

**NHS SCOTLAND HEAT PERFORMANCE
MANAGEMENT SYSTEM 2009-10**

**TARGET A11 - To offer drug misusers faster access
to appropriate treatment to support their recovery**

Guidance on Referral Pathways

Scottish Government

National Delivery Group

HEAT TARGET ON DRUG TREATMENT SERVICES: GUIDANCE ON REFERRAL PATHWAYS

Contents	Page
Introduction	<u>3</u>
Context	<u>4</u>
Core components for reducing problem drug use	<u>8</u>
Referral Pathways	<u>12</u>
Starting the clock	<u>23</u>
Annex A: Definitions	<u>26</u>

Introduction

This guidance, drawn up by the Scottish Government together with the Drugs HEAT target National Delivery Group, is intended to help Health Boards and their partners deliver a reduction in waiting times for services that help the recovery of individuals with problem drug use.

The Government expects that the guidance, setting out how to introduce a structured system of referral for drug treatment services, will be used in the following ways:

- as one of the key reference points for Health Boards and their partners (particularly with and in local Alcohol and Drug Partnerships) when drawing up local strategies and performance management frameworks to reduce problem drug use;
- as a foundation for the development, or amendment, of local referral pathways guidance;
- as a reference for the Scottish Government when discussing with Health Boards their trajectories and, ultimately, successful delivery of the HEAT target; and
- to determine when to 'start' and 'stop' the clock for the purpose of calculating waiting times.

We hope that this guidance is useful and look forward to working with you to help more individuals with problem drug use recover.

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Section 1: Context

1. This new HEAT target is being introduced at a time of significant change for Scottish drug treatment services. The Scottish Government's 2008 drugs strategy, *The Road to Recovery*, signalled a fundamental shift in how society should seek to reduce problem drug use, and called for services to work together actively to promote recovery and help individuals with problem drug use meet their aspirations.

Box 1: *The Road to Recovery*

The Scottish Government's drugs strategy, *The Road to Recovery*, was published in May 2008 and approved unanimously in the Scottish Parliament the following month. Tackling drug misuse more effectively, with an estimated £2.6bn cost to the country every year, will make a significant contribution to the Purpose of Government – providing opportunities for all to flourish and increasing sustainable economic growth – and to achieving several of the 15 national outcomes.

The strategy sets out a new vision where all drug treatment and rehabilitation services are based on the principle of recovery. This will only be achieved through changes to the way that services are planned, commissioned and delivered. At the same time, the strategy takes a broad approach to reducing future demand for drugs, recognising explicitly the strong links between tackling problem drug use and the Government's wider policies such as mental health, early years and growing the economy. Reducing the supply of drugs is also a vital part of the strategy, as is piloting the extension of Drug Treatment and Testing Orders (DTTOs) to lower tariff offenders, and improving treatment in prisons. The strategy also sets out in motion a programme of action to support children affected by substance misusing parents.

2. This is the first time that a target to reduce waiting times for drug treatment services has been incorporated in the HEAT system. It is based on the principle that individuals with problem drug use are entitled to the same level of care as other patients in the NHS. Treatment for drug use has been repeatedly shown to be effective in impacting positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses (BBVs). Reducing waiting times for these services will help maximise the chances of individuals' recovery from problem drug use in an area where the motivation of the individual is a key criterion for a successful outcome. Having services available at the point of need is critical.
3. Waiting times for drug treatment services are currently collated and published by NHS Health Scotland's Information Service Division (ISD). This resource – the Scottish Drug Treatment Waiting Times Framework – has been running since 2004. Data suggest that performance on waiting times is extremely variable, with the best performing areas showing, for example, an average wait from referral to assessment of 2 weeks, and the worst, of more than a year. However, comprehensive analysis of the patterns and trends involved has not been attempted due to endemic problems of poor data quality: it is not clear if (or what proportion of) the perceived long waits are due to poor

data rather than capacity to respond. Improving the quality of data supplied is therefore a key part of the developmental phase of this HEAT target and has begun with an audit of waiting times data during April – June 2009. Weaknesses have been identified and appropriate training is being delivered ahead of target implementation. ISD expect that the data is of good enough quality to set viable targets for 2010/11.

4. It will be important for NHS Boards to understand fully the wider context of reforms to delivery of drug treatment services. The new HEAT target is being introduced as part of a wide range of measures to implement the 2008 drugs strategy. Other measures include:
 - reform and improvement of partnership arrangements to oversee local strategies, commissioning and performance management of services as outlined in the, *New Framework for Local Partnerships on Alcohol and Drugs* report published in April 2009;
 - an expectation from Government that partners will plan and commission local drug treatment services on the basis of effectiveness, value and locally identified need, monitoring them on the basis of outcomes;
 - the development of greater national support from Government to local partners to assist with change management and the implementation of the drugs strategy;
 - the provision of significant additional resources available to Health Boards for tackling drugs by the Scottish Government; and
 - The establishment of eight Community Justice Authorities in Scotland, under the Management of Offenders etc (Scotland) Act, 2005 which charged local authorities, police forces and health boards to cooperate in the production of and compliance with, Area Plans for reducing reoffending.
5. The drugs strategy is clear that a wide range of services must be available, at the point of need, to individuals with problem drug use, to support their recovery. The range of services required will be significant and will need to take cognisance of the needs of dependent children and carers. For an individual drug user's complex and challenging needs to be met, a full range of high quality services must be available at the point of need. This complexity is recognised in the 2007 updated *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (the so-called 'Orange Guidelines'). The Guidelines state that a range of treatment goals will ordinarily be associated with recovery from drug use, including both harm reduction measures and, where appropriate, abstinence. It is rare that one service will be able to meet these needs in isolation. It is therefore important that a comprehensive assessment be conducted that relates to all the conditions and presenting issues associated with problem drug use – not just the addiction itself.

Box 2: Drug Misuse and Dependence: UK Guidelines on Clinical Management

The 'Orange Guidelines' provide guidance on the treatment of drug use in the UK and are based on current evidence and professional consensus on how to provide drug treatment for the majority of patients, in most cases.

They emphasise the need for both pharmacological and psychosocial treatments for drug users, with individual care plans and co-ordination of care across professional groups, including health and social care.

They focus on care of the individual drug user, but also acknowledge the importance of considering the impact of their drug use on others, especially dependent children and on communities.

The Government strongly supports these Guidelines as the basis on which clinicians and other professionals should consider the treatment of patients with problem drug use.

