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23rd December 2004

Dear Sirs,

Re: Consultation for Models of care for drug misusers (MoCDM)

Please find attached comments from the Royal Pharmaceutical Society of Great Britain on the stage one of the review of Models of care for drug misusers.

I hope these comments are useful. If you require further information or if there is anything in the response that you would like clarifying, please do not hesitate to get in touch.

Thank you for consulting the Society.

Yours sincerely,

Sadia Khan
Practice Division

National Treatment Agency for Substance Misuse

Models of care for drug misusers – stage one consultation Questionnaire

Section 1: The current *Models of care for drug misusers (MoCDM)* – how can it be revised and improved?

This section asks questions on how *MoCDM* can be revised and improved. Each sub-section refers to a different aspect of drug treatment.

1.1 Screening and assessment

MoCDM currently contains a number of processes for identifying and assessing the treatment needs of drug users. These processes range from screening, which can be done by non-specialists, to comprehensive assessments that have to be carried out by trained professionals.

(a) Do you find the different levels of assessment contained in *MoCDM* meaningful and useful?

Yes ☒
No ☐

Please comment.

The theory behind the concept of MoCDM is to be commended. Unfortunately, for pharmacists, the theory is not met in practice as they are often excluded/overlooked, especially when it comes to the referral/assessment processes. Other practitioners often fail to communicate with pharmacists. The important knowledge/understanding that community pharmacists have because they see people/patients in a non-threatening 'normal' environment is ignored.

(b) How do you think the guidance on screening and assessment can be improved by the NTA?

NTA could promote expertise/role of pharmacist in this area of practice. Pharmacists see patients in treatment on more or less daily basis, yet their opinion is rarely sought during ongoing appraisal.

1.2 Care planning

Care planning involves drawing up individual plans that are structured, often multi-disciplinary and goal-oriented. These plans detail the essential steps in the care of a drug misuser and describe the user's expected treatment and care course. Care plans should be regularly reviewed with clients. The NTA is concerned that the central importance of this process is not clear enough in the current *MoCDM*.

(a) Do you think that more emphasis should be placed on achieving treatment goals via the delivery of the care plan and the 'client treatment journey' rather than just focussing on individual modalities or types of treatment?

Yes ☒
No ☐

What do you think should be done to ensure good quality care planning in drug treatment?

Greater integration of all professionals and patients involved. The emergence of supplementary and independent prescribing by pharmacists and nurses in accordance with agreed treatment/care plans could greatly enhance patient care in community settings

(b) Drug treatment is currently regarded as starting when a user attends their first appointment at a structured treatment service. Should the implementation date of the care plan be regarded as the start of structured treatment in the future?

Yes ☐
No ☒

(c) In the view of the NTA, it is important that users' individual views, needs and agreement are reflected in their care plan; can you suggest ways in which users can be involved in care planning and review to help ensure that this happens?

Maintain open dialogue – include patients "in". Ask their views; ask opinion advice of local user groups, the Alliance etc. Consult.

1.3 Integrated care pathways

(a) The 'integrated care pathways' outlined in *MoCDM* are designed to provide a guide that sets out the ideal course of treatment for a particular patient. Have these 'pathways' proved to be useful in your work?

Yes ☐
No ☐

(b) Please describe any further 'integrated care pathways' that are not in *MoCDM* and, in your view, should be.

Care plan to include ancillary medications e.g. by using Supplementary Prescribing/Independent Prescribing by both pharmacists and nurses. Encourage use of these new systems; provide training guidance. Work with local professional bodies to develop standard operating procedures appropriate to care of drug misusers in the community

1.4 Care co-ordination

Clients who meet set criteria for care co-ordination should have access to a care co-ordinator to ensure that there is a comprehensive and integrated approach to the care provided by different services.

(a) Is care co-ordination required in all cases?

Yes ☒
No ☐

(b) If no, which clients should care coordination be reserved for?

