, including anxiety, affective, anti-social and other personality disorders (*Refs. 47, 48*). For example, many patients in NTORs had high levels of psychological health problems at intake to treatment, including thoughts of suicide (*Ref. 49*). While reports of psychological symptoms were reduced at 1, 2 and 4–5 year follow-up, other studies have shown that those who enter treatment with formal psychiatric disorders are more likely to have poorer outcomes (*Refs. 13, 50, 51*). Special assessment and care management arrangements are required for these patients.

- **Treatment motivation and therapeutic relationships**

Several studies have looked at the extent of patients' motivation and degree of engagement in treatment (*Refs. 52, 53*). For example, patients who engage early with LTR, community prescribing or community counselling stay longer in treatment (*Ref. 54*). These findings are supported by work that suggests that improved outcome is generated by counsellors who have strong interpersonal and organisational skills, see their patients more frequently, refer to ancillary services as needed and generally establish a practical 'therapeutic alliance' with their patients (*Refs. 55, 56*).

- **Treatment duration**

Longer stays in maintenance, rehabilitation and counselling treatment are related to better outcomes and retention is a fairly reliable proxy measure of success for most programmes (*Ref. 57*). NTORs has identified various 'critical times' for residential treatment that are associated with increased levels of abstinence from heroin at one-year follow-up. These are 28 days for inpatient and STR programmes, and 90 days for LTR programmes (*Ref. 41*). A treatment duration effect has also been identified for inpatient and community detoxification programmes. When detoxification extends for more than 21 days, the mean completion rate is 31 per cent, compared to 58 per cent for treatment completed in 21 days or less (*Ref. 3*).

- **Social and environmental factors**

Effective treatment must attend to a patient's multiple needs, including related social, vocational and legal problems. Studies have shown that treatment benefits can diminish rapidly if the patient has poor social and familial supports (*Refs. 58, 59*). Social supports and stresses should be an integral part of the assessment process and programmes that seek to improve patients' integration and stability, address life problems, family relationships and personal resources will be valuable.

Other issues

Economic evaluations

Economic evaluations examine whether the investment of treatment resources is effective in tackling problems across the four problem domains (*Ref. 60*). Studies that have looked at changes in crime (largely acquisitive or property oriented) during and after a treatment episode have pointed to reductions in victim costs to individuals, retailers and insurers (*Refs. 61, 62, 63*). Economic analyses in NTORs have focused on the overall costs of providing treatment in relation to the costs due to crime within the cohort. Reductions in criminal behaviour at one year represented cost savings worth around £5.2 million to victims and the criminal justice system, leading to the conclusion that for every extra £1 spent on treatment there is a return of more than £3 in terms of cost savings to victims and the criminal justice system (*Ref. 64*). The impressive crime-related benefits of long-term residential rehabilitation and outpatient drug-free treatments for cocaine dependence have also been reported by DATOS (*Ref. 65*).

Crime issues and treatment in the justice system

In the NTORs cohort, 50 per cent of patients had committed some form of acquisitive crime (shoplifting, fraud, robbery or other theft) in the three months before intake and a minority engaged repeatedly in criminal behaviour to fund their habit. There is now a substantial investment of resources in the UK to tackle the problem in the criminal justice system (*Ref. 66*). The research literature indicates that drug users within the criminal justice system who are

coerced into treatment achieve the same outcomes as those seeking treatment on a voluntary basis

(Refs. 67, 68).

In terms of crime outcomes, US evaluations of drug courts (which involve prison diversion through mandatory treatment) and in-prison treatment suggest that participants report more reduced drug use than comparison groups (Refs. 69, 70, 71). Follow-up assessments in NTORs showed a reduction of 67 per cent in the number of crimes committed reported at 1 year and a maintenance of this effect at 2 and 4–5 year follow-ups (Refs. 72, 73). In the UK, there have been no published outcome evaluations of specific criminal justice referral and treatment interventions in peer-reviewed journals, although outcome evaluations are now in progress.

HIV and AIDS

The sharing of injecting equipment is the main cause of the HIV epidemic amongst drug injectors. Drug treatment generally, and substitute prescribing in particular, have been shown to be highly effective in encouraging patients to change their injecting behaviour and avoid or cease sharing injecting equipment (Refs. 74, 75). The international research evidence shows that on average MMT achieves reductions in injecting behaviour and the sharing of contaminated injecting equipment, and may reduce the incidence of unprotected sexual activity (Ref. 76, 9).

NTORs has reported improvements in sharing of needles and syringes and improvements in injecting in several reports for inpatient, residential and methadone prescribing programmes. At six-month follow-up, there was a 40 per cent reduction in the proportion of patients injecting and a 68 per cent reduction in sharing (Ref. 6). Rates of injecting and sharing remained low across the five-year follow-up period. Injecting fell from 60 per cent at intake to 37 per cent at 4–5 years while the rate of sharing fell from 14 to 5 per cent (Ref. 13).