6. Building on the 'Orange Guidelines', the 2008 *Essential Care* report from the Scottish Advisory Committee on Drug Misuse (SACDM) sets out the full range of services required to address an individual's physical, psychological and social functioning and give them the best chance of pursuing their recovery. The Scottish Government has endorsed this approach and will build on this through its commitment to updating statements of essential services on alcohol and drugs.
7. In some parts of Scotland, this new approach will require significant change. It is essential that the new HEAT target helps the NHS and its partners reinforce this fundamental shift. At the same time as reducing waiting times, services need always to maintain the needs of the individual as their primary focus. There is potential for tension between these requirements.
8. While HEAT is a Health Board target, it is important that there is a whole-system approach to reducing waiting times for individuals with problem drug use. Data will therefore continue to be collated and monitored for all tier 3 and tier 4 drug treatment services with a view to reducing waiting times for them all.
9. The new HEAT target must be something that helps introduce a new dynamism into services, and encourages people to move along their recovery journey. Referrals must be based on clinical need and the aspirations of the individual. Achieving this goal and meeting the HEAT targets will make a very significant positive impact on the drive to reduce problem drug use in Scotland.

Key points

- The drugs strategy signals a fundamental shift towards promoting recovery.

- Currently, waiting times for services are too long in many parts of Scotland. Treatment is successful, for those able to access it, but individual motivation is key. Access at the point of need is essential.
- Understanding the reform of delivery arrangements for drug treatment services is essential to delivering the HEAT target.
- A range of services will need to be in place at the local level to promote recovery.

Box 3: SACDM Report on *Essential Care*

The *Essential Care* report, prepared by a sub-group of SACDM, was published on 26 March 2008. This built on earlier work, including the *key document, Reducing Harm and Promoting Recovery: a Report on Methadone Treatment for Substance Misuse in Scotland (2007)*.

The report highlighted a number of important principles for reform of service delivery, including:

- recovery should become the focus of care;
- assessment and recovery plans should address the totality of people's lives; and
- people with substance use problems have aspirations, and should have access to the same services as anyone else.

The report also set out comprehensively the range of services to which people with problem drug use need access, in order to remove obstacles to recovery.

Section 2: Core components for reducing problem drug use

10. This chapter describes the core components for reducing problem drug use at the local level. It will look at governance; needs assessments; local strategies; whole systems approaches; outcomes-based commissioning; and monitoring. An understanding of these issues is essential for effectively delivering the HEAT target. Health Boards need to put in place arrangements that match these recommendations, to the extent that they are not already there.

Governance

11. Health Boards should play a central role in the arrangements for planning and funding drug treatment services at the local level. The Scottish Government, COSLA and the NHS have produced a joint response to the December 2008 report from the SACDM/SMACAP Delivery Reform Group. Health Boards will need to take cognisance of the operational implications of the, *New Framework for Local Partnerships on Alcohol and Drugs*, published in April 2009.
12. The Framework clearly states that Health Boards are accountable for their performance directly to Scottish Ministers. Each year Boards submit Local Delivery Plans (LDPs) which set out work against HEAT targets and how they will achieve them. The LDPs are agreed with Government and form an annual “performance contract” for which NHS Board Chairs and Chief Executives are held accountable directly by Ministers. In addition, annual visits will be held between the Scottish Government and Health Boards to discuss progress against the HEAT target and other related issues.
13. Alcohol and Drug Partnerships (ADPs) – their chairs and support officers – will have a key role to play in helping Health Boards achieve the targets set out under HEAT. We recommend that Health Board leads for the drug treatment HEAT target make early contact with their ADP representatives and work closely with them.

Needs assessment

14. A vital function for ADPs is the development of comprehensive local needs assessments. Health Boards should work with local partners through the ADP to:
 - estimate local prevalence, including pattern of drug consumption. This will be informed by national studies, such as the 2006 report estimating the national and local prevalence of drug misuse (and its 2009 successor which, at time of going to print, was expected in the autumn of 2009);
 - conduct surveys of drug users, their families and local communities. The information so gathered should complement prevalence data to provide a richer picture of local drug use; and

- draw up information on local workforce recruitment, retention and development needs.
15. Mapping an assessment of need against current levels of service provision and workforce capacity will therefore be an essential part of planning a strategic approach in each area. It will also be an integral part of planning and implementing this HEAT target.

