

Drug treatment service provision in the UK: policy comprehensiveness versus practice effectiveness

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INTRODUCTION

The contemporary history of drug abuse treatment service provision in the United Kingdom (UK) can be traced to the late 1960s when the first drug clinics were opened following the introduction of the Dangerous Drugs Act. Treatment services were established then to tackle the emerging problem of opiate dependence and associated morbidity and mortality. Since then, service provision has come a long way to reflect population needs as different problems emerged. Service provision was expanded to include community drug teams whose remit was wider than offering only opiate substitution therapy. The emergence of HIV/AIDS in the 1980's also resulted in another treatment response that was geared towards reducing the risk of HIV transmission.

The last few years, however, have seen the introduction of major policies that should have far reaching effects on the provision of drug treatment services in the UK.

Some of these policies and related documents are generic while others are specific to drug abuse treatment.

The NHS Plan (Department of Health, 2000) articulates the objectives and operational requirements of earlier policy documents such as the New NHS: modern and dependable (Department of Health, 1997); the NHS Performance Framework (Department of Health, 1998a); Saving Lives: Our Healthier Nation (1999); Modernising Mental Health Services: Safe, Sound and Supportive (Department of Health, 1998b); among many others.

The core principles of the NHS Plan (Department of Health, 2000) are as follows:

- Provision of a universal service for all, based on clinical need, rather than on ability to pay

- Provision of a comprehensive range of services
- Development of services in response to the needs and preferences of individual patients, their families and carers.
- Appropriate response to the needs of different populations
- Continuous improvement in quality service provision and minimisation of errors
- Support for and value of staff
- Devotion of public funds for healthcare solely to patients
- Joint working with other parties to ensure a seamless service for patients
- Promotion of health and reduction of health inequalities
- Respect for confidentiality of individual patients and provision of open access to information about services, treatment and performance.

Specific policies relating to drug abuse treatment were anchored in the 10-year National Drug Strategy, 'Tackling Drugs to Build a Better Britain' (1998), which has treatment as one of its four main components. Other components relate to young people, communities and availability. The main objectives of the strategy are:

- To help young people resist drug misuse in order to achieve their full potential in society;
- To protect communities from drug-related, anti-social and criminal behaviour;
- To enable people with drug problems to overcome them and live healthy and crime-free lives; and
- To stifle the availability of illegal drugs on streets.

One of the operational requirements of the strategy was the establishment of the UK Anti-Drugs Co-ordinating Unit (UKADCU) which sets and oversees the agenda of local implementation groups, the Drug Action Teams (DATs). Key performance indicators were developed to evaluate the extent to which the strategy's objectives were being met.

This article articulates a framework for current treatment service provision in the UK, using the core principles of the NHS plan.

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Provision of a universal service for all based on clinical view

Following the Health Advisory Service's (HAS, 1996) report on young people, there is now a general assumption in the UK that service configuration occurs in a tiered fashion. Four of such tiers have been identified.

'Tier 1' services are mainly generic services that offer care to drug abusers; they include primary care, accident and emergency departments, community pharmacies, general hospitals, probation officers etc. The services offered include advice and information, health education, general medical services, generic counselling, support for carers and onward referrals.

'Tier 2' services offer low threshold, open access intervention targeted toward drug abusers. Such services include non-statutory community based drug services, day care services, outreach services, specialist needle exchange schemes, self-help groups, primary care, etc.

'Tier 3' services are mainly NHS mainstream specialist, community and hospital-based drug services which offer a wide range of services, sometimes in collaboration with primary care in a 'shared care' fashion.

'Tier 4' services are notably in-patient treatment programmes, including recovery and rehabilitation programmes.

Perhaps the most useful function of service segmentation represented in the tier system is treatment matching. The prerequisite of this, however, is the development of patient profiles based on comprehensive needs assessment. The extent to which this requirement is fulfilled as part of service development is unclear.

Provision of a comprehensive range of services

One of the main objectives of the 10-year strategy is the improvement of access to treatment for drug abusers. Service provision has been expanded to interface with the criminal justice system. This has resulted in the development of Arrest Referral Schemes, Drug Treatment and Testing Orders (DTTO) and the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) programmes in prisons. The aim of the arrest referral schemes is to reduce drug-related offending by facilitating treatment entry for arrested problematic drug users. The DTTO makes it possible for courts, with the offenders' consent, to impose an order that requires drug-abusing offenders to undertake treatment for their drug use, and abstain from illicit drug use while the order is in force.

Paradoxically, these robustly funded programmes are

now being associated with two major pitfalls. Firstly, there is a growing concern that access to treatment is easier through the criminal justice system than in mainstream services; drug-abusing offenders are more likely to enter treatment quicker than their non-criminal justice system counterparts.

