# NICE Consultation on Potential Indicators for COF

## Response from DrugScope

**February 2012**

### About DrugScope

DrugScope is the UK's leading independent centre of expertise on drugs and drug use and the national membership organisation for the drugs field, with around 500 members. It incorporates the London Drug and Alcohol Network (LDAN). DrugScope is a registered charity (charity number: 255030). Further information is on the DrugScope website at www.drugscope.org.uk

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| **COMMENTS PROFORMA** |
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| Consultee name: DRUGSCOPE<br>Contact: Dr Marcus Roberts, Director of Policy and Membership, DrugScope<br>E-mail: marcusr@drugscope.org.uk, telephone: 020 7520 7556 |
| **What are your views on the scope of the COF? Do you think there is sufficient breadth of topics covered in this consultation, if not, can you suggest other topics that may be appropriate for COF indicator development?**<br>DrugScope welcomes the opportunity to comment on the COF indicators, and we hope our comments are useful. We are concerned that the specification, definition and development of the COF indicators should make appropriate reference to drug and alcohol issues. While we recognise that the primary responsibility will rest with public health, it appears to us incongruous to have no reference at all to drug or alcohol issues in the COF given the high incidence of drug and alcohol-related health conditions among the patient populations for which CCGs will be commissioning.<br><br>Co-morbidity of mental health and substance misuse problems<br>There is a particular concern that strategic and commissioning frameworks (notably the Public Health Outcome Framework and COF) should be developed in complementary ways to ensure that services are available for people with dual diagnosis and multiple needs.<br><br>DrugScope – in partnership with the Centre for Mental Health and UK Drug Policy Commission – has recently produced a discussion paper on 'Dual Diagnosis: a challenge for the reformed NHS and Public Health England'. It comments that 'robust |

outcome measures are vital to support the commissioning and provision of integrated support for the full range of people with a dual diagnosis. We need to develop meaningful and measurable outcome indicators that cross public sector silos and align different organisations to the same ends, achieving outcomes that matter to service users in a timely manner'. It also notes: 'the larger number of individuals with less severe mental health conditions alongside substance misuse problems … may be particularly at risk from any fragmentation of service provision arising from the different commissioning arrangements for mental health and substance misuse services under the current reforms. It is important that the differing needs of both these groups are considered as the reform process develops'.

Responsibility for drug and alcohol services

Lead responsibility for drug and alcohol interventions will rest with the public health service from April 2013. Local Directors of Public Health – employed by Local Authorities – will have primary responsibility for commissioning substance misuse services. This process will be informed by the Public Health Outcome Framework (PHOF) and by Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), developed by Health and Wellbeing Boards (HWBs).

This is, however, an important agenda for CCGs and one that will be critical to the delivery of many COF indicators. It is also important that different health and social care outcome frameworks are developed in a way that enhances and supports holistic responses to patients, carers and communities, and does not encourage a 'siloed' approach to planning and commissioning. We note that:

1. As statutory members of HWBs, CCGs will have a responsibility to contribute to JSNAs and JHWSs;
2. HWBs are intended to catalyse and facilitate joint commissioning and pooling of budgets where this can add value locally, and this will often be the case in developing responses to people with drug and alcohol problems, including those with co-morbid mental health conditions;
3. GP practices and other health services that CCGs will be involved in commissioning are working with many people who have drug and/or alcohol problems, or where drug and/or alcohol use is a contributory factor to their health or mental health problems;
4. Drug and alcohol use can be a significant determinant of people's ability to access health and mental health services and of how they are treated in those services;
5. Drug and alcohol use is a significant determinant of health inequalities, and is often linked with other problems that are associated with health and mental health problems, such as homelessness, worklessness and imprisonment.

Summary of key points

Against this background, we believe that drug and alcohol issues should be more 'visible' in the COF, and note there is no reference to them in the COF consultation document. We would highlight six points in particular.

1. While primary responsibility for commissioning drug and alcohol services lies with public health, we would ask NICE to consider the case for inclusion of a specific indicator or indicators on drug and or alcohol services. Given that the public health focus is on successful completion of drug treatment, there would be a case for including an indicator or indicators with a focus on the

management of the health and mental health harms that are associated with drug and alcohol use.