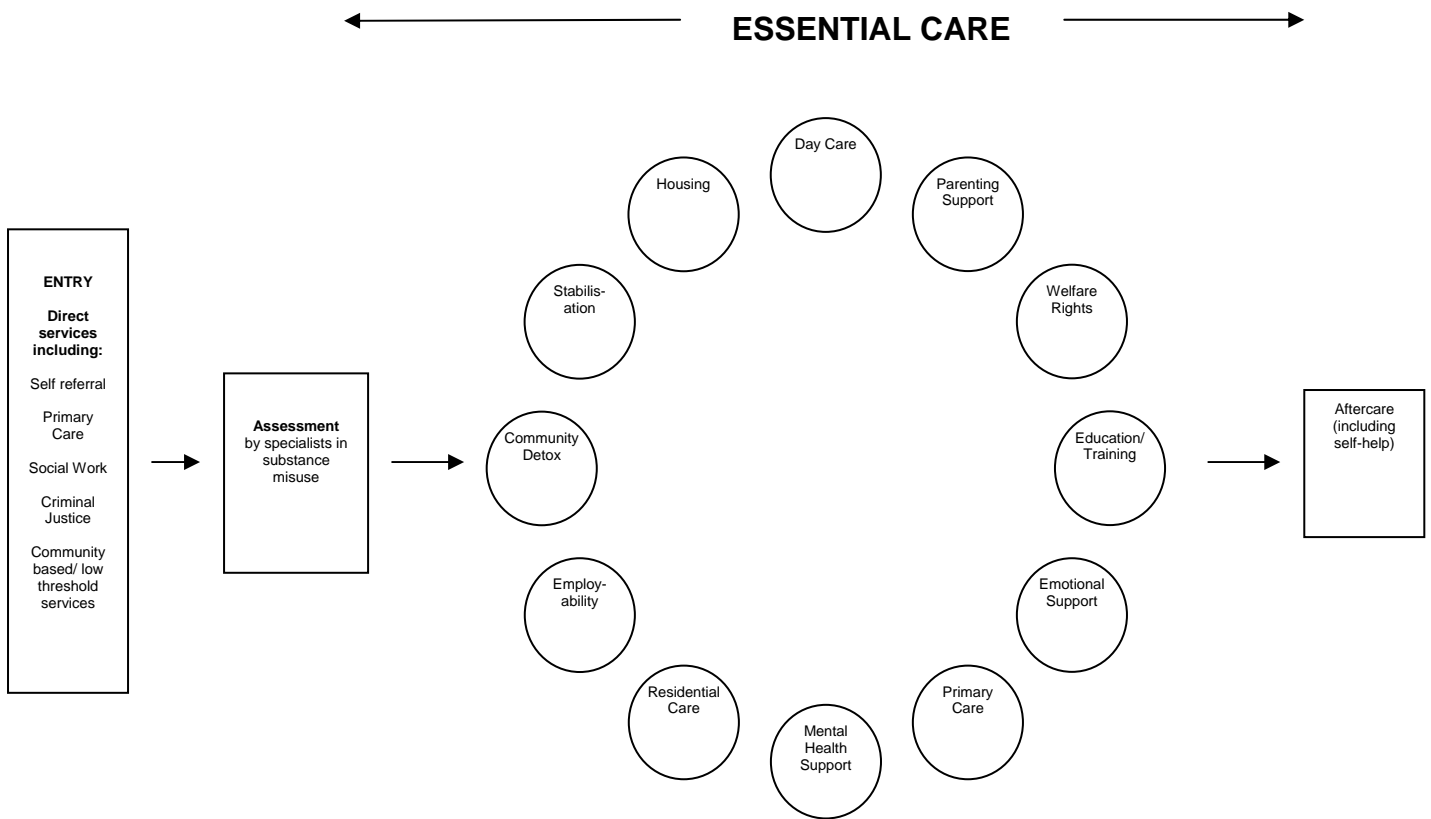
Strategy

16. Each ADP should work to develop a local strategy. This should set out the outcomes the strategy will deliver, and their contribution to outcomes detailed in Community Planning Partnership Single Outcome Agreements. The strategy should clearly set out the respective roles of partner agencies in the NHS, local authority and voluntary sector and their responsibilities. It will include outcomes and measures relating to prevention, communication, community resilience and child protection, as well as more traditional treatment interventions.

Whole system approach

17. It is highly desirable that local strategies be conceptualised and visualised in terms of a 'whole system'. This would map service provision in terms of a care or recovery pathway, leading dynamically through recovery and to abstinence, where appropriate. A visual depiction of this would add value for local strategists in ADPs, but also for service commissioners and individual practitioners, who will be able to see and understand their respective roles in the overall treatment system. This will be particularly valuable for those practitioners working at system 'entry points' (e.g. GPs) who will have a better understanding of the possibilities for referral. It could also inform and empower service users, giving them a sense of hope and what is possible.
18. Box 4 suggests a hypothetical system map. It is expected that each ADP will develop their own map, if they have not done so already, reflecting their local recovery pathway.

Box 4: Recovery Oriented Pathways for Individuals with Problem Drug Use



The pathway above reflects the SACDM Report on *Essential Care* and highlights the range of services that individuals with problem drug use may require to enable their recovery. As problem drug use is a relapsing condition, individuals will re-enter the pathway, but with the aim of moving onwards, and being enabled to achieve their aspirations and goals.

19. A main focus of energy, resource and service provision has been on engaging clients in treatment with a view to stabilising their drug dependency and lives as a whole. The challenge for ADP partners will be to ensure that services are in place that play to their own strengths and are committed to supporting individuals with problem drug use through the whole recovery pathway. The pathway must work as one to provide clients with hope and enable them to achieve their full potential. Work is therefore required to develop a 'recovery focused' culture within the substance misuse workforce and substance misusing community so that there is an active commitment to enabling clients to achieve a substance-free life and become an active and contributing member of society. Work is currently underway to develop an alcohol and drugs workforce development strategy which will be published during 2009. It is intended that this will help ensure the enhanced capability of the substance misuse workforce around identified priorities, including recovery.

Commissioning/Outcomes/Monitoring

20. With a strategy established and a system mapped, services should be commissioned. This should be done squarely on the basis of outcomes – i.e. each service will be commissioned to deliver certain outcomes within the context of the overall system or pathway. Data on performance in delivering these outcomes will be collected, alongside waiting times, to allow commissioners and ADPs to monitor effectiveness and best value. It is expected that waiting times and outcome reporting will be built into any contracts or service level agreements of any drug treatment services commissioned by ADPs, NHS Boards and local authorities.
21. As suggested in *Essential Care*, while many services will be provided from within the locality, there may be a strong case for provision of services on a regional or even national basis. These could include in-patient detoxification programmes and residential rehabilitation.

Key points

- Understanding and implementing the reforms to local alcohol and drug governance arrangements is key for delivering the HEAT target
- Alcohol and Drug Partnerships will play a key role in supporting Health Boards deliver the target
- An understanding of the whole system in place at the local level is essential for strategists, practitioners and service users
- Services should be commissioned on the basis of outcomes they can deliver

Section 3: Referral Pathways

22. This chapter describes how referral decisions should be based on clinical need. As described in section 2, the range and availability of services should be sufficiently broad to respond to the potentially wide-ranging and complex nature of this client group's health and social care needs. Health Boards and ADPs need to ensure that this range of services is in place.
23. Many administrators have found it convenient and useful to consider drug treatment services in terms of 'tiers' or 'phases'. These often reflect the stages of a person's recovery journey, from crisis to stabilisation to psychosocial interventions to wider services, such as training or pre-employment. The English National Treatment Agency (NTA) use 4 tiers when discussing drug treatment services as shown in the box below. For the purposes of this HEAT target, we suggest that Health Boards also think in terms of these 4 tiers.

It is important to recognise that access to services as defined in the HEAT target, relates only to access to tiers 3 and 4.

Box 5: NTA Models of Care 4 tier system

Tier 1: Drug-related information and advice, screening and referral by generic services

Tier 1 interventions take place within setting of universal services, such as general healthcare, social care or criminal justice settings. They include drug treatment screening and assessment, referral to specialised drug treatment and drug advice and information.

Increasingly, the entry point into treatment is through non-specialist services, such as homeless services, community or practice nurse, pharmacist or social worker. Many initial contacts with services are prompted by an interaction with the criminal justice system (see below). Presentation may be directly connected with drug taking, a complication of drug use, or as an incidental finding. It is often the result of an individual crisis in a person's life that prompts them to seek help (or have help offered to them in the case of criminal justice social work interventions).

Access to tier 1 services will not form part of this HEAT target.

Tier 2: Open access, non care-planned drug specific interventions

Tier 2 includes provision of drug-related information and advice, referral to structured drug treatment, brief psychosocial interventions and harm reduction interventions (e.g. needle exchange). Settings will often be the same as tier 3, but there may in addition be access through pharmacies or criminal justice settings.

Access to tier 2 services will not form part of this HEAT target.

Tier 3: Structured, care-planned drug treatment

Tier 3 includes provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison. This would include comprehensive drug misuse assessment, care planning, a range of prescribing interventions in the context of a package of care, a range of psychosocial interventions. These would normally be delivered within specialised drug treatment services in their own premises in the community or on hospital sites. Primary care and criminal justice settings are also typical.

Comprehensive guidance on assessment of individuals with problem drug use is set out in the Orange Guidelines. This recognises that assessment may be a process that lasts several sessions, possibly involving a number of professionals. It will address immediate concerns and assess risk. This will also be the point at which practitioners are expected to record information for the Scottish Drugs Misuse Database (SDMD).

