CHAPTER 2 INTEGRATED CARE: DEFINITIONS AND CONCEPTS

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

It sets out:

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

What is Integrated Care?

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

It requires:

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

The rationale: Why is integrated care important?

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

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

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

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

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

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

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

Key Principles that underpin an Integrated Care approach

Principles of Joint Future

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

- **Joint management** is the overall term that covers the elements needed to ensure a more co-ordinated and effective approach to services including planning, commissioning and operational management. The critical factor is that the relevant range of services is under single management. Joint management needs to happen at different levels including strategic and operational levels.

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

- **Single shared assessment** aims to create a single point of entry to community care services with a view to better use of resources and more effective outcomes for people in need. The new assessment arrangements initiated under the Joint Future agenda will apply to all community care groups by April 2003. This should simplify and make more effective use of staff and information to produce better and faster results. For more information please see: http://www.scotland.gov.uk/health/jointfutureunit/singshareass.asp

- **Intensive Care Management** is a process to redesignate care management by concentrating on people with complex or frequently changing needs. Work on intensive care management is ongoing at the Joint Future Unit in the Scottish Executive. (The key point is to match the level of management and intervention with the level of need.)

- **Information Sharing** is being introduced as part of Joint Future. The key principle is that the information provided in confidence by service users to one agency should, in normal circumstances, only be disclosed to other agencies with the consent of the individual concerned. There must be clear and shared understanding of how information will be protected and used.

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

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

Further principles of integrated care for drug users

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

- needs assessment and review of services

- developing evidence-based practice

- monitoring and evaluating

- involving users

- involving communities

We also highlight further resources relevant to each principle.

Needs assessment and review of services

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

Developing evidence-based practice

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

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

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

Monitoring and evaluating

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

Involving users

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

Involving communities

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

Goals of Integrated Care

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

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

The goals of care are to:

> **Reduce illicit drug use** by stabilising on a substitute medication or detoxifying (where appropriate), by reducing the range of different substances being used by the individual, by reducing the frequency of drug use and by minimising the risk of future relapse. The ultimate goal may be to help the individual to stabilise or to become drug free.
>
> **Reduce the risk of the spread of blood-borne viruses**, in particular the risk of HIV, hepatitis B and C, and other blood-borne infections from injecting and sharing injecting equipment. This may be achieved through a reduction or cessation of sharing injecting equipment and injecting paraphernalia, a reduction or cessation of injecting and by the reduction or cessation of risky sexual practices.
>
> **Improve all aspects of health** by assisting the individual to reach and maintain a state of good physical and psychological health. This will be partly achieved by the goals above, but drug users may also have a number of other physical health problems to address. Mental health problems are a serious problem amongst this population, particularly depression and anxiety.
>
> **Reduce involvement in criminal activity,** in particular to reduce the need for criminal activity to support or finance drug use, including prostitution, theft and offences regarding the supply of drugs.
>
> **Improve personal, social and family functioning** by assisting the individuals to maximise their ability to make clear and rational decisions and enable them to develop a level of social and family interaction with which they feel comfortable. This may include an improvement in family relationships and the development of new social networks.
>
> **Improved education and employment prospects** by assisting the individual to access existing opportunities to increase their employability and providing support to them while they are undertaking education or training, or beginning voluntary or paid employment.
>
> **Improved stability of housing / accommodation** by assisting the individual to access opportunities for housing, or improvements in housing and to provide support while they are undertaking any change in housing.

Which service providers are involved?

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

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

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

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

Which partner agencies need to work together?