2. Given that 'dual diagnosis' is widely acknowledged as one of the biggest challenges for mental health services and is associated with poor outcomes across a range of domains relevant to the COF, we would favour the inclusion of an indicator or indicators for co-morbidity.
3. We are concerned that all indicators for serious mental illness should include a direct and specific reference to co-morbidity of mental health and substance misuse problems (and, where appropriate, to multiple need).
4. There are a number of indicators where we would like to see specific safeguards built into the COF framework to incentivise a pro-active approach to responding to the needs of those patient groups who may experience stigma or marginalisation, as well as the most serious health inequalities – including individuals and families affected by drug and alcohol problems (for example, the indicators on access to and experience of, health services).
5. We note that the PHOF document states that the PHOF and COF will 'share a small number of indicators across the public health and NHS outcomes frameworks where there is a strong argument for a shared approach'. We recognise the value of this, but it is important to also encourage shared approaches in areas where there are not shared indicators, including drug and alcohol treatment. It would be helpful if there was cross-referencing to relevant PHOF indicators, and an explicit statement of the significance of CCG activity in supporting the delivery of public health priorities, including drug and alcohol treatment.
6. It would be useful to provide a definitive statement of the status of the COF indicators, including the significance of local JSNA and JHWS for CCG commissioning (for example, to what extent, if any, could local decision-making identify some COF indicators and deprioritise others? What levers will be available if CCGs are not commissioning in line with the COF?).

| **Domain 1: Preventing People from dying prematurely** | |
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| Domain 1: Indicators derived from NHS Outcomes Framework | |
| 1.3 Under 75 mortality rate from liver disease | <u>To what extent do you think the indicators may be influenced by the commissioning activities of CCGs?</u><br>DrugScope notes the critical contribution that substance misuse interventions and services will make to reducing the under 75 mortality rate from liver disease. Alcohol misuse is a significant contributor to liver disease. There remains a significant level of hepatitis infection as a result of illegal drug use (particularly injecting drug use). The commissioning activities of CCGs will therefore have most impact where they are successfully integrated with public health commissioning, and PH indicators on:<br>- Successful completion of drug treatment; |

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| | - Alcohol related admissions to hospital;<br>- People entering prison with substance dependency issues who were previously not known to community treatment.<br><br><u>Payment by results</u><br>We also note that commissioning through payment by results will be relevant to achieving this outcome. For example, the Drug Recovery PbR pilots include an outcome on completion of Hepatitis B vaccinations and outcomes are currently under discussion for Alcohol Treatment PbR within the National Health Service.<br><br><u>What if any are the potential unintended consequences resulting from these indicators applied at CCG population level?</u> We are not in a position to identify unintended consequences as such, but note that consideration will need to be given to effectively incentivising and monitoring the impact of preventative and other interventions that will contribute to the delivery of the outcome only in the long-run and over a significant period of time. |
| Domain 1: Indicators derived from quality standards and existing collections | |
| 1.25-1.29 Maternity | <u>Comments</u><br>DrugScope would note that parental drug and alcohol use are a consideration for maternity services and relevant to achieving COF indicators in this domain. This is discussed in Anne Whittaker, The Essential Guide to Problem Substance Use During Pregnancy – A resource book for professionals, DrugScope 2011. |
| 1.30 People with severe mental illness who have received complete list of physical checks<br>1.31 Duration of untreated psychosis<br>1.32 The number of those with first onset psychosis taken on by early intervention (EI) services as a proportion of local incidence | <u>Comments</u><br>We suggest that all COF indicators for severe mental illness include a direct reference to dual diagnosis. This will incentivise joint commissioning at local level and integrated service provision. The importance of integrated approaches has been highlighted in a series of guidance documents, such as the Department of Health's 'Dual diagnosis – Good Practice Guideline' (2002). |

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| | We note that the importance of effective and integrated responses to co-morbidity is also highlighted in NICE Guidelines, including:<br>- NICE Clinical Guideline 115 – Alcohol Dependence<br>- NICE Clinical Guideline 51 – Drug Misuse: Psychosocial interventions.<br><br>Dual diagnosis is also identified as a priority issue in 'Drug misuse and dependence: UK clinical guidelines' (2007). This document discusses the evidence that people with a dual diagnosis experience worse outcomes over a range of health and indicators, including:<br>- poorer prognosis;<br>- higher rates of relapse;<br>- increased hospitalisation;<br>- poorer compliance with treatment;<br>- higher suicide rates; and<br>- higher costs to services.<br><br>We note that the 2011 Mental Health Strategy 'No health without mental health' states that: 'Dual diagnosis (co-existing mental health and drug and alcohol problems) covers a wide range of problems. It is important that the appropriate services are available locally in the right settings including the provision of fully integrated care, when this is appropriate, to meet this breadth of need. The Government will continue to actively promote and support improvements in commissioning and service provision for this group, their families and carers'.<br><br>The Drug Strategy 2010 includes 'improvement in mental and physical health and wellbeing' as one of eight best practice outcomes.<br><br>We would also welcome consideration of whether some indicators could be specified to encompass people with |