Single Shared Assessment (SSA) remains a key element of the Scottish Government's Joint Futures agenda. SSA integrates assessment and service delivery across professions and agencies bringing together referral, assessment, planning for care and service delivery into the one shared process. The aim is that assessment and subsequent care planning is person-centred, needs led, co-ordinated and effective. SSA should result in easier and quicker access to appropriate services.

The National Minimum Information Standards (NMIS) for all adults have evolved from the original SSA guidance ([Circular CCD8/2001](#)) and cover assessment, shared care and support plans and review. It also includes NMIS for the identification of needs and support for Carers ('Carers Assessment/Support Plan'). The Standards complement the guidance on care management issued by the then Scottish Executive in 2004 ([Circular CCD8/2004](#)) and, subsequently, the Care Management Framework published in 2006 ([Circular CCD2/2006](#)). Development of the Standards, including those for carers, have clear links with the Community Care Outcomes Framework and support the approach objectives and their measurement.

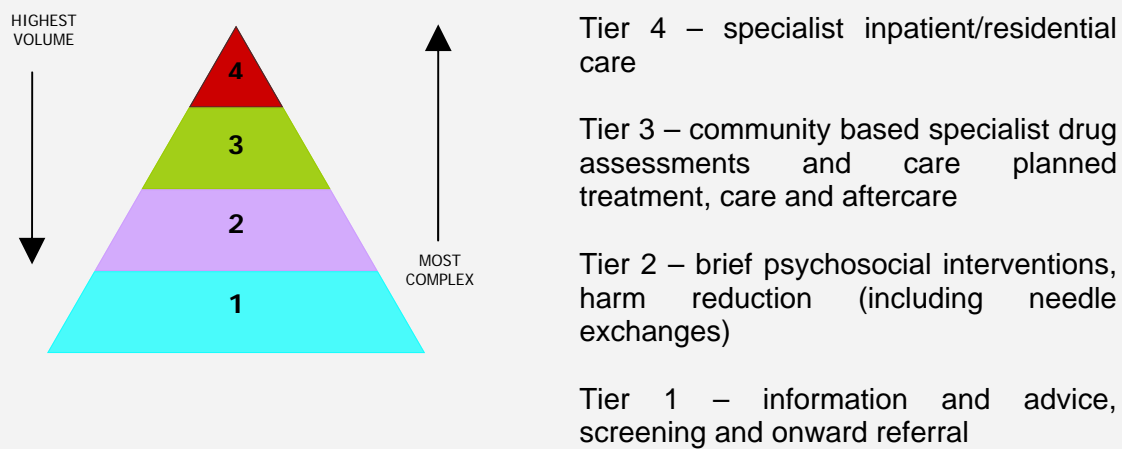
National Minimum Information Standards for Assessment and Care Planning for Adults provided an updated version of the NMIS for assessment and introduced new standards for shared care and support plans, and for reviews. All partnerships were asked to ensure that they were operating the updated guidance, at least within their paper systems, by March 2009 ([Circular CCD3/2008](#)).

Tier 3 interventions include substitute prescribing. *The Road to Recovery* recognises that there is a continuing role for substitute prescribing as a main plank of the Scottish approach to opiate dependency. However, the strategy also calls for a more aspirational approach to substitute prescription maintenance, that recognises the importance of providing additional, integrated care that will help people move on their recovery journey and achieve outcomes. This is also recognised both in the Orange Guidelines and in the NTA Models of Care guidance. In other words, although important, substitute prescribing on its own is not enough, nor should it be seen as the only option for treatment of opiate users.

Tier 4: Drug specialist inpatient treatment and residential rehabilitation

Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare. These will include inpatient specialist assessment, stabilisation and detoxification; a range of rehabilitation units; a range of supportive accommodation; and provision for special groups, such as pregnant women, individuals with co-occurring mental health and drug problems. Settings will include dedicated inpatient or residential substance misuse units or wards.

This tiered approach can be summarised as follows:



Integrated Care Pathways

24. Section 2 set out the need for local planners and commissioners to work through ADPs to map out an integrated or whole system of services to respond to local need. This should reflect adequate access to the 4 tiers described above.
25. Drug addiction tends to be a chronic condition, which can be marked by frequent relapse. It is not intended that any recovery pathway be regarded as linear in nature, with a necessarily smooth progression from one tier to another. Nevertheless, a sense of dynamism and movement from access to referral to treatment to discharge and return to the community is essential, both to achieve outcomes and also for the achievement of this HEAT target. The nature of this movement will depend on effective recovery planning and the input of the service user themselves. Movement will usually involve transition between sectors and professional settings, and therefore a sense of working to integrated pathways will be important.

Recovery planning and service users

26. From the perspective of the service user, agreeing a recovery plan with a service user is an integral part of mapping out an individual's pathway against the overall care system. The Orange Guidelines state that care plans should cover drug and alcohol use, physical and psychological health, criminal involvement and offending and social functioning. This wide range of need will nearly always require practitioners to have input or facilitate referral to a range of other professionals. This will often include access to generic mainstream services, such as general practice. Recovery plans must be holistic and address the totality of peoples' lives, including the roles of families and needs of any dependent children or vulnerable people. This is likely to require the sharing of information with partner agencies and, where not in place, the development of agreed protocols for that process.
27. It is also recommended that assistance be offered to service users to oversee their recovery journey through the pathways. Different models are available to achieve this, but minimising the points of contact throughout a person's whole recovery journey would be the optimal solution. This would further empower service users to express their views on the success of their journey, as well as build in added resilience to deal with inevitable relapses. Keyworkers can also help address social needs and provide information, e.g. in relation to accessing benefits.
28. This is explicitly addressed in the revised Orange Guidelines, which state that 'there may be several clinicians involved in the patient's treatment – these should be named in the recovery plan along with a clear identified lead clinician.' It is also important that the shared responsibilities of the relevant health staff and other disciplines are clearly set out in the recovery plan.
29. The active role of the service user in drawing up their recovery plan has been repeatedly emphasised in guidance. The Orange Guidelines note that service users 'must be involved in their own treatment and should be involved in planning, developing, designing and delivering local drug treatment services, as far as their competence and interests allow.' Involving service users is good practice and helps achieve better outcomes.
30. Pathways should also include the need to address general health considerations, such as reducing the potential harm due to overdose, BBVs and other infections. Individuals with problem drug use who are misusing alcohol or smoke tobacco should be offered alcohol treatments and smoking cessation interventions respectively.

Referral

31. It is essential that clinicians, practitioners and other professionals involved in providing treatment on the recovery pathway have up to date knowledge of the possible treatments and services available in the local area. The most appropriate services for the individual will ordinarily be set out in the recovery plan, but a general awareness will be essential to allow clinicians and key

workers to make adjustments, in consultation with the individual. We would expect, therefore, each ADP to make widely available to practitioners the systems map suggested in section 2, illustrated hypothetically in box 4.