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

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

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

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

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

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

- The NACRO Guide to effective partnership working at:

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

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

At strategic level, the DAT and partners should agree:

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

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

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

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

THE KEY ELEMENTS OF INTEGRATED CARE

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

The Key Elements of Care

Element of integrated care process	Aspects of service to consider
1. Accessibility	• Distance to travel • Hours of opening • Service information for users and other agencies • Women's issues • Ethnicity • Homelessness • Range of services for non-opiate users • Waiting times
2. Assessment	• Core Data Sets • Assessment protocols and tools • Models • Individual's view of their problem • Information sharing procedures including confidentiality
3. Planning and Delivery	• Liaison with other services • Service-user participation • Advocacy • Goal setting • Care planning • Co-ordinating and delivering care • Communication between services • Joint funding and resourcing
4. Information sharing	• Information sharing leaflet for clients / service users • Inter-agency information sharing protocol • Informed client consent to information sharing
5. Monitoring	• Collecting process data • Collecting cost data • Ensuring monitoring is integral to, and informs, service delivery
6. Evaluation	• Service level evaluations • Strategic level evaluation • Building an evaluation culture

Current models of integrated care

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

AND FINALLY.......... Introducing Harry

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

INTRODUCING HARRY

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

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

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

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

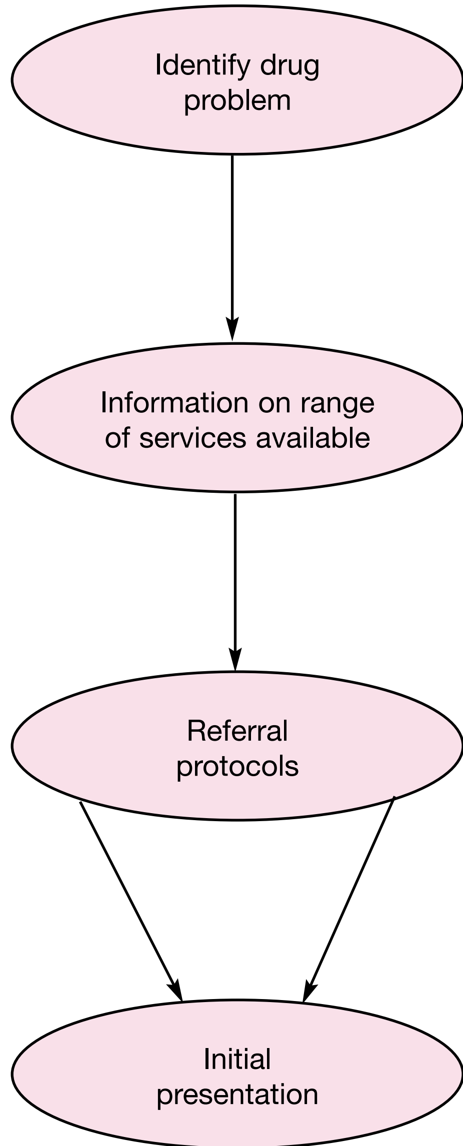
Integrated Care Pathways

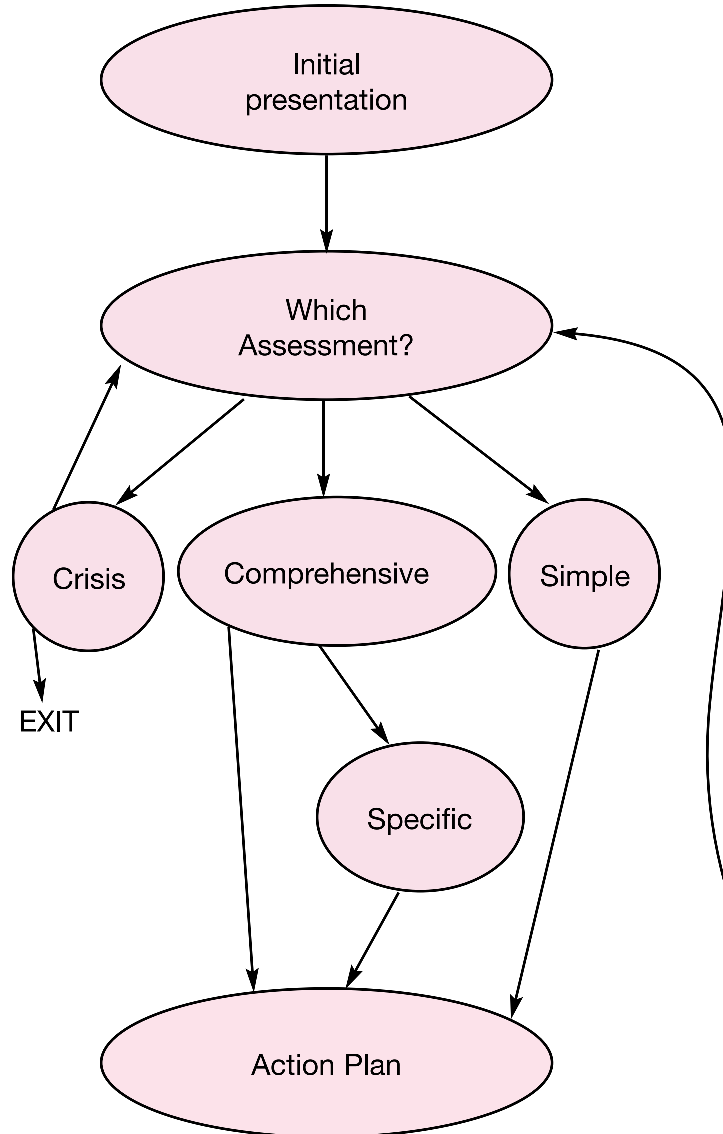
An Integrated Care Pathway (ICP) determines locally agreed, multi-disciplinary practice based on guidelines and evidence, where available, for a specific patient/client group. It forms all or part of the clinical record, documents care given and facilitates the evaluation of outcomes for continuous quality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