(c) If yes, please comment on the balance between care co-ordination and service delivery. Are there enough staff and resources to effectively deliver both?

Balance will need to be maintained depending on complexity of individual's needs

1.5 The four tiered model

The revised *MoCDM* document will probably retain the four tier framework for commissioning drug services. These tiers are:

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

(a) Do you support the view that the four tier structure should be retained?

Yes ☒
No ☐

(b) In your view, how do you think the four tier framework can be improved?

Greater recognition of expertise of pharmacists in community, primary and secondary care. Greater recognition of potential role for pharmacists in provision of NEX – beyond passive supply of clean equipment.

Increased involvement in all 4 tiers

(c) In your view, what are the overall strengths or weaknesses of the four tier system?

Strengths	Weaknesses
Structured approach	Structure may inhibit flexibility and progress up and down tier structure. Dialogue between professionals in different tiers often inhibited (absent)

(d) In your view, are there any drug treatment service modalities or types missing from any of the four tiers?

Yes ☒
No ☐

(e) If your answer is yes, what are these, and where in the four tiers should they be placed?

Greater involvement of community, primary care and hospital pharmacists in treatment planning and NEX services. Pharmacists with additional training/expertise could advise/treat wounds – Use of Supplementary and Independent Prescribing. Use of pharmacies at tier 1 to provided information on other tiers of service. Involvement of pharmacists with additional training (e.g. RCGP Part 2 Cert) in Tiers 2, 3 and 4. Recognition of importance of supervised consumption, prescription monitoring and adjunct to Tier 2 Prescribing services

1.6 Specific tiers

Please provide specific feedback on each of the four tiers, noting current strengths and weaknesses and other comments you may wish to add. These comments could include how the services could be improved or how they could be expanded.

Please note: there are further specific questions for some of the four tiers.

(a) Tier one

Examples of tier one services include: a range of non drug-specific personal healthcare interventions; health promotion advice and information; Hepatitis B vaccination and other interventions to prevent spread of blood-borne viruses; drug and alcohol screening.

Providers of tier one services include: primary, secondary and tertiary healthcare services; social services; housing and homelessness services; general psychiatric services; accident and emergency services.

Strengths	Weaknesses
Ease of access for potential client; gateway to there Tiers of service provision	No mention of role of pharmacists in list of service providers (see above) Pharmacists are undertaking an ever increasingly important role in this area of practice.

Further comments on tier one

(b) Tier two

Current examples of tier two services include: all tier one interventions, drug-related information and advice, open access and drop-in services, brief interventions, motivational interviewing, needle exchange, outreach services, low threshold prescribing, drug misuse-specific assessment and care management.

Providers of tier two services include: specialist community drug treatment services, specialist and pharmacy-based needle exchange services, specialist substance misuse social workers and some residential treatment services.

Strengths	Weaknesses
	Exclusion of pharmacists except in relation to NEX. Not enough emphasis on extension of PNEX beyond simple supply of clean equipment

	e.g. should include supplementary/Independent prescribing for wound management, coughs, colds, toothache, headaches etc.

The NTA is concerned that tier two (open access) services may not be valued as much by the drug treatment sector as tier three (structured community based treatment) or tier four (residential treatment), due to the emphasis on national targets for structured treatment

Do you agree with this?

Yes ☒
No ☐

If yes, how can the NTA rectify this situation?

By promoting strengths to commissioners and users of services; encouraging recognition of importance of these tiers in overall care and treatment of drug misusers

The NTA has some concerns that the majority of harm reduction activity has been equated with tier two services, including blood-borne virus interventions and reducing drug-related deaths. Would you agree with this concern?

Yes ☒
No ☐

The NTA wishes to ensure that appropriate action is taken in all tiers of drug treatment to reduce the risk of drug-related harm (e.g. risk of drug-related deaths and spread of blood-borne viruses). What could drug treatment services (of all types) do to ensure this happens?