Summary

There is a considerable international literature on the effectiveness of treatment for illegal drug misuse problems and a growing domestic evidence base for the impact of community prescribing treatments and residential care. But the picture is far from complete. The impact of structured community counselling programmes and the impact of psychotherapy and counselling generally require further study in the context of treatment service delivery in the UK. There should be much to be gained from the detailed study of links between programme variation factors and patient outcome. There is also a growing need to focus on the impact of treatment for specific population groups, including younger people, people with psychiatric co-morbidity and people within the criminal justice system.

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Glossary

Abstinence

In absolute terms, abstinence refers to the complete absence of drug use, including alcohol, tobacco, and medically prescribed medicines. More pragmatically, heroin misusers may be considered to have achieved abstinence if they have ceased all opioid drug use.

Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs (ACMD) was set up under the Misuse of Drugs Act 1971 to advise Government on all aspects of drug misuse.

Its terms of reference are:

‘to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem’.

Addiction

See drug dependence.

Christian-based programmes

These residential programmes either require clients to follow the Christian faith, or use Christian teachings solely to motivate staff.

Complementary therapies

A range of alternative medicine techniques are used in the treatment of drug dependency. For example, auricular acupuncture (in the ear) is believed by some to relieve cravings for crack.

Controlled drugs

In the UK, controlled drugs are preparations subject to the requirements of the Misuse of Drugs Regulations 1985. The regulations divide drugs into five schedules, and for each of these covers import, export, production, supply, possession, prescribing, and appropriate record keeping.

Detoxification

The way in which a drug such as heroin is eliminated from the drug user's body, often with the help of a doctor and/or specialist drug worker. This is often a gradual process, and can involve the use of other drugs (e.g. methadone) to help deal with withdrawal symptoms.

Drop in

A service, or part of a service, offering open access for drug misusers. Typically, potential clients may receive initial help and advice without an appointment.

Drug dependence

Drug dependence is defined by the WHO (1993) as ‘a cluster of physiological, behavioural and cognitive phenomena of variable intensity, in which the use of a psychoactive drug (or drugs) takes on a high priority’. The state is characterised by a ‘preoccupation with a desire to obtain and take the drug and persistent drug seeking behaviour. Determinants and the problematic consequences of drug dependence may be biological, psychological or social and usually interact’. The degree of psychological dependence may be approximated to the amount of negative effect experienced in the absence of the desired drug.

Repeated use of some drugs (for example, opioids) leads to physiological changes in the drug taker, such that when the drug is not present a range of physiological withdrawal symptoms result. These are rapidly relieved by further use of the drug. This physical dependence is broadly equivalent to 'addiction'. Not all drug users are drug dependent.

Drug Dependency Unit (DDUs)

Clinical teams, mostly consultant psychiatrist-led, that are able to offer treatment to particularly complex or difficult cases. Many DDUs run outpatient services and day programmes, and have access to specialist hospital inpatient beds.

Drug misuse/abuse

Drug use that is hazardous or harmful; often used to denote all illicit drug taking, reflecting the legal problems users may incur.

Drug offence

Offence involving controlled drugs. Offences under the Misuse of Drugs Act 1971 include unlawful possession, unlawful production, unlawful supply, possession with intent to supply unlawfully and permitting premises to be used for unlawful purposes. Unlawful import or export of controlled drugs are offences under the Customs and Excise Management Act 1979.

Dual diagnosis

This refers to co-existing diagnoses of mental illness and substance use.

Harm reduction/minimisation

Harm reduction initiatives concentrate on trying to reduce the harm that people do to themselves, or other people, through their drug use (for example, syringe exchange schemes).

Low threshold

Low threshold refers to services or types of treatment that are relatively easy to access, and require little commitment from the user (for example, syringe exchange).

Methadone leakage

The diversion of prescribed methadone into the illicit market.

Methadone maintenance programme

The long term prescribing of methadone to heroin users to maximise stability and encourage harm reduction. In the UK, some specialists view a maintenance programme as a stage towards gradual reduction and eventual abstinence.

Methadone reduction programme

The prescribing of methadone to opiate users to control withdrawal symptoms. The aim is to gradually reduce the quantity prescribed until the user experiences no withdrawal complaints and is drug free. The degree of reduction and length of time afforded to achieve abstinence can vary greatly, depending on the requirements of the individual.

Naltrexone

Naltrexone is a drug that blocks the effects of heroin and other opioids by blocking the opioid receptors in the brain. It is used following detoxification so that recovering patients know they will be unable to achieve any 'high', even if they take heroin.