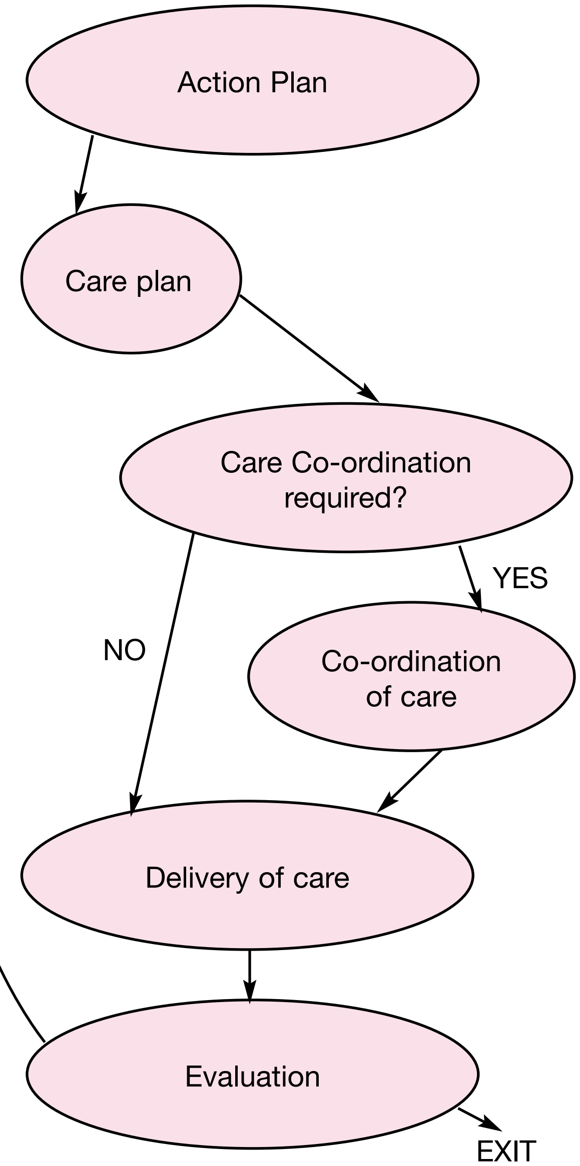
The outline care pathway below sets out some of the processes and outcomes that should be considered when developing local ICPs. Chapters 3, 4, and 5 include illustrations of how these relate to the care of an individual client, Harry.

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

OUTLINE INTEGRATED CARE PATHWAY







Outline of possible roles of service providers in integrated care.