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| | complex and multiple needs. For example, it would make a significant contribution to addressing health inequalities if indicator 1.30 incentivised physical checks of the most vulnerable and marginalised (e.g. the homeless). |
| Domain 2: Enhanced quality of life for people with long-term conditions | |
| Domain 2: Indicators derived from NHS Outcomes Framework | |
| 2. Health-related quality of life for people with long-term conditions<br>2.1 Proportion of people feeling supported to manage their condition<br>2.2 Employment of people with long-term conditions<br>2.5 Employment of people with mental illness | Note on definition: While we recognise that indicators in the NHS Outcomes Framework are not open for consultation, we would welcome recognition in their development of drug and alcohol dependency as constituting a 'long-term condition'. The WHO has defined drug dependency as a 'chronic relapsing condition'. The NICE Guideline 'Drug Misuse – Psychosocial Interventions' (51) states that 'opioid misuse is often characterised as a long-term, chronic condition with periods of remission and relapse'. Drug and alcohol misuse can also be a contributory factor for other long-term conditions.<br><br>To what extent do you think the indicators may be influenced by the commissioning activities of CCGs?<br>CCGs will need to work collaboratively with other commissioners and stakeholders if they are going to improve the employment of people with long-term conditions and mental illness (including those with a history of 'dual diagnosis'). Drug and alcohol treatment services are increasingly developing innovative pathways into employment, and CCGs will want to work with public health commissioners to ensure these services are supported.<br><br>Consideration should be given to how the COF framework relates to the Department of Work and Pension's 'Work Programme' where 'prime providers' may also have a role in commissioning services to provide support into employment for people with experience of mental health problems (including |

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| | ‘dual diagnosis’ and substance misuse).<br><br>The definition of ‘employment’ will be critical in developing these outcomes. For people with a history of drug and alcohol problems (including those who have experienced dual diagnosis and complex need) a return to full-time mainstream employment may not be feasible or desirable in the short term and voluntary work or training may be a better option. There is significant therapeutic value in a range of meaningful activities other than paid employment, and it would be helpful to develop these outcomes to reflect this.<br><br><u>What if any are the potential unintended consequences resulting from these indicators applied at CCG population level?</u> There is a risk that entry into employment at too early a stage or where employment is inappropriate could result in relapse, and will therefore be a barrier to achieving other outcomes. |
| Domain 2: Indicators derived from quality standards and existing collections | |
| Mental Health<br>2.79 People on CPA followed-up within 7 days of discharge from psychiatric inpatient stay<br>2.80 Number of Home Treatment episodes carried by Crisis Resolution/Home Treatment Teams<br>2.81 Percentage of inpatient admissions that were gate kept by Crisis Resolution/Home Treatment Teams | <u>Comments</u><br>We suggest that all COF indicators for severe mental illness include a direct reference to dual diagnosis (see comments on indicators 1.30 to 1.32 above).<br><br>The importance of CPA (2.79) for people with a dual diagnosis has been highlighted in guidance and policy documents. For example, the Department of Health’s ‘Refocusing the Care Programme Approach: Policy and Positive Practice Guidance’ (2008) identified mental health service users with a dual diagnosis as one of five patient groups who needed a CPA approach. |
| Domain 3: Helping people to recover from episodes of ill-health or following injury | |
| Domain 3: Indicators derived from quality standards and existing collections | |
| Depression | |
| 3.18 People with new presentation of severity depression who receive appropriate treatment | <u>Comments</u><br>A 2002 survey found that 27 per cent of drug treatment clients and 47 per cent in |

