Royal College of General Practitioners

SMMGP SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

Primary care drug and alcohol treatment: commissioning and provision against a backdrop of localism

This joint paper considers the future impact of the changing commissioning environment on primary care drug and alcohol treatment. It considers the specific challenges and opportunities for primary care, being uniquely placed to respond to this in a period of significant change as part of the wider health and social care economy

Background – a new era of localism

In April 2013 locally based Public Health bodies will become responsible for commissioning of drug and alcohol services, with Health and Wellbeing Boards (HWB) playing a strategic co-ordinating role. Clinical Commissioning Groups (CCG) will work closely with HWBs, and will be securing public health expertise and *vice versa*. The recently appointed Police and Crime Commissioners will also have an influence over budgets for drug and alcohol interventions within the criminal justice system. This represents an enormous change in commissioning, and ushers in a new era of localism, with decision making moving away from national bodies [the National Treatment Agency for Substance Misuse (NTA) will cease to exist as of the 1st April 2013, and its functions transferred into Public Health England] to be firmly placed within local areas. This offers significant challenges and opportunities for primary care based drug and alcohol treatment.

Whilst there is a potential threat for areas to disinvest in drug and alcohol treatment, there is an opportunity for clinicians to influence commissioners to provide needs based drug and alcohol services that promote recovery.

A move from 'outputs' to 'outcomes'

The Drug Strategy 2010[1] introduced the concept of Payment by Results (PbR) to the drug and alcohol field, and in April 2012 eight sites began 2 year PBR pilots which will be evaluated in 2014. Whilst there is no indication that payment by results will be a mandatory element of commissioning drug and alcohol services, areas have begun to adopt this concept prior to the results of the pilot sites being completed, and it is important that primary care drug and alcohol treatment is prepared for this new agenda if they are to continue to contribute to the provision of good quality services. It could be argued that an element of PbR has already been introduced into the system, with areas experiencing cuts and increases in funding over the last 2 years from the NTA, dependent on local performance figures.

[1] HM Government (2010) Drug strategy 2010: reducing demand, restricting supply, building recovery: supporting people to live a drug-free life

The Drug Strategy 2010 introduced the concept of recovery from drugs and alcohol dependency into policy with clear practice outcomes, namely:

- Freedom from dependence on drugs or alcohol
- Prevention of drug-related deaths and blood borne viruses
- A reduction in crime and re-offending
- Sustained employment
- The ability to access and sustain suitable accommodation
- Improvement in mental and physical health, and well-being
- Improved relationships with family members, partners and friends
- The capacity to be a caring and effective parent

The agreed outcome definitions for the PbR pilot sites were a simplification of many of the outcomes outlined in the 2010 drug strategy and were agreed as the following:

- freedom from drug(s) of dependence
- reduced offending
- improved health and wellbeing

Whilst the outcome framework is prescriptive, each pilot site area has been given freedom to develop the parameters of their projects including additional outcome fields. The effects of this localism are very apparent, with the finer detail of the outcomes of the 8 pilot sites being surprisingly wide ranging, as are the proposed mechanisms for payment http://recoverypbr.dh.gov.uk/

For many the concept of payment by results is unpalatable, challenging the notion of patient centred care, and failing to acknowledge the financial benefits for good quality harm reduction with the notion of a 'price tag' hanging over the head of each patient they see. However, it would be difficult to argue against a shift in emphasis toward outcome oriented care and many of the outcomes identified in the pilot sites - for example, one area's outcomes include reducing coronary disease and improving health outcomes. This paper will show that primary care clinicians, with their wealth of understanding of local populations and needs, should prepare to work with local commissioners to set realistic outcomes that will benefit the needs of patients and their communities.

Toward the end of 2012 a scoping and feasibility report was published by the PbR evaluation team . The report describes issues emerging in the early implementation phase and the lessons learned from the stakeholder liaison undertaken. It is interesting to note that the original research questions have been refined in the light of the policy background and the interest in PbR across a range of government departments and a critical assessment of the existing evidence and literature on outcome measures for individuals in drug and alcohol treatment.