Agencies	Possible roles
General practitioners / primary care team	• General medical services to all people with drug problems • Ongoing management of the care and treatment to the majority of individuals stabilised on substitute prescribing programmes and those maintaining abstinence
Community & hospital pharmacies	• Providing services related to needle exchange • Dispensing, and supervision, of methadone • Dispensing other medicines used in the treatment of drug use, e.g. lofexidine, naltrexone, buprenorphine • Advice and health education, including advice on secure handling and storage of medicines • Promotion of healthy lifestyles • Referral to appropriate agencies • Advising on safe sex and supplying condoms
Community based specialist drug services (statutory and voluntary)	• Overall treatment and care of people with drug problems • Assessment • Care planning • Substitute prescribing • Community / home detoxification • Social skills training • Counselling • Advice & information • Education • Monitoring & evaluation of planned care • Primary care liaison • Links to hospital & community services
Providers of residential detoxification or rehabilitation services	• Range of services for people with drug problems including detoxification and rehabilitation
Scottish Prison Service	• Providing range of treatment options within the prisons
Providers of SPS transitional care arrangements	• Providing appropriate transitional care arrangements between prisons and the community
Health specialties such as A&E departments, Ante-natal and hepatology services	• Specialist input to (and management of) pregnancy and specific, identified conditions such as Hepatitis C or mental health problems
Criminal Justice services such as Drugs Courts, DTTOs and Arrest Referral Schemes	• Referral to appropriate treatment, care and support services.
Social work community care, children and families teams and criminal justice teams	• Range of services including comprehensive assessments, carer assessment, family support, child protection services
Housing services	• Providing service, advice and information including support in Homelessness
Employment, Education and Training providers	• Specific services to promote re-integration into employment and education • Further education colleges and the enterprise networks

After care services such as those provided through New Futures Projects	• Range of services and interventions to support stablilised and former users into employment, education and training
Business organisations (including small business forums as well as national companies and public sector employers)	• Managerial experience, advice and support to new projects or provide opportunities for employment through a range of 'work taster schemes'
Wider community services	• Services to drug users could be seen as an extension to mainstream services, e.g. Police, Churches, Leisure Services
Other support organisations	• Specifically aimed to deal with drug use issues, for example, family support groups, drug awareness groups, recovery groups • Main remit targets other presenting issues but among whose clients there is an incidence of problem drug use, such as services to the homeless