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| | alcohol treatment had severe depression. (Tim Weaver et al, A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations, Department of Heath, 2002).<br><br>Ensuring that people with severe depression receive appropriate treatment will necessitate engagement with drug and alcohol services and interventions.<br><br>Nice Guideline 50 on 'Drug Misuse – Psychosocial Interventions' recommends evidence-based psychological treatments for people who have co-morbid depression and anxiety disorders in line with existing NICE guidelines.<br><br>Nice Guideline 115 on Alcohol Use Disorders highlights the link between harmful and dependent drinking and depression, and the need for appropriate treatment pathways for co-morbidity. Specifically, it states that 'for people who misuse alcohol and have comorbid depression and anxiety disorders, treat the alcohol misuse first as this may lead to significant improvements in depression and anxiety'. |
| Mental Health | |
| 3.24 Movement towards recovery following treatment for depression by secondary mental health services<br>3.25 The proportion of those receiving talking therapies aged >65<br>3.26 Recovery following talking therapies all ages and aged >65<br>3.27 Length of stay: Severe Mental Illness<br>3.28 Delayed discharge from psychiatric inpatient ward | <u>Comments</u><br>We note our comments above on the need to include reference to people with dual diagnosis. There is evidence of a link between dual diagnosis and outcomes against some of these indicators – for example, 3.27 Length of stay: Severe Mental Illness and 3.28 Delayed Discharge. We also note that there is evidence that people with co-morbid problems have faced barriers to accessing talking therapies. |
| Domain 4: Ensuring people have a positive experience of care | |
| Domain 4: Indicators derived from NHS Outcomes Framework | |
| 4a Patient experience of GP out-of-hours services<br>4b Patient experience of hospital care<br>4.1 Patient experience of outpatient services | <u>To what extent do you think the indicators may be influenced by the commissioning activities of CCGs?</u> We would note the value of service user consultation and involvement in |

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| 4.2 Responsiveness to in-patients' personal needs<br>4.3 Patient experience of A&E services<br>4.5 Women's experience of maternity services<br>4.7 Patient experience of community mental health services | improving the experience of services, and emphasise the need to ensure that this encompasses all service users including those who may be stigmatised and marginalised, such as people with drug and alcohol problems (and their families and carers).<br><br><u>What if any are the potential unintended consequences resulting from these indicators applied at CCG population level?</u> Patients are not a homogeneous group and there is a risk that improving the experience for some patient groups may be detrimental to other patient groups. One example would be the exclusion of people from services who have been (or are perceived by other patients to be) disruptive or threatening. It is important to ensure a balanced approach, and we would welcome a 'check' in developing these indicators that requires commissioners to have particular regard to the experiences of patients drawn from populations that experience the worst health inequalities and access issues (including equalities groups). This would include patients experiencing drug and alcohol problems, and those with dual diagnosis and multiple needs (including, for example, the homeless). |
| Domain 4: Indicators derived from quality standards and existing collections | |
| Mental health | |
| 4.19 Patient experience of IAPT services | <u>Comments</u><br>DrugScope would welcome a further development of this indicator (or additional indicators) to capture the experiences of specific groups, particularly those who have a high incidence of mental health problems but have traditionally found it difficult to access psychological therapies, including those with co-morbid drug and alcohol problems.<br><br>DrugScope has had concerns that some IAPT services appear to have been inappropriately excluding people involved with drug and alcohol services and need |

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| | support to work effectively with many existing clients for whom drug or alcohol use will be a contributory factor.<br><br>To address this issue DrugScope worked in partnership with IAPT and the National Treatment Agency to produce the 'IAPT positive practice guide for working with people who use drugs and alcohol', which is available to download from the IAPT website at www.iapt.nhs.uk<br>NICE Guidance 51 on Drug Misuse – Psycho-social interventions states that 'evidence-based psychological treatments (in particular, cognitive behavioural therapy) should be considered for the treatment of comorbid depression and anxiety disorders in line with existing NICE guidance (see section 6) for people who misuse cannabis or stimulants, and for those who have achieved abstinence or are stabilised on opioid maintenance treatment'. |

**COMMENTS on POSSIBLE ADDITIONAL INDICATORS**

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| Domain 1: Preventing people from dying prematurely | |
| Domain 1: Indicators derived from NHS Outcomes Framework | |
| 1a Potential Years of Life Lost from causes considered amenable to health care<br>1.5 Excess under 75 mortality rate in adults with serious mental illness | <u>To what extent do you think the indicators may be influenced by the commissioning activities of CCGs?</u> We note that these indicators also depend on public health provision, including the availability of drug and alcohol treatment services and integrated interventions for people with dual diagnosis.<br><br><u>What if any are the potential unintended consequences resulting from these indicators applied at CCG population level?</u> Consideration will need to be given to effectively incentivising and monitoring the impact of preventative and other interventions that will contribute to the delivery of the outcome in the longer-term. |
| Domain 1: Further indicators by topic | |
| 1.33 Smoking rates in people with | <u>Comment</u> |