Opiate/opioid

Opiates are drugs derived from the opium poppy, and are known as narcotic analgesics (for example, heroin, morphine and codeine). Opioid is a generic term for the many synthetically produced narcotic analgesic drugs (for example, methadone, pethidine, dihydrocodeine), but is commonly used to refer to all narcotic analgesics.

Outcome funding	Grant funding where the funding is contingent upon specifically defined targets and outcomes being met within a certain period. These would be agreed by the agency and the funder, with regular monitoring of progress.
Outreach	Services that target individuals and groups that are under-represented in treatment either because they do not seek, or do not gain easy access to, treatment.
Overdose	Overdose refers to the use of any drug in such quantities that acute adverse physical or mental effects occur. Overdose may result in death, for example through heart, liver or respiratory failure.
Polydrug use	Polydrug use describes drug misuse where two or more drugs are taken concurrently. There is often a primary drug of use, with others taken less frequently or in smaller quantities. Most problem drug misusers show some degree of polydrug use.
Psychosis	Drug misuse can result in the user experiencing a psychotic episode. Psychosis can include a variety of symptoms, for example sensory hallucinations, delusions or paranoia.
Psychosocial treatment	Treatment techniques based on psychological and social principles and functioning (for example, motivational interviewing, relationship counselling).
Recreational drug use	Drug use on an occasional and infrequent basis, often of cannabis, ecstasy and amphetamines, as part of social recreation. The link between recreational and problem drug misuse is unclear.
Rehabilitation	Establishing a state in which individuals are physically, psychologically and socially capable of coping with situations encountered, and able to take advantage of opportunities that are available to other people in the same age group in society.
Relapse prevention	Relapse prevention programmes may be offered to drug users who have completed detoxification. Issues addressed might include the recognition of potential relapse situations, communication skills, job support, relationship management, and assertiveness.
Risk behaviour	Behaviour which carries significant health, social and legal risks. For example, injecting a drug into veins carries risks beyond those of the effect of the drug itself: local infection, tissue damage, etc.
Structured daycare	Community-based structured programmes, which may include activities such as one-to-one counselling, group therapy, relapse prevention, workshops, lectures and seminars. Structured day care is usually designed for people who have completed detoxification, as an aid to recovery and rehabilitation into the community. Programmes often require participants to be abstinent.
Structured methadone programme	A pre-determined structure and plan of methadone dispensing coupled with psychosocial interventions, regular testing, and frequent monitoring.

Substitute prescribing	The use of a drug substitute for a drug of dependence (for example, of oral methadone for illegal heroin). The substitute will be legal, safer and easier to manage clinically in effective treatment.
Supervised consumption	The supervised consumption of methadone, by a pharmacist or appropriate professional, is designed to ensure both that the patient receives the correct dose and that the drug is not diverted onto the illegal market.
Supported accommodation	Arrangements whereby support is made available to vulnerable people, to help them to continue living independently in the community. In the case of an individual with drug misuse problems, the role of the support worker might be to ensure the person retains a level of stability in day-to-day living, including attendance at rehabilitation programmes. These services may be provided alongside a more intensive programme of rehabilitation or medication.
Therapeutic Communities (TCs)	Residents of TCs are encouraged to support and constructively confront each other in order to bring about behavioural change. Clients will also engage in individual development, and may earn additional privileges during their stay.
Twelve-step model	Programmes of 12 steps can be used to aid recovery from addiction, and are based upon the principles of Narcotics Anonymous (NA). Problem drug misuse is viewed as a disease from which only incremental improvements or ‘steps’ can be made, with abstinence being the ultimate aim.
Withdrawal	The body’s reaction to the absence of a drug to which the user has become physically dependent.

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Over the last 20 years, drug misuse has increased and become more closely associated with social disadvantage. The impact of drug problems often spreads to local communities who face a rise in anti-social behaviour, crime and family breakdown. Policing drug misuse and supporting those affected by a drug habit also places additional burdens on taxpayers, with recent estimates putting the cost to the public purse at between £3-4 billion a year.

Drug treatment services can help drug misusers to overcome their problems and Government policy recognises that caring for this group should be a priority. But the uneven availability of different types of treatment and lengthy delays often make it hard for drug misusers to get the help they need, when they need it. Many drug misusers also have multiple problems, but poor co-ordination between different services offers little guarantee that their care will be managed in a 'seamless' way. And lack of support for those completing treatment increases the risk that people will resume their habit and re-enter services a number of times.

Changing Habits makes a number of recommendations for improving services at a local level, highlighting both good practice and problems with current service delivery. It also identifies the steps that central government could take to strengthen the national framework of policy guidance and performance monitoring. With drug treatment high on the political agenda, the report is essential reading for all those involved in the commissioning and delivery of drug treatment services.

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