ABERDEEN CITY DAT INTEGRATED CARE MODEL

Background

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

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

Horizontal and Vertical Integration

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

Phase 1: Integrated Infrastructure

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

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

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

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

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

Phase 2: Structural Integration

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

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

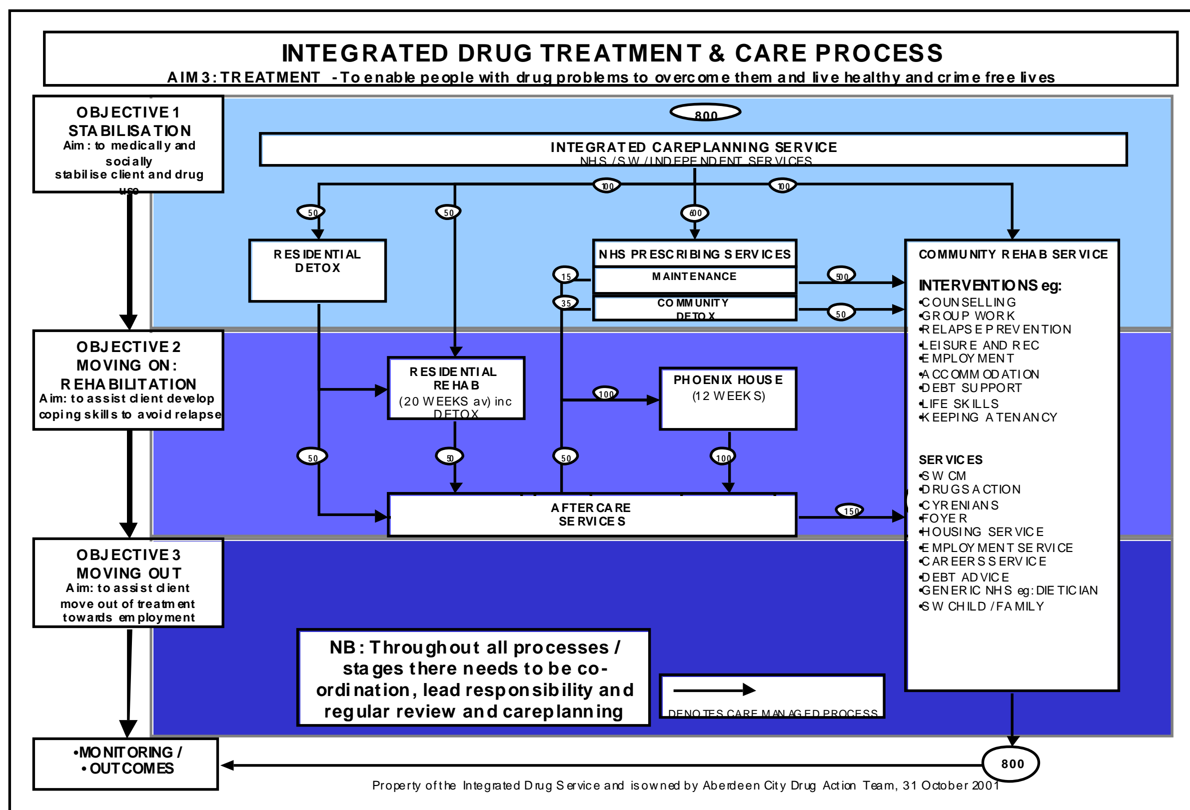
From these discussions initial plans were drawn up that started to build multi-agency "teams" around GP practices and other identifiable client groupings. However at this time there were no additional resources to take this further forward.

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

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

- Stabilisation
- Moving On: Rehabilitation
- Moving Out

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



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

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

What we have learned / things that helped and hindered

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

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

FORTH VALLEY INTEGRATED CARE SERVICES

Background and history

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

The key problems:

Service delivery

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

Strategy – SAT

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

Integrating Services to improve outcomes

Strategic change

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

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

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

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

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

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

Tier 3 – referral only; specialised medical interventions

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

Delivery – New Services

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

Signpost Forth Valley

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

Forth Dimension & 4D Structured Day Programme

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

CADS Shared Care Service

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

CSCA becomes CSSAD

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

Delivery – Processes of Care & New Systems

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

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

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

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

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

Key Positive influences for change & difficulties encountered

Positive influences

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

- **SAT team development & stability:** the commitment to invest in development of the SAT as a unit has been crucial. This has resulted in an improved culture of trust among the partner organisations and has allowed a true partnership approach to evolve with a real focus on improving outcomes for drug users.

- **Strategic Commitment & agency accountability:** The resulting commitment to a corporate approach from all partners has enhanced the ability to "join up" resources & services.

- **Community engagement & communication:** The community has been positively engaged by recruiting a community representative onto the SAT and ensuring that all SAT decisions are informed by discussions at the forums.

Difficulties encountered

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

- **Commitment to & sustaining the joint SAT approach:** Initially (& still on occasion) it has proved difficult to keep all agencies committed to the joint approach. Pressures on the health system or political disagreements within local authorities can have the potential to divert resources from their agreed targets. Such issues must be honestly addressed at the SAT.

- **Culture:** As in most areas, FVSAT emerged from a local culture which included a lack of trust among agencies as well as a belief within the community that the SAT would not respond to their opinions regarding service delivery. These issues have been overcome by the SAT engaging in real community consultation (eg regarding the Tier 1 service which was ultimately awarded to a community consortium).

- **Communication problems – SAT & Community forums:** The forums required a lot of development work & support to empower them and ensure they functioned effectively. Previously they saw themselves simply as "pressure groups" and they required to make considerable culture change.