Whilst the jury is still very much out on the benefits to be realised for service users through PbR, primary care is in fact no stranger to this agenda having been successfully engaged for many years in quality incentive schemes such as QOF. Whilst the PbR pilots are some way from reporting their key findings, what we do know is that there is unlikely to be a single 'one size fits all' blueprint for a PbR in drugs recovery leaving the options open for primary care and local shared care schemes to work with their local commissioner as part of a local treatment system to design a financial rewards/incentive scheme that drives up quality and outcomes for service users in their respective areas.

Primary care drug and alcohol treatment and recovery

There are a number of themes that have emerged regarding how to achieve recovery from drug and alcohol dependency over the last 2 years, with key documents being the 2010 Drug Strategy, its 2011 review[2], and the 2012 Medications in Recovery report[3]. Primary care is well positioned to support recovery, and there are a number of ways in which primary care might evidence its contribution to a full range of recovery focused outcomes in an environment where PbR is likely to feature in the future. However, the most common tool for commissioning primary care drug treatment, the Local/ National Enhanced Service (LES/ NES) is woefully out of date and usually provides financial reward for numbers in treatment alone, without evidencing outcomes or quality of treatment.

The necessity to evidence a recovery focused system has become more important with the news that at least 1 shared care scheme in England has been decommissioned for an alleged failure to have a recovery focus. A combination of poor data collection, lack of on going audit in some schemes, and a reliance on payment for numbers treated alone, may have fed in to the perception that primary care has been unable to evidence the care it is delivering. If primary care can robustly produce the evidence that it *is* delivering recovery focused care, it will be in a position to influence local outcome setting as this happens. Considering recovery focused outcomes can also serve as a self audit tool to ensure quality in local systems.

Outcome focused payments, not a new concept for primary care, may allow the opportunity for primary care to evidence and promote a range of activities that it is uniquely placed to offer which may have gone unnoticed in the past, for example improved health outcomes, signposting, multiagency collaboration and work with families; all from a community base that provides a non stigmatising environment from which to receive treatment.

Key themes of recovery oriented treatment

Key themes of recovery oriented treatment that are particularly applicable to primary care are considered below, followed by a checklist on how to evidence that services are working towards these themes (some of these suggestions come from the 2012 Strang report, and providers should be encouraged to consider all the guidance in this report). This may guide primary care drug and alcohol treatment to improve the quality of their systems, provide evidence to commissioners that they are working in a recovery focused way, and also to stimulate ideas for local outcome setting.

1 Good quality opioid substitute treatment can play an essential role in recovery

"Entering and staying in treatment, coming off opioid substitution treatment (OST) and exiting structured treatment are all important indicators of an individual's recovery progress, but they do not in themselves constitute recovery. Coming off OST or exiting treatment prematurely can harm individuals, especially if it leads to relapse, which is also harmful to society. Recovery is a broader and more complex journey that incorporates overcoming dependence, reducing risk-taking behaviour and offending, improving health, functioning as a productive member of society and becoming personally fulfilled. These recovery outcomes are often mutually reinforcing." (Medications in Recovery report 2012).

[2] HM Government (2011) Drug Strategy review

[3] National Treatment Agency for Substance Misuse (2012) *Medications in recovery: reorientating drug dependence treatment*

The 2010 Drug Strategy and the 2012 Medications in Recovery report make clear that recovery is not an end state (e.g. abstinence) but rather a journey of improvements and that there remains an important role for OST within this. However, the report also highlights the importance of having a balanced and ambitious system that encourages patients to consider a full range of options, including detoxification. Primary care is able to deliver a full range of effective OST interventions, including detoxification.

Self audit check list

- Have clinicians completed appropriate training to provide treatment?[4]
- Do clinicians access regular opportunities for continuing professional development (e.g. local training)?
- Are patients able to receive a full range of clinical services from primary care (titration, detoxification, blood borne virus services and where relevant long term conditions management)? If not, are there accessible care pathways to these parts of the system?
- Do regular audits of practice take place? Are results fed back to clinicians, with action plans for improvements where appropriate?
- Is mentoring/clinical support for clinicians available?
- Is there a clear clinical governance structure for all clinicians involved?
- Are caseloads audited to ensure that a balance of harm reduction and overcoming dependence coexists?
- Do individual clinicians apply a personalised assessment for each patient, repeat it regularly and based upon its findings readjust the treatment plan with the patient?
- Is data accurately recorded for all patients in primary care on the National Drug Treatment Monitoring System?