32. Thereafter, referrals should be on the basis of health and social care needs. It will be for the individual clinician or practitioner to take a view on the readiness of the service user to proceed to the next recovery episode, in conjunction with the user themselves. This may be across professional or sectoral boundaries (e.g. from a NHS-based service to a local authority one). The ease with which this is possible will depend on the strength of local governance arrangements and the awareness and training of the professional.
33. In keeping with *The Road to Recovery*, the Scottish Government expects that each recovery journey will involve a sense of dynamism and movement. In other words, referrals should encourage flow through the system (based on professional judgement) rather than a static maintenance. The health of the system overall (and the effectiveness with which waiting times targets are met) will depend on this flow, including across sectoral boundaries. We would expect to see ADPs to work closely with Health Boards to ensure this movement, and commission and monitor services on the basis of their success in meeting outcomes that generate dynamism.
34. To assist with that, the National Delivery Group will publish in due course further hypothetical treatment system models, populated with indicative times for treatment in each episode. This will be based on the data collected in 2009/10 to inform the waiting times target, as well as clinical best practice. It will also be consistent with the eventual waiting times target set for referral to assessment, and assessment to date of first tier 3 or tier 4 treatment.

Measuring referral outcomes: Treatment modalities

35. For purposes of data collection and policy analysis, it is important to be able to record – with a degree of precision – referral outcomes. In other words, to be able to say how many people in a given area have been referred to a certain type of service (or ‘modality’).
36. The Scottish Waiting Times Framework (SWTF) currently defines four treatment modalities, numbered from (1) to (4):
 - (1) Structured preparatory and motivational intervention (MI)
 - (2) Prescribed drug treatment (including detoxification, maintenance or reduction programme)
 - (3) Community based support and/or rehabilitation
 - (4) Residential detoxification and rehabilitation
37. Given the constraints of time and the practical difficulties of adjusting these definitions, we intend to retain them for the developmental phase of the HEAT target (i.e. until April 2010). Thereafter, we propose moving to the modality definitions employed by the NTA. The principal reason for doing this is the

additional richness of the NTA definitions, which better capture some of the subtle – but important – differences between treatment settings (e.g. between different prescribing settings). Feedback for the NTA’s definitions has been positive in England; it could also – in time – allow for a degree of comparison which could be instructive for both administrations.

38. The NTA define 7 treatment modalities and these are identified below, from (a) to (g). The NTA guidance notes offer very detailed descriptions of these modalities ([National Treatment Agency\(NTA\) Waiting Times Guidance](#)).
39. The two sets of treatment modalities map against each other in a straightforward way (although more detailed, most NTA treatments fall into SWTF categories) with the exception of (d) GP prescribing and (f) inpatient treatment.

SWTF	NTA
(1) Structured preparatory and motivational intervention (MI)	(a) Structured psychosocial interventions
(2) Prescribed drug treatment (including detoxification, maintenance or reduction programme)	(b) Community prescribing (c) Specialist prescribing (d) GP prescribing – not currently recorded on the SWTF
(3) Community based support and/or rehabilitation	(e) Structured day programmes (f) Other structured drug treatment, i.e. <ul style="list-style-type: none"> • Second stage’ rehabilitation in drug-free supported accommodation where a client often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a care plan, and receive key-work and a range of drug and non-drug-related support • Other supported accommodation, with the rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different nearby sites(s)
(4) Residential detoxification and rehabilitation	(f) Residential detoxification and rehabilitation, i.e. <ul style="list-style-type: none"> • Residential drug and alcohol crisis

	<p>intervention services (in larger urban areas)</p> <ul style="list-style-type: none"> • Inpatient detoxification directly attached to residential rehabilitation programmes • Residential treatment programmes for specific client groups (e.g. for drug-using pregnant women, drug users with liver problems, drugs users with severe and enduring mental illness) • Some drug-specific therapeutic communities and 12-Step programmes in prisons
	<p>(g) Inpatient treatment: generic hospital based services as follows not currently recorded on the SWTF</p> <p>Inpatient drug treatment interventions usually involve short episodes of hospital-based (or equivalent) drug and alcohol medical treatment. This normally includes 24-hour medical cover and multi-disciplinary team support for treatment such as:</p> <ul style="list-style-type: none"> • Medically supervised assessment • Stabilisation on substitute medication • Detoxification/assisted withdrawal from illegal and substitute • Drugs and alcohol in the case of poly-dependence • Specialist inpatient treatments for stimulant users • Emergency medical care for drug users in drug-related crisis

Information Sharing

40. Effective integration and smooth referral pathways will require information sharing. The Orange Guidelines recognise that this can be of great value to the direct care of individual service users and may also contribute indirectly to the delivery and effectiveness of the drug treatment system. Clinicians need to comply with NHS rules and any additional national guidance. ADPs should work closely with local partners to develop and implement appropriate information sharing protocols.

Children affected by Substance Misuse

41. The need for all drug treatment services to address the needs of children of parents with problem drug use is clearly outlined in *Getting Our Priorities Right*, *Hidden Harm* and *Road to Recovery*. In response, Child Protection Committees have a responsibility to develop local inter-agency guidelines recognizing the risk posed to children affected by substance misuse. Reducing waiting times for drug treatment services must be considered in the broader context of these documents.
42. A significant minority of young people under the age of 18 experiment with or use illegal drugs occasionally. Even fewer young people use drugs regularly to the extent that it has a negative impact on their lives. For those young people for whom substance misuse is a problem, the Orange Guidelines highlight that rapid improvements can be made if engaged in the right interventions, due to the shorter history of substance misuse. The need for young people to have specialist treatment, at the time of need, is therefore essential and must be delivered, as the Orange Guidelines state, in the context of a broader package of care that involves mainstream health, education and other children's services. The HEAT target will apply to young people accessing tier 3 and tier 4 specialist drug treatment services.

Relapse

43. If a service user has successfully completed treatment, they still may have ongoing needs to prevent relapse. Many individuals with problem drug use relapse and it is important that they can gain speedy access back to drug treatment if they do. The HEAT target will also apply to drug users who have relapsed and therefore require to re-access services in a way that sustains their motivation and their recovery.

Criminal justice

44. Those who use drugs often also commit crimes (most commonly to fund an addiction, where their often chaotic lifestyle does not support paid employment). Individuals with problem drug use may come into contact with, and increasingly be offered treatment in, the criminal justice system at various points. Clinicians need to understand the nature of these interactions and, considering the statutory nature of the treatment provision within the criminal justice setting (including as a condition of a Probation Order, Parole Order,

(DTTO) and Enhanced Probation Order), where their involvement lies. As the Orange Guidelines recognise, individuals with problem drug use in the criminal justice system should neither receive higher priority, nor should their legal status deny them access to care equivalent to that available in the community.