- **Information sharing – organisational "preciousness":** The development of the information-sharing policy generated considerable resistance from some agencies. This may simply have reflected a fastidious approach to policy but can easily be related to agency preciousness.

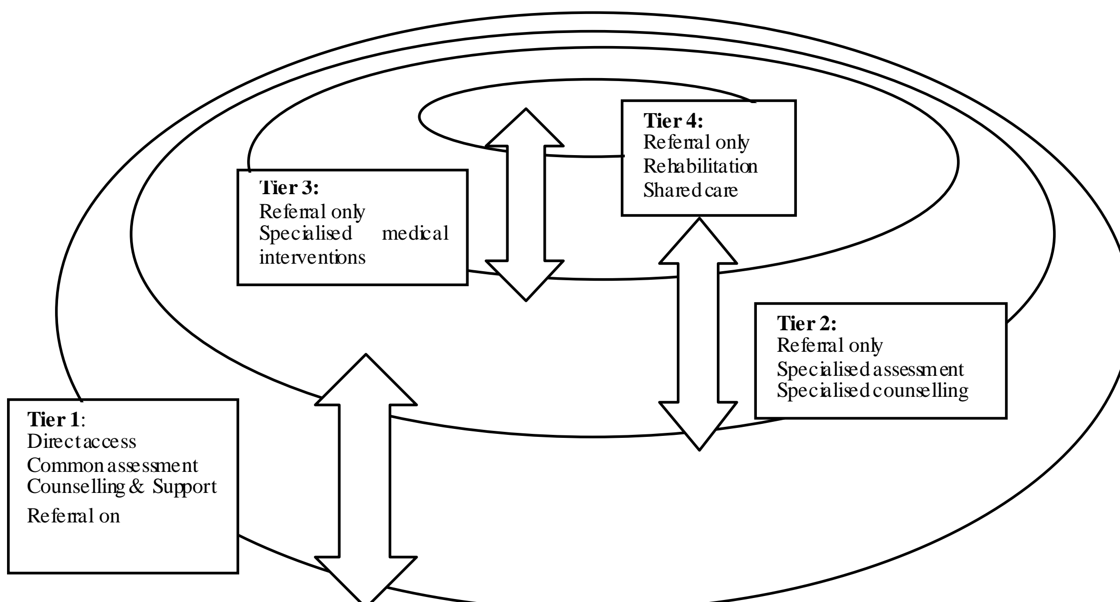
- **Over-commitment of a small number of key agencies:** with such considerable development there has been a need for agencies to be involved in many meetings - which can over-stretch staff.

- **National funded projects:** Nationally committed funds can appear in an area with no attempt to relate these to local planning or systems of service delivery. The SPS throughcare service is one example which has not been helpful in Forth Valley.