Harm Reduction (minimisation) should be constant thread across all Tiers. It must not be restricted to one Tier only. As important in Tier 1 as in other Tiers – use of Primary Prevention messages/measures. Reinforcement of harm reduction across tiers is essential

Tier two services, are currently not monitored by the NTA. In your view, should they be monitored?

Yes ☒
No ☐

Should tier two services that are provided as part of a care plan, be monitored as structured treatment?

Yes ☒
No ☐

Please indicate how should tier two services be monitored?

Activity data, quality data, Clinical Governance procedures

Further comments on tier two

(c) Tier three

Examples of tier three services include: community-based prescribing, stabilisation and maintenance prescribing, structured care planned counselling, structured day programmes, community-based detoxification services, structured aftercare programmes and drug-specific care planning.

Providers of tier three services include: specialist community drug treatment services and GP shared care prescribing schemes

Strengths	Weaknesses
	Overlooks/excludes community pharmacy supervised consumption, medicines management, etc. Shared care must include all involved in patient's care, including patient

Further comments on tier three

(d) Tier four (a) services

Examples of tier four (a) services include: inpatient detoxification and stabilisation services, residential rehabilitation services, residential substance misuse crisis centres, specialist residential substance misuse units targeting specific groups (e.g. parent and child units).

Providers of tier four (a) services include: specialist substance misuse inpatient treatment units and residential rehabilitation units (including those that provide detoxification as part of a programme of rehabilitation).

Strengths	Weaknesses

Please comment on the commissioning of tier four (a) services and whether regional or national mechanisms would be beneficial.

Further comments on tier four (a)

1.7 Throughcare and aftercare

(a) In the view of the NTA, *MoCDM* may need to focus more on throughcare and aftercare – i.e. the additional support services a patient requires during, or after leaving, structured treatment (such as supported housing, employment support and relapse prevention). Do you agree with this view?

Yes ☒
No ☐

(b) How can throughcare and aftercare services be better represented in *MoCDM*?

More information on relapse prevention, signposting to other services relevant to client's needs at this point in treatment pathway

1.8 Terminology

(a) Are there any terms in the current *MoCDM* that you do not understand or would like to see clarified?

(b) *Models of care for drug misusers (MoCDM)* is the current working title for the revised document; in your opinion, is this an appropriate title?

Yes ☐
No ☐

If no, please suggest an alternative title

Section 2: The structure for the revised *MoCDM*

2.1 Comments on the revised structure

New structure for *MoCDM* is outlined below:

Foreword

Executive summary

Chapter 1: Setting the scene

Purpose: Different audiences and how they can use MOCDM

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More treatment, better treatment, fairer treatment

Scope: What is covered by MOCDM and what is not

Policy and context: Updated and abbreviated from current text, including drug policy and wider policy agendas

Individuals needing drug treatment: An overview of different users and their needs. This may involve developing a typology of drug and treatment needs.

Goals of drug treatment: Treatment domains and hierarchy of goals. This section will also introduce the concept of the 'patient journey' through treatment.

Effective treatment: A summary of effective treatment for different types of drug users.

The four-tier commissioning framework for delivering drug treatment: description of the four tiers

Links to other initiatives: How MOCDM links to public service agreements (PSAs), Department of Health's Standards for Better Health (SfBH), NHS Knowledge and Skills Framework (KSF), Drug and Alcohol National Occupational Standards (DANOS), Quality in Drug and Alcohol Service (QuADS) and Substance Misuse Advisory Service (SMAS) Commissioning Standards.

Chapter 2: the standards

This chapter will have a brief introduction and then be divided into a number of sections each focusing on a specific outcome for the individual. Each section will have a similar structure:

- **aim** – what are we trying to achieve?
- **standard(s)** – what is the standard of service we expect to be delivered?
- **rationale** – why is it important to meet these standards?
- **service models** – what are the models of service that are effective?
- **links** – how does this standards link to SfBH and NHS KSF?
- **measures** – how can we tell we are meeting the standard?
- **milestones** – when do we expect to be at which point?
- **case studies** – illustrations of service delivery from the user's perspective.