Secondly, the remuneration in the criminal justice-based services is perceived to be more generous than those for mainstream services, thus suggesting that many drug workers may move from mainstream to criminal justice-based posts. Furthermore, the rapid introduction of these programmes has made a huge demand on the human resource capacity of specialist workers, generally, with inadequate arrangements for recruiting competent staff.

Development of services in response to the needs and preferences of individual patients, their families and carers and providing appropriate response to the needs of different populations

The 10-year drug strategy is geared toward improving proper access for problem drug users, especially to populations that are often considered as under-represented – young people, ethnic minorities and women. Specific targets have been set for health authorities to increase treatment capacity by 15%. Further funds have been made available via the 1998 Comprehensive Spending Review (CSR) to achieve these targets (Cabinet Office, 2000a). In some health authorities the CSR funds have been dedicated to assessing the treatment needs of the under-represented population and the development of appropriate treatment programmes. Some of these activities are also essential components of Health Improvement Programmes (HIMPs) in health authorities.

The Department of Health (1999) has published new clinical guidelines which sets out among other things the development, establishment and expansion of joint working arrangements between general practitioners and specialist drug services, i.e. 'shared care', in order to provide comprehensive care for those with drug problems. The modality of such arrangements, however, should reflect local population needs.

Continuous improvement in quality service provisions and minimisation of errors

Quality of care and minimisation of errors should be the hallmark of an effective treatment programme. In

practice these values can be difficult to achieve. Poor quality programmes can be characterised by poor staffing; poor physical and social accessibility; long waiting time for admission; lack of treatment policies and procedures; poorly developed monitoring systems; absence of continuing professional development programmes for staff; and absence of research to inform practice. The consequences of poor quality service provision are increased drug-related morbidity and mortality. In recognition of these deficits, the Department of Health and UKADCU, individually and jointly, have provided commissioned documents and guidelines to assist treatment providers in developing good quality services.

The Department of Health's (1999) guideline on clinical management provides guidance on ensuring effective drug treatment service provision. Another Department of Health-funded document 'Quality in Alcohol and Drug Services' (1998) provides general quality standards for treatment providers. There are national targets for reducing waiting time in drug treatment services and Drug Action Teams are expected to establish a maximum waiting time for admission and monitor progress accordingly.

Perhaps the most influential policy relating to improvement in quality service provision is the NHS Executive Health Service Circular 1999/065, 'Clinical Governance in the New NHS' (NHS Executive, 1999). This circular articulates the importance of quality monitoring in the Government's 10-year modernisation strategy for the NHS, 'The New NHS, Modern Dependable'. It also defines 'clinical governance' as a "framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (p.6).

The three core elements of clinical governance are: setting clear national quality standards; ensuring local delivery and monitoring. The first element is the responsibility of the National Institute for Clinical Excellence, while the remaining elements are operationalised by NHS drug services at the local level.

The components of clinical governance at the local service level are as follows:

- Integrated planning for quality;
- Workforce solutions;
- Good information for assessing quality and performance;
- Evidence-based applications;
- Rectifying poor practitioner performance;

- Learning from experience;
- Adopting good practice; and
- Linking clinical governance with wider control assurance.

As part of the culture of quality improvement, all clinical governance activities are expected to be demonstrable; they should include the following elements:

- A baseline position (where did it start?)
- An action plan, monitoring and evaluation (what progress has been made and how did we know?)
- A future plan (where are we going next?)

Although its ideals are laudable, the implementation of clinical governance has been described as bureaucratic. For instance a clinical governance forum in South England have identified some barriers to implementation in drug treatment services that include the following:

- Introduction of cost improvement programmes (CIP) in some health authorities in conflict with the ideals of clinical governance;
- Inability to identify the training needs for drug treatment workers;
- Lack of a practical framework for involving service users and their families in service development and provision;
- Low participation of staff in continuing professional development as a result of a heavy caseload;
- Lack of commitment of the leadership of some NHS Trusts
- Isolation of some drug treatment services from their organisation's clinical governance agenda (Addictions Resource Agency for Commissioners, 2000)

Another main barrier to clinical governance is the exclusion of voluntary drug treatment services from its implementation. This compromises the overall quality of service expected nationally. One way around this, however, is to promote joint working between statutory (NHS) and voluntary treatment services. By so doing, voluntary services, by association, would be expected to comply to clinical governance ideals. Health Authorities and commissioners of drug treatment services can also specify clinical governance requirements in service level agreements with voluntary drug services.

Support and value of staff

In addition to the clinical governance requirement for staff support, the UKADCU's target is to establish

National Occupational Standards for specialist drug and alcohol workers in 2002 (Cabinet Office, 2000b). There are also plans to provide substantial funding for training and recruitment of drug treatment workers through funding contribution from the Confiscated Assets fund (CAF) (Cabinet Office, 2000b). While the Government recruitment drive is laudable, there is a need to make working conditions in mainstream drug services more attractive given the potentially high risk of losing mainstream staff to the seemingly better-funded criminal justice-based drug services.