45. Attention will need to be given to the transitional or exit arrangements which will be required to be put in place as an offender moves from legally mandated treatment to other community provision. These transition or exit arrangements should be developed as part of the recovery plan.
46. The criminal justice system is used to engaging 'hard to reach' groups. Rather than being seen as a coercive intervention, it can be better viewed as opportunistic, engaging with people when they come in contact with the criminal justice system at a time of crisis. Given the nature of the criminal justice system in Scotland, different drug treatment interventions have been targeted at different stages of the criminal justice system.

Arrest

47. At the point of arrest, formal Diversion Schemes and Arrest Referral Schemes may be available. These schemes target alleged offenders either at the point of arrest or prior to prosecution, and can provide basic harm reduction information, refer onto other agencies and liaise with specialised support services.

Sentencing

48. At the point of sentencing, as an alternative to custody, DTTOs, Drug Courts (Fife and Glasgow) and the Fast Track Programme in Forth Valley target people with a prolific criminal history and an associated extensive substance use problem. Through an intensive form of intervention, using a multi-disciplinary approach monitored within the criminal justice system, these services impact by reducing substance use and related offending behaviour.

Custody

49. When a custodial sentence is imposed, the Scottish Prison Service (SPS) provide a range of interventions. Historically, the SPS detoxified prisoners on admission and provided for their health needs within custody. Increasingly, methadone is being prescribed in the prison setting and this has been shown to be of benefit for those in receipt of this medication.
50. Since 2004 the SPS has promoted a single model of delivery of interventions and activities and to ensure consistency across all establishments these areas have been branded 'LINKS Centres'. Within the LINKS Centre, staff and external partners use the Integrated Case Management (ICM) process, encouraging prisoners to engage in the development of a Community Integration Plan (CIP). Prisoners identified with problem substance use often have a range of issues to address. ICM facilitates an integrated package of

treatment and care, whereby the CIP aims to provide purpose to the individuals' time in custody by sequencing interventions appropriately according to risk, need and responsiveness.

Release and continuing care

51. The Throughcare Addiction Service (TAS), provided by local authority criminal justice social work in the community, aims to facilitate access to addiction services and other community-based support services. The term 'throughcare' is used to denote the provision of a range of services to prisoners and their families from the point of sentence up to and following release into the community. These services are primarily focused on assisting prisoners to prepare for release, and to help them to resettle in the community.
52. TAS seeks to engage prisoners at least six weeks prior to release from custody, to motivate them to address substance use and associated problems, and link them into community-based resources upon release. The service continues through the six-week period post release. During this period, the TAS worker will seek to motivate the offender to address their difficulties, provide them with information on how to avoid further problem substance use and offending, and link them into appropriate community based services.

HEAT and Criminal Justice

53. It is desirable in theory that the HEAT target applies to individuals with problem drug use who have engaged with treatment in a criminal justice setting. In practical terms, particularly on, for example, liberation from prison, speedy access to services can reduce re-offending, assist with re-integration and also offset the considerable risks of overdose or even death. This was recognised in the Scottish Government's report on health inequalities, *Equally Well*, which called for offenders who have engaged in the TAS to be assessed and able to access addiction services within six weeks of release.

Key points

- For the purposes of the HEAT target, it is proposed to adopt the NTA model of 4 tiers of services. This HEAT target will only apply to referrals to tier 3 or tier 4 services.
- Referrals should be on the basis of health and social care needs and involve seamless transitions within and between local treatment systems. This will involve a high degree of integration between NHS, Local Authority and voluntary sector services.
- A high degree of service user input into their recovery plan is important and delivers better outcomes.

- Guidance will be issued in due course on indicative, 'typical' times for each treatment episode.
- The HEAT target will also apply to service users accessing services after relapse.
- The Scottish Government will work to resolve the practical obstacles that currently prevent the inclusion of waiting time information in relation to treatment and the criminal justice system.

Section 4: Starting the Clock

54. This chapter gives a technical explanation of how and when the clock is started and stopped for the purpose of measuring this HEAT target. It should be read in conjunction with Annex A on definitions.

Measuring Waiting Times

55. There are two perspectives from which we can measure waiting times: (1) the perspective of the service (which measures service capacity), and (2) that of the client (which measures the 'true' client wait).
56. The waiting times framework currently only measures (1). It does **not** record the date the client was referred to the specialist service and nor does it record the date the client actually begins treatment i.e. it cannot measure how long a client waits from referral until they actually begin treatment.
57. As part of the development of this HEAT target, we intend to pilot and alter the data collection system to allow this to happen. However, this will not be before 2011/12 – a year after the target 'goes live'. In the meantime, for the purposes of establishing a baseline – and as the only available proxy for actual client wait – we will be continuing the practice of the existing Waiting Times Framework. In summary:

Developmental Phase: April 2009 to March 2010: Development of data definitions, referral pathways, quality assurance procedures; baseline data and target trajectories

Phase 1: April 2010 to March 2011: Waiting time from service perspective.

- a) As now, we will measure waiting times from the date of referral received to the first reasonable appointment date offered for assessment.

Clock starts: Date referral received /first contact Clock stops: First appointment date offered for assessment

- b) We will also measure waiting times from date of assessment (see Annex A for definition) to first Tier 3 or Tier 4 treatment date offered

Clock starts: Date of assessment Clock stops: First treatment date offered

Phase 2: April 2011 onwards waiting time for clients

In addition to Phase 1 data:

a) We will measure waiting times from the date of the referral being made/received¹ to the date assessment begins

Clock starts: Date referral received /first contact
Clock stops: Date assessment begins

b) We will measure waiting times from the date of assessment to the date an individual commences Tier 3 or 4 treatment. The date of the first treatment appointment the client actually attends should be recorded as the 'modality start date'.

Clock starts: Date of assessment
Clock stops: Date an individual commences recovery-planned, structured treatment following triage/ assessment.

c) We will measure waiting times from the date of referral being received to the date the first appointment date offered to a client to initiate the first treatment intervention identified.

Clock starts: Date referral received/first contact
Clock stops: Date an individual commences recovery-planned, structured treatment following triage/ assessment.