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| serious mental illness | We would welcome a reference to people with co-morbidity and people with drug and alcohol problems in developing this indicator.<br><br>There is an exceptionally high rate of smoking among people with multiple needs, co-morbidity and drug/alcohol problems. A 2008 DH 'Consultation on the Future of Tobacco Control' noted that the chances of being a smoker were substantially increased among people experiencing social exclusion and that 'in groups with an extreme clustering of deprivation indicators (such as prisoners and homeless people sleeping rough) rates of smoking prevalence as high as 85-90% have been observed'.<br><br>A 2006 survey of available research on smoking by people with drug and alcohol problems cites a UK study of outpatient methadone patients which found that 93 per cent were tobacco smokers (Kimber R and Arnsten J (2006), 'A rational model for addressing tobacco dependence in substance abuse treatment', Directory of Open Access Journals (DOAJ), Vol 1, Issue 1). In a presentation to the National Drug Treatment Conference 2007 (NDTC 2007), smoking cessation expert Gay Sutherland stated that 'most people in drug treatment smoke (between 70 to 90 per cent) and are more nicotine dependent than the general population of smokers'. |
| Domain 2: Enhancing quality of life for people with long term conditions | |
| Domain 2: Indicators derived from the NHS Outcomes Framework | |
| 2.4 Health-related quality of life for carers | To what extent do you think the indicators may be influenced by the commissioning activities of CCGs? This should include the quality of life of carers of people with drug and alcohol problems, who will often require support for health and mental health problems that will be related to their caring roles. A recent study by the UK Drug Policy Commission has estimated that minimally 1.5 million adults in the UK will |

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| | be significantly affected by a family members drug use, with the costs of the harms they experience amounting to the equivalent of £1.8 billion a year (UKDPC 2009, 'Adult family members and carers of dependent drug users: prevalence, social cost, resource saving and treatment response'). |
| Domain 2 – further indicators by topic | |
| 2.9 People with long term conditions who develop further long-term conditions | Comment<br>As discussed above, we would welcome recognition of drug and alcohol dependency as a 'long-term condition' for the purposes of this indicator. The WHO has defined drug dependency as a 'chronic relapsing condition'. The NICE Guideline 'Drug Misuse – Psychosocial Interventions' (CG51) states that 'opioid misuse is often characterised as a long-term, chronic condition with periods of remission and relapse'. |
| Carers | |
| 2.19 Carers identified on practice registers<br>2.20 Delayed discharge from hospital<br>2.21 Number of information prescriptions for carers<br>2.22 Referrals to Local Authorities and the voluntary sector for advice and support | Comment<br>As discussed above, all indicators for carers should include the quality of life of carers of people with drug and alcohol problems. |
| Liver disease | |
| 2.78 Variations in liver disease admissions/attendances between practices in CCG | Comment<br>As discussed above, DrugScope notes the critical contribution that substance misuse interventions and services will make to the prevention and treatment of liver disease. The availability and approach of local drug and alcohol treatment services and the effectiveness with which GP practices engage and work with this client group will be a significant contributory factor in determining variations in liver disease admissions/attendances between practices. |
| Mental health | |
| 2.82 Improvement after 6 months based on HoNOS for patients with SMI starting a new spell of care | Comment<br>As discussed above, all indicators for serious mental illness should explicitly |

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| 2.83 People with SMI in settled accommodation<br>2.84 Reported incidents of physical assault on users of specialised mental health services | include patients with co-morbid drug and alcohol problems, who are known to have worse outcomes across a number of key indicators. |
| Domain 3: Helping people to recover from episodes of ill health or following injury | |
| Domain 3: Further indicators by topic | |
| Depression | |
| 3.19 People who receive treatment from supervised practitioners as defined – at least 1 hour per fortnight<br>3.20 People with chronic physical ill health and new presentation of severity of depression who receive appropriate treatment<br>3.21 People with new presentation of depression who are assessed as non-case 6 months after the initiation of treatment | Comment<br>As discussed above, all indicators for depression should recognise and address the issue of co-morbidity. |
| Domain 4: Ensuring that people have a positive experience of care | |
| Domain 4: Further indicators by topic | |
| Carers | |
| 4.12 Involvement of carers: unplanned readmissions with or without care plan<br>4.13 Involvement of carers: delayed discharge from hospital | Comment<br>As discussed above, all indicators for carers should include the quality of life of carers of people with drug and alcohol problems. |