Conclusions

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

The Tiered Approach



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

Background

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

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

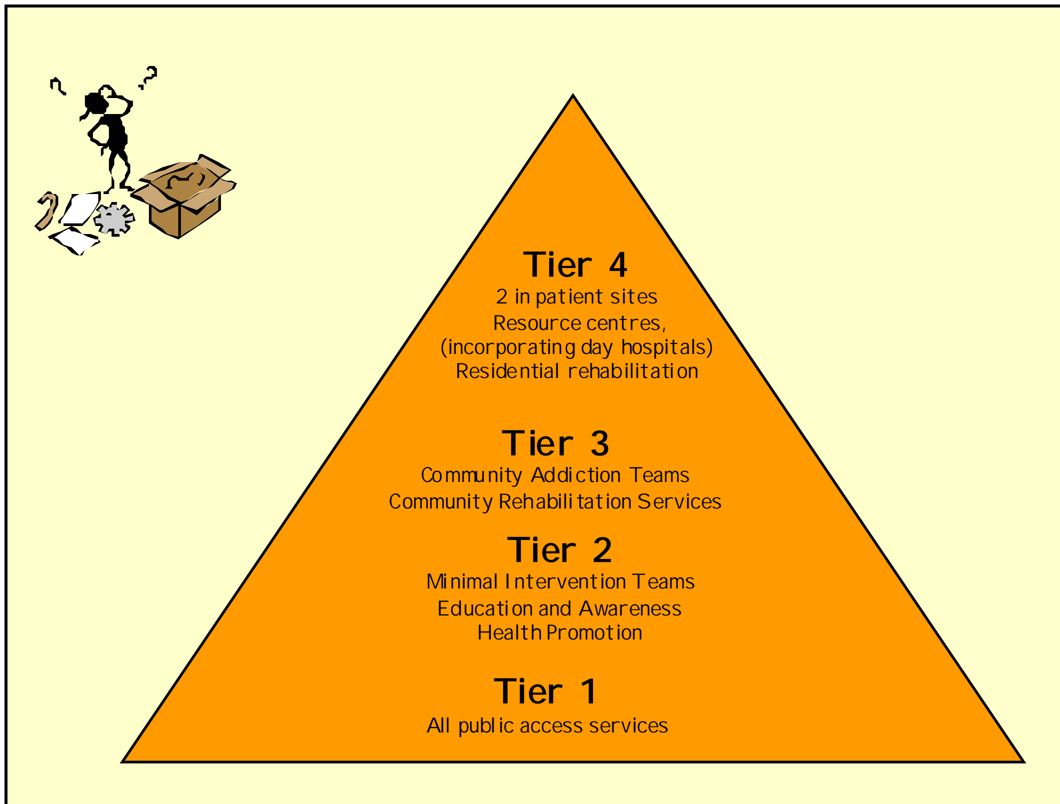
Further work is being undertaken in relation to developing a model for highly specialist treatment and care services within the Health Service and a review of services purchased from the independent sector is underway. Both these pieces of work are due to conclude later this year.

A Four Tier Model of Service Provision

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

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

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


Tier 4
2 in patient sites
Resource centres,
(incorporating day hospitals)
Residential rehabilitation
Tier 3
Community Addiction Teams
Community Rehabilitation Services
Tier 2
Minimal Intervention Teams
Education and Awareness
Health Promotion
Tier 1
All public access services