Discharge Date

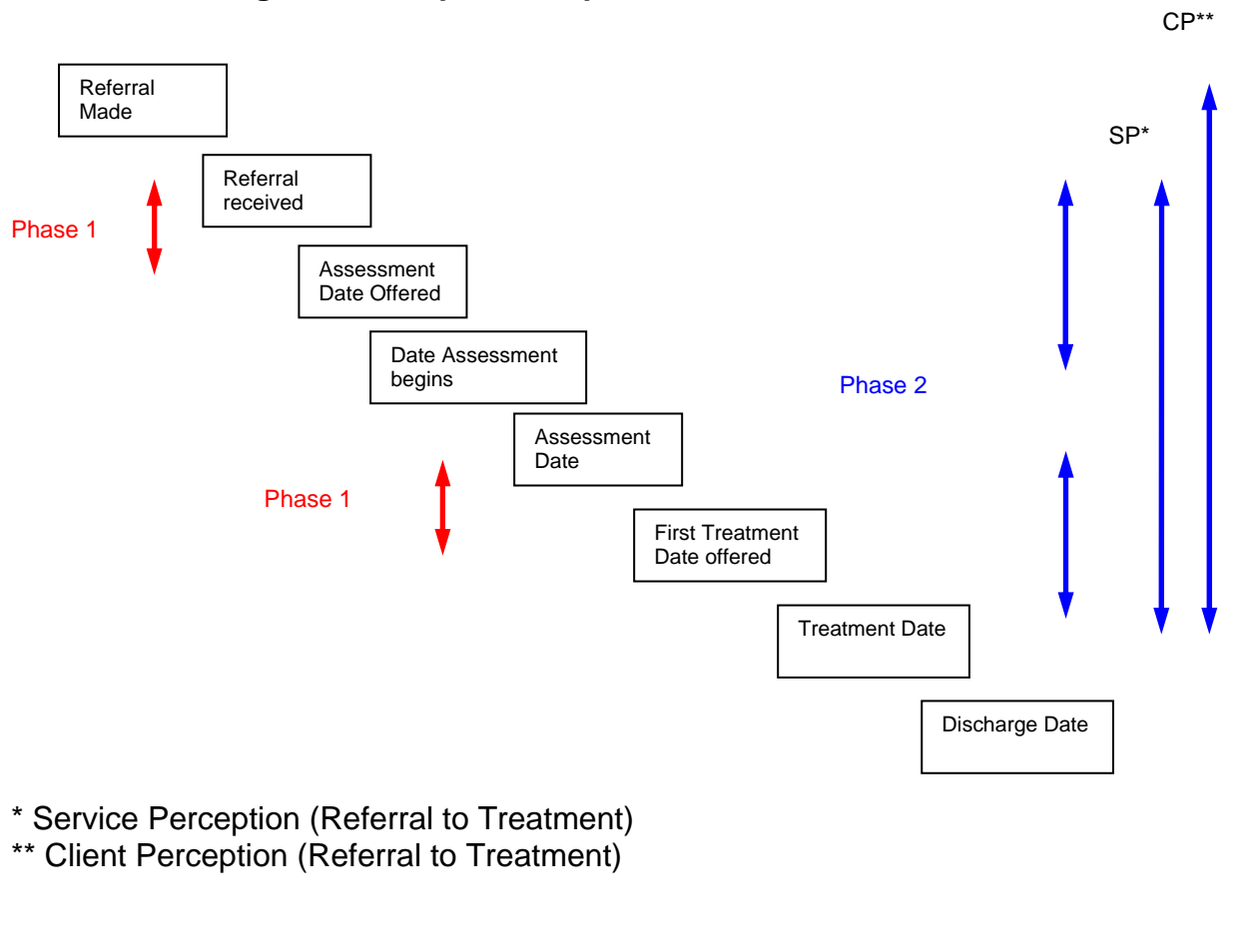
58. Discharge date is not part of the HEAT target (we are not yet measuring how long clients remain in treatment) but will be a valuable data quality metric. Discharge dates are currently collected in the Waiting Times Framework.

Key Points

- Phase 1 of this HEAT target will measure waiting times from the date of referral received to the first appointment date offered for assessment; and from date of assessment to first Tier 3 or Tier 4 treatment date offered
- Phase 2 will measure waiting times from the date of the referral being received to the date assessment begins; and from the date of assessment to the date an individual commences Tier 3 or 4 treatment.
- Phase 2 will also measure the client's entire wait, from date of referral/first contact to the date treatment begins.

¹ Dependent on outcome of pilot in year 1.

Box 6: HEAT target – development of performance measures



ANNEX A: DEFINITIONS

Definitions

This annex defines various key terms for the definition and implementation of this HEAT target.

These definitions have been adapted from the [Scottish Waiting Times Framework \(SWTF\)](#) and have been mapped against definitions used by the [National Treatment Agency \(NTA\) waiting times data collection system](#) and have been agreed by the Drugs HEAT Target Technical Sub Group.

Note: *Data items in blue italics are not currently measured by the waiting times framework.*

Drug misuse: Substance misuse is where the substance (prescribed or unprescribed) is causing harm to an individual that requires intervention.

Individual with problem drug use: any person who experiences social, psychological, physical or legal problems relating to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her own use of drugs.

Client ID: number, name or code that identifies client. Defined by service, must be unique for every episode (i.e. client coming back to a service from which they have previously been discharged should have a new ID).

Service

Tier 3 Structured, care-planned drug treatment: includes provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison. This would include comprehensive drug misuse assessment, recovery planning, a range of prescribing interventions in the context of a package of care, a range of psychosocial interventions. These would normally be delivered within specialised drug treatment services in their own premises in the community or on hospital sites. Primary care and criminal justice settings are also typical. Tier 3 interventions includes substitute prescription.

Tier 4 Drug specialist inpatient treatment and residential rehabilitation: includes provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare. These will include inpatient specialist assessment, stabilisation and detoxification; a range of rehabilitation units; a range of supportive accommodation; and provision for special groups, such as pregnant women, individuals with co-occurring mental health and drug problems. Settings will include dedicated inpatient or residential substance misuse units or wards.

Referral

Date of referral:

The date that the referral is made

Date referral received /first contact:

The date that:

- a) the referral notification is received by the agency, or
- b) the date that the client first made contact with an agency as a result of problem drug use, including written, face-to-face and telephone contact.

Both the above include the following:

- Self-referral
- Referral from third party
- Referrals from 'gateway' systems
- Intra agency referrals for an agency providing both tier 2 and 3 interventions
- Intra agency referrals between tier 3 interventions
- Inter agency referrals between tier 3 interventions

Assessment

First appointment date offered for assessment:

The date of the first appointment offered to a client to identify their needs and aspirations with a view to establishing a clear statement of the type and level of treatment, care and support required. The data item should relate to the first date the client was offered an appointment for assessment, **not** the date the client actually attended which might be later.

Date assessment begins:

Beginning of the assessment process

Date of assessment:

The date that:

- a) a client's recovery plan is signed off by client and staff or
- b) in the absence of a recovery plan, the date that agency staff and the client agree the type and level of treatment, care and support to be provided.

In some cases the date that an assessment is started and the date that a recovery plan is agreed or decision on treatment is made may be the same date.

Treatment

First treatment date offered:

Date offered for beginning of the type of structured care initially required by the client as stated in the recovery plan or agreed with the client.

The first appointment date offered to a client to initiate the first treatment intervention identified.

Treatment modality 1:

Structured preparatory and MI: planned intervention that stabilises the client or prepares them for further interventions. It must be structured and have agreed goals.