Section 1: Providing equitable access and treatment - this will include issues for diverse client groups (e.g. stimulant users, Black and minority ethnic drug users, women drug users)

Section 2: Minimising drug-related harm - this will include information on:
(a) improving public health (e.g. advice and information, needle exchange, blood-borne viruses)
(b) community safety, including criminal justice issues

Section 3: Assessing individuals' substance misuse needs – this will include information on assessment and may link to a typology of drug users.

Section 4: Tackling individuals' drug use through early interventions

Section 5: Tackling individuals' drug use through standard treatment – this will include information on integrated care pathways, commissioning, care planning as well as treatment types or modalities

Section 6: Tackling the drug use of individuals with more complex substance misuse (and other) problems – this will include information on integrated care pathways, commissioning, care planning and care coordination and treatment types or modalities.

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Section 7: throughcare and aftercare – this will include issues on appropriate ranges of support and aftercare services.

Section 8: Meeting the needs of those affected by someone else's substance misuse - this will include issues on: substance misusing parents and users; carers etc

Section 9: Managing services to meet the standards - this will contain information drawn largely from sources such as QuADS and DANOS

Section 10: Commissioning services to meet the needs of the local population - this will draw contain new information, drawn largely from the SMAS commissioning standards and DANOS

Section 11: Monitoring performance and outcomes – this will include information on performance and outcome monitoring

Chapter 3: Delivering MOCDM

A concise chapter identifying national, regional and local responsibilities for delivering MOCDM.

Appendices (including integrated care pathways)

(a) Please let us know your views on the above structure; for example, have we got the structure right?

2 2 Alcohol

(a) We are also developing *Models of care for alcohol misusers (MoCAM)* by March 2005. Do you think *MoCDM* and *MoCAM* should be brought together into the same document?

Yes ☐
No ☐

If your answer is yes, when should they be brought together?

2.3 Young people

(a) How should we deal with substance misuse treatment for the under-18s?

Should it be a completely separate *Models of care* in line with *Every child matters* (ACMD, 2003)Is this correct title? Do you mean Hidden Harm? and the *Substance of young need* (HAS, 2001)? Yes ☐ No ☐

Or Should it be incorporated into *Models of care alcohol* and *MoCDM*? Yes ☐ No ☐

Section 3: Additional comments

Please use this box for any further comments you wish to make which either expand on the areas addressed above, or have not been addressed in the questionnaire.

Section 4: Respondent information

1	Name:	Ms Sadia Khan
2	Organisation:	Royal Pharmaceutical Society of Great Britain (Practice Division)
3	Contact details (including phone and email)	1 Lambeth High Street Lambeth London SE1 7JN Tel: 0207 572 2537 Email: sadia.khan@rpsgb

4 Type of organisation:

☐	Community advice and information service
☐	Needle exchange
☐	Structured day programme
☐	Community-based prescribing service
☐	Community-based drug treatment for offenders on DTTOs
☐	CJIP service
☐	In-patient drug treatment service
☐	Residential rehabilitation service
☐	Residential crisis centre
☐	Drug action team
☒	Other, please specify

The Royal Pharmaceutical Society is the professional and self-regulatory body for pharmacists in Great Britain.

5 Role in organisation:	Practice Pharmacist
6 Involvement with *Models of care:* (Please describe in your own words).	I have co-ordinated the Society's response to MoCDM by consulting with pharmacist specialists in the area of substance misuse.
7 DAT area(s):	

8 Please indicate if this response is:

☐	An individual response
☒	An organisational response

Thank you for your time. Please return this questionnaire by 17th December 2004 either by e-mail to **consultation@nta-nhs.org.uk** or by post to ***MoCDM*, Stage one consultation, NTA, 5th Floor, Hannibal House, Elephant and Castle, London SE1 6TE**