2 Drug treatment is not expected to deliver drug treatment on its own but can integrate with and benefit from other support (Medications in Recovery report 2012)

An integrated recovery-orientated system of care should be commissioned in each locality which includes other health and social care services with drug treatment, to provide recovery support, including mental health, employment, housing, mutual aid, recovery communities.

Primary care is able to deliver a range of services from a community base, from clinical services for substance use, to general medical services and also a range of psychosocial services. The authors are aware of an enormous range of diverse services being available from primary care including interpreter services, Citizens Advice clinics, IAPT, smoking cessation clinics, quick access to dental services, midwifery services, counselling: the list is endless. Primary care is also expert at signposting individuals to services when they are not available 'on site', and working with care pathways between agencies. Primary care includes community pharmacy and dentistry, and GP surgeries often have strong links with their colleagues.

[4] Royal College of General Practitioners and Royal College of Psychiatrists (2012) Delivering quality care for drug and alcohol users: the roles and competencies of doctors: A guide for commissioners, providers and clinicians CR173

Self audit check list

- Are clinicians/ keyworkers aware of the range of services available such as housing/ employment/ support for families/ carers?
- Are GPs/ clinicians involved in care planning with the keyworker and patient? Is there regular communication between the keyworker and GP about patient care? Does the GP see patients regularly (at least every 3 months?). Are patients offered a full range recovery oriented of services?
- Do effective care pathways exist between all parts of the treatment system? Are they monitored, and is there a forum to troubleshoot problems?
- Are clinicians/ keyworkers trained to deliver recovery focused care planning?
- Are commissioners aware of the full range of services available from primary care?

3 Improvement in health is an essential element of recovery

"For some people – and especially as the treatment population ages – physical health problems may be a persistent barrier to recovery….The provision and organisation of physical (as well as mental) healthcare for those in drug treatment needs to reflect the problems of access and stigmatisation commonly faced by drug users. Support may be needed for them to effectively use health and care services…Primary health care services can play a pivotal role in providing for the physical health needs of drug users but may need support from drug services." (Medications in Recovery report 2012).

Drug treatment in primary care allows people's general health needs to be addressed as well as their substance use issues from a non-stigmatising community base. This is a unique and important characteristic of primary care treatment in light of the general poor health of this group, together with the co-morbity issues of an aging population of opioid users.

Self audit checklist

- Are patients general health needs reviewed on a regular basis?
- Is primary care evidencing the general health services and outcomes people are achieving (for example contraception, blood borne virus immunisation and testing, smoking cessation services, mental health interventions), and is this audited on a regular basis? Can read codes/ templates be used to evidence the interventions that are being carried out with this group?

4 Active promotion of mutual aid networks will be essential

There is a growing evidence base for the benefits of mutual aid, and also evidence suggests that people do better when they access mutual aid while in treatment. Primary care is used to signposting and can develop links with local community groups. The 2012 Medications in Recovery report suggests that recovery be made visible to people at all stages of their treatment journey.

Self audit checklist

- Are keyworkers/ clinicians aware of the full range of mutual aid meetings in their area? Are they aware of the benefits of patient's attendance at these groups? Are they assertively encouraging people to attend?
- Do patients have access to recovery champions throughout their treatment journey?

- Do they have access to people who will take service users to meetings? Have clinicians taken the opportunity to attend an open mutual aid meeting themselves?
- Could mutual aid meetings be held at the surgery?

5 Evidence shows that treatment is more likely to be effective, and recovery to be sustained, where families, partners and carers are closely involved.