Devotion of public funds for healthcare solely to patients

Generally, there has been an increase in government funding for drug treatment. For instance, additional resources were allocated to health authorities (£50 million) and local authorities (£20.5 million) in the 1998 Comprehensive Spending Review over a 3-year period (Cabinet Office, 2000a). One of the goals of this allocation is expansion of drug treatment provision by about 33%.

Further funding has been secured via the 2000 Spending Review (SR 2000) for the expansion of drug treatment services to include: advice and information services, needle exchanges, inpatient prescribing, community-based specialist prescribing services; community-based GP prescribing services; assessment and care management systems; structured one-to-one counselling services; and structured day programmes.

Furthermore in a recent announcement (May 2001), the Secretary of State for Health revealed the government's intention to reduce the number of health authorities by more than half, with the intention of transferring the cost-saving directly to patient care. The modality of this new arrangement, however, is yet to be specified.

Joint working with other parties to ensure seamless service

The harmonisation of the aims of the Drugs Strategy and the New NHS has resulted in the promotion of joint working among different sectors - drug treatment service providers, health authorities, social services, probation services, the police, prison, local authorities and Drug Action Teams. This joint working arrangements is evident in the diverse membership of Drug Action

Teams, which often include representation from the aforementioned service sectors.

From the treatment provision perspective, the drug strategy has also encouraged joint working between the criminal justice systems and treatment services. However, there are ethical issues, especially patient confidentiality, that seem to be compromised in this arrangement. This is a contentious issue that is discussed elsewhere. There is much expectation of joint working between specialist drug services and general practitioners within a shared-care arrangement. The Department of Health (1999) has suggested different models for such joint working and the expectation for such a partnership. The establishment of Primary Care Groups (PCGs) and Primary Care Trusts (PCTs) is meant to facilitate care provision at the local level.

Promotion of health and reduction in inequalities

As previously discussed, there are specific targets in the strategy geared toward meeting the needs of populations assumed to be under-represented in treatment services – young people, minority ethnic groups and women. There is support for the development of pilot treatment services targeting these populations, and expansion of existing mainstream services. The areas of concern, however, are inability to clearly identify the needs of minority ethnic service users; lack of clear criteria for developing culturally competent services; insufficient involvement of minority ethnic community communities in service development and performance monitoring.

Respect for confidentiality of individual patients

Patient confidentiality is a fundamental tenet of clinicians in general. Those responsible for the care of drug abusers are no exception. However, the interface between mainstream treatment services and the criminal justice system encourages the violation of this principle. The police and probation, for instance, would often wish to obtain confidential information on patients whose treatment is being financed by these agencies.

Another area of concern is the request for attributable patient data from treatment agencies by Regional Drug Misuse Databases (RDMDs) – agencies responsible for collating service presentation data in different regions of the UK. In the past, only one RDMD, the South Thames (West) Substance Use Database respected patient

confidentiality; it requested non-attributable data from treatment agencies.

The second phase of the strategic review of RDMDs, therefore, provides an opportunity for the Department of Health to resolve the ethical dilemma inherent in the provision of patient identifiers to RDMDs, by drug treatment workers, in violation of their respective professional code of ethics.

CONCLUSION

A framework for comprehensive drug treatment service provision in the UK has been articulated. The UK Government's effort to tackle drug problems through a comprehensive demand reduction strategy is highly commendable. However, the mechanism for policy implementation still appears cumbersome. There are areas of duplication of functions between various departments. These need to be streamlined. Furthermore, policy makers are gradually curtailing the capacity of treatment providers to make informed choice about patient care. It is hoped that the proposed National Treatment Agency (NTA) for substance misuse, a special health authority will address this anomaly.

Secondly, given the apparently low level of manpower required to successfully implement the strategy, it is advisable that the Department of Health and the UKADCU consult with major providers of specialist substance misuse education and training in UK's universities and teaching hospitals. The aim of such initiative is to facilitate specialist post-qualification postgraduate education and training programmes that are accessible and affordable for existing and potential drug treatment services' staff.

Finally, it is probable that the huge demand reduction efforts that are being vigorously pursued can be sabotaged through irresponsible clinical practice, especially in the private sector where standards of care

for drug abusers are less vigorously monitored. The proposed licensing arrangement for doctors to prescribe substitute and other controlled drugs is commendable. It is advisable that the Department of Health and the Home Office should introduced stiff penalty for non-compliance and/or subs-standard practice to serve as a deterrent, especially to doctors whose irrational prescribing can often result in numerous avoidable deaths among drug abusers.

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