The following list is compiled from a range of service providers from the 3rd Sector and NHS statutory drug and alcohol services on their views of what Treatment 1 means.

- In depth assessment
- Supporting clients to go to appointments
- Improving self confidence
- Harm reduction education/advice/information
- Liaising with services on behalf of the client
- Structured psychosocial interventions
- Working with Young People on motivational enhancement/interviewing which includes pros and cons/challenging the decisional balance/creating dissonance triggers/functional analysis, diaries and Seemingly Irrelevant Decisions (SIDS) which also incorporates CBT techniques of ABC, antecedent/behaviour/consequence
- Multi-agency work e.g. housing, benefits agency, CAB
- Preparation for detox/reduction plans
- Preparation for substitute prescribing programmes
- Talking therapies to support people where there is no substitute prescribing e.g. psycho-stimulant users
- Preparation for entry into residential rehabilitation
- Preparation for other therapies e.g. occupational therapy, psychology
- Preparation for transfer of care to shared care with GPs/IDS partners

These fall into 5 broad categories:

- Motivational interviewing work in the formal sense as a piece of distinct work carried out over a small number of sessions (i.e. not integrated as a general approach to working with clients in psychological interventions/support work)
- Any holding support work for people in chaos (which may not be by its nature particularly structured but is still significant in terms of staff time and as an intervention)
- Another intervention (for e.g. a group) or guided self help offered to people prior to the core intervention

- Another intervention carried out with chaotic clients which is the core work of the service (outreach for example) which prepares them for interventions at other services
- Motivational work which forms the first part of a treatment intervention and continues on with the same worker to other psychological interventions and may continue alongside other work (CBT, humanistic/person centred counselling, etc)

It has been pointed out that Treatment 1 interventions are primarily **non-medical**.

Another issue to keep in mind is that MIs in general are often integrated both as an approach to client work and in terms of specific skills into more general psychological interventions/support work in the community – so the line between Treatment 1 intervention and Treatment 3 (community based support and/or rehabilitation) can be quite blurred. Motivational work may continue or be re-introduced (for e.g. following relapse or low mood episode) in Treatment 3 work. A general point here is that many distinct interventions separated out for the purpose of clinical trials are used in an integrated fashion in practice in the community.

As this code is often used for first treatment (within the SWTF) there is a risk that the HEAT target will not be capturing all waits for other more medical based treatments e.g. often, a patient will be given a date for Treatment 1, then a subsequent date for Treatment 2 (often prescribing treatment).

There is some concern that the SWTF is under-reporting the extent to which people are waiting for prescribing treatment.

This can be resolved by calculating all the waits for the 4 treatment modalities ignoring whether or not it is the first or second treatment offered i.e. the wait from **client ready for treatment** (date recovery plan agreed or date client ready for second treatment) to **date offered for treatment**. This would successfully capturing the wait for any treatment regardless of whether it was the client's first or second treatment. **The HEAT target would therefore no longer be looking at offer of 'first' treatment but offer of any treatment.**

The database currently collects information on the wait between:

date care plan agreed and offer of first treatment

and

date client ready for second treatment and date offered for second treatment.

Therefore both these waits could be used to calculate waits for all 4 treatment types.

The SWTF will a) continue to collect data on Treatment 1, incorporating all the detail above into the data definition and b) report, in addition, on how long patients are waiting for their second treatment.

Treatment modality 2

Community prescribing; specialist prescribing

Note: GP prescribing is not currently recorded on the waiting times framework

Treatment modality 3

Structured day programmes; other structured drug treatment

Treatment modality 4

Residential detoxification and rehabilitation

- Residential drug and alcohol crisis intervention services (in larger urban areas)
- Inpatient detoxification directly attached to residential rehabilitation programmes
- Residential treatment programmes for specific client groups (e.g. for drug-using pregnant women, drug users with liver problems, drug users with severe and enduring mental illness)
- Some drug-specific therapeutic communities and 12-Step programmes in prisons
- 'Second stage' rehabilitation in drug-free supported accommodation where a client often moves after completing an episode of care in a residential rehabilitation unit, and where they continue to have a recovery plan, and receive keywork and a range of drug and non-drug-related support
- Other supported accommodation, with the rehabilitation interventions (therapeutic drug-related and non-drug-related interventions) provided at a different nearby site(s).

Inpatient treatment: not currently recorded on the waiting times framework

Inpatient drug treatment interventions usually involve short episodes of hospital-based (or equivalent) drug and alcohol medical treatment. This normally includes 24-hour medical cover and multidisciplinary team support for treatment such as:

- *Medically supervised assessment*
- *Stabilisation on substitute medication*
- *Detoxification/assisted withdrawal from illegal and substitute*
- *drugs and alcohol in the case of poly-dependence*
- *Specialist inpatient treatments for stimulant users*
- *Emergency medical care for drug users in drug-related crisis*

Did Not Attend (DNAs) and Could Not Attend (CNAs)

If a client does not attend the first appointment offered for recovery-planned, structured treatment, further appointments should be offered in line with service provider policy. If a client then enters treatment – having previously failed to attend the first appointment offered – **the waiting time is calculated to the date of the first treatment appointment that the client failed to attend**. This is to ensure that service providers are not penalised by having to submit artificially long waiting times due to a client's non-attendance.

A DNA is a client who did not attend the first appointment and failed to give prior notice. A CNA is a client who did not attend the first appointment and did give prior notice.

Discharge date

Discharge date is not part of the HEAT target (we are not yet measuring how long clients remain in treatment) but will be a valuable data quality metric. Discharge dates are currently collected in the SWTF.

For the purpose of the SWTF we are only interested in the date the client ceased waiting; therefore, because the database is episode based, we only need a date the episode is finished to close off any outstanding waits (i.e. not a true discharge from treatment date).

In this context, the following definitions (from the NTA NDTMS) can be applied:

The date that the client was discharged ending the current structured (Tier 3/Tier 4) treatment episode.

If a client has had a planned discharge then the date agreed within this plan should be used.

If a client's discharge was unplanned then the date of last face to face contact with the treatment provider should be used.

If a client has had no contact with the treatment provider for two months then for NDTMS purposes it is assumed that the client has exited treatment and a discharge date should be returned at this point using the date of the last face to face contact with the client.

It should be noted that this is not meant to determine clinical practice and it is understood that further work beyond this point to re-engage the client may occur.

It is important to note that these definitions are designed to support accurate data reporting of the client's treatment journey. However, they should not be used to subvert established clinical practice within agencies. For example, an agency may have a policy of keeping cases open for 2-3 months following the last face-to-face contact with the client to attempt to re-engage them in treatment. This is fine, but the data should reflect that the client was discharged on the date of the last face-to-face contact (NDTMS current definitions allow a client to remain 'open' for a maximum of 2 months following the last face-to-face contact).

Ref: [National Drug Treatment Monitoring System \(NDTMS\)](#)