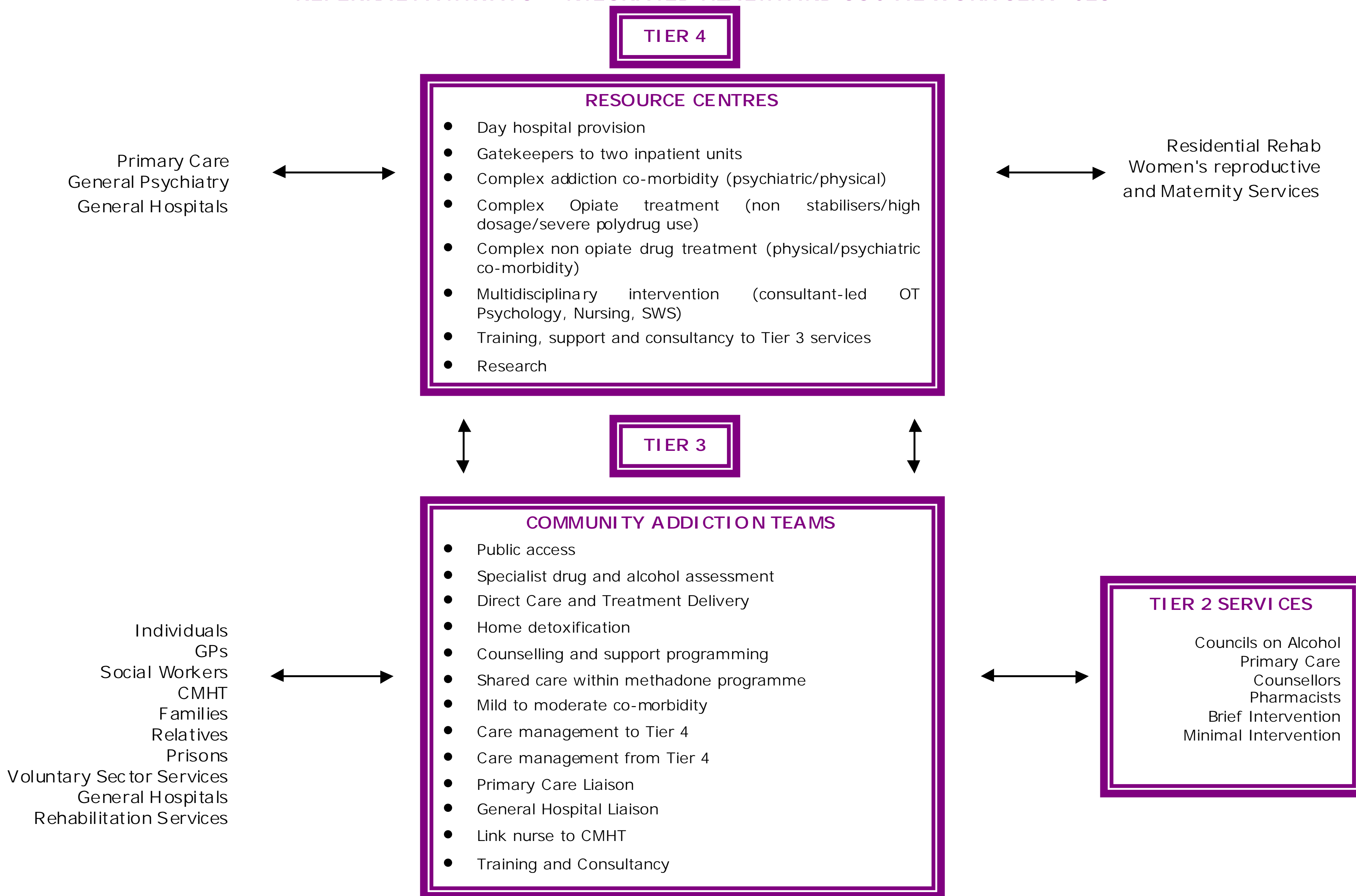
Tier 4 Services – highly specialist treatment and Care
Inpatient Residential care Resource Centres/Day Hospitals
WRHS Specialist Treatment Services GDCC Residential
Tier 3 Services - Specialist treatment and care
Community Addiction Teams GDCC One Stop Community Rehabillitation Services Needle Exchange
Tier 2 Services - Generic with specialist functions
GP's within shared care scheme Councils on Alcohol
Health Visitors Primary Care Counsellors
SWS Area Services Pharmacists (shared care)
Supported accommodation services
Tier 1 Services - generic services
GP's (outwith shared care) Pharmacists (non shared care)
Benefits Agency Housing
Complexity of need
Numbers of users

Community Addiction Teams

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

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

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


REFERRAL PATHWAYS - INTEGRATED HEALTH AND SOCIAL WORK SERVICES
TIER 4
RESOURCE CENTRES
Day hospital provision
Gatekeepers to two inpatient units
Complex addiction co-morbidity (psychiatric/physical)
Complex Opiate treatment (non stabilisers/high dosage/severe polydrug use)
Complex non opiate drug treatment (physical/psychiatric co-morbidity)
Multidisciplinary intervention (consultant-led OT Psychology, Nursing, SWS)
Training, support and consultancy to Tier 3 services
Research
Primary Care
General Psychiatry
General Hospitals
Residential Rehab
Women's reproductive
and Maternity Services
TIER 3
COMMUNITY ADDICTION TEAMS
Public access
Specialist drug and alcohol assessment
Direct Care and Treatment Delivery
Home detoxification
Counselling and support programming
Shared care within methadone programme
Mild to moderate co-morbidity
Care management to Tier 4
Care management from Tier 4
Primary Care Liaison
General Hospital Liaison
Link nurse to CMHT
Training and Consultancy
Individuals
GPs
Social Workers
CMHT
Families
Relatives
Prisons
Voluntary Sector Services
General Hospitals
Rehabilitation Services
TIER 2 SERVICES
Councils on Alcohol
Primary Care
Counsellors
Pharmacists
Brief Intervention
Minimal Intervention