Primary care often know the families / partners of those in treatment, and it is therefore more likely that they will also be seen, and involved in recovery planning with patients (when appropriate). There is evidence that primary care can also provide effective support to families and carers of people who use drugs and alcohol in their own right[5]. As the age of people on OST rises, a number of service users are becoming carers of their parents and primary care can also support this.

Primary care tends to build up relationships with local schools/ children's services and provides invaluable support from health visitors. It is well placed to provide support for parenting, and safeguarding of children. Primary care may also play an important part in the emerging 'Troubled Families' agenda.

Self audit checklist

- Do clinicians/ keyworkers involve and record the involvement of other family members in the care of patients?
- Do clinicians/ keyworkers record independent interventions with families and carers of drug users?
- Do clinicians/ keyworkers record the multiagency work that takes place with children's services/ health visitor interventions?

6 Substance misuse treatment should be widening the focus to consider dependence on all drugs and alcohol (Drug Strategy (2010)

Primary care is well positioned to provide recovery oriented treatment for people who use drugs and alcohol. The reasons for this include:

Primary care can act as a discrete beginning-to-end service in people's community, which can deal with a range of drug and alcohol problems, including new trends such as over-the-counter medication misuse, misuse of prescribed medications and legal highs.

Primary care is accessible as it is in people's communities, appointments can usually be made on the day, and primary care understands and is able to deal with the full range of diversity of its community. Primary care is designed to work with people with disabilities and people from a range of ethnic backgrounds, sensitive to the specific needs of its community. It is a non stigmatising community service.

Self audit checklist

- Are clinicians/ keyworkers trained to deal with a range of drug and alcohol problems?

[5] Copello et al (2009)The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomized trial Addiction Volume 104, Issue 1, pages 49–58, January 2009

- Are care pathways fit for purpose to deal with the multiplicity of substance misuse problems from a primary care base?

Looking to the future – primary care and the local public health agenda

As Public Health England establishes itself and begins to articulate its central message, what is becoming apparent through its leaders is a sense that the NHS's effort to improve health and reduce illness over the past four decades has not fully addressed the gaps in life expectancy and anticipated improvements in good health. In some cases and areas of deprivation it is arguably getting worse and that measures are needed to focus on redressing this imbalance.

This is where primary care can move to take centre stage but in so doing it will need to acknowledge the role of patients, their local communities and the general public. One way of achieving this is to form partnerships with local voluntary sector agencies and local charities that have the skills, and competencies to compliment the primary care offer of clinical support and chronic disease management. These partnerships can work with the patient to build a person centred plan that identifies the individual's assets giving them the resilience with which to make the lifestyle changes and choices that benefit their health.

Local areas should be considering moves to improve and join up services to support victims of domestic violence, the government's 'Troubled Families' agenda which looks to provide targeted case management support and coordinated care to improve the lives of adults and children in respect of school attainment, worklessness and antisocial behaviour. The work to reduce preventable deaths, particularly those linked to alcohol and liver disease all play to the strengths and transferable skills set of the primary care substance misuse and shared care/inclusion teams. The fact that the primary care substance misuse staff cohort already has firm and established links with the Practice team provides a head start in positioning primary care to lead on joining up the agenda and being the first to realise the benefits of moving the public health agenda closer to that of local government.

Conclusion

Primary care is able to deliver the vision of the 2010 Drug Strategy as an integrated part of the local treatment system. Primary care provides 'added value' in terms of health interventions, provision of a non stigmatising community based service, its ability to work with families, community groups, and its ability to signpost and work with other agencies. It has a continuity and a 'memory' that is increasingly rare in the word of re-tendering and re-commissioning of services; this can provide stability for patients and providers alike. Primary care can also provide clinical leadership and support to providers and commissioners including invaluable roles within clinical commissioning groups and their links with Health and Wellbeing Boards, and the ability to meet wider public health outcomes for local areas. Those of us who deliver primary care substance misuse are proud of our legacy of excellent care and life saving interventions. We should be proactive in forging a future where we evolve, grow and transfer our skills to support the raft of initiatives that will define the new public health agenda tackling local health inequalities as defined by every local health and well being and clinical commissioning group strategy.

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