Despite recent initiatives to increase the involvement of GPs in the treatment of drug users **Chris Ford** and **Jenny Keen** argue that Models of Care ignores all this, writes doctors out of the script and so is fatally flawed

Models of care

is there a GP in the plan?

PRIMARY care was intended to be a significant element in the strategy for dealing with the increasing numbers of drug users accessing treatment. Yet there was no primary care representative in the team assembled by the Department of Health to write Models of Care (MC). Right from the start, MC failed to reflect the reality of drug treatment provision in primary care and so, in our opinion, is fatally flawed. This omission is self-evident in the policy section of the final document which sets the tone for the rest:

- No mention of the government's policy of increasing the number of drug users seen in primary care and the increasing numbers of GPs treating drug users.
- Only a passing mention of GPs and primary health care teams.
- Does not consider primary care based services or the new and flexible local approaches being developed involving GPs with a special interest and intermediate and specialist-level GP-led services.
- Fails to address any potential policy developments which might follow the contractual changes within primary care.

ENDING IN TIERS

MC fails to describe the role of primary care operating across different levels in the system. It fails to take account of the levels of training and remuneration which have been developed for GPs involved in this work and the lead role played by GPs with a special interest (GPSIs) in many areas. This is surprising given the reliance on primary care to implement targets for the increased numbers of drug users in treatment. Furthermore the tiered model doesn't really chime with the reality of general practice which spans the first three tiers and works flexibly. Just for tier three for example, there is no mention here of the various new models developing throughout country, such as intermediate primary care services or of primary care – led services, led by a GP 'specialist'.

In discussing local commissioning, MC fails to mention the importance of dovetailing commissioning with commissioning of GPs to provide what are now labelled national enhanced services under the new GP contract. Nor is there any mention of commissioning GPSIs. Yet both these levels of GP involvement were being developed at the time it was written and are essential to meeting targets for increasing numbers of patients treated. This omission is the more extraordinary given the relative cost-effectiveness of primary care services and their essential role in providing services in most areas.

PATHWAYS OR DEAD-ENDS?

Integrated care pathways can potentially have some advantages in that they state the aims of the treatment being provided, who is being served and the development of agreed treatment goals. They provide a description of the treatment process, referral pathway, screening and assessment. Unfortunately it is difficult to relate the process described to primary care where ongoing assessment at all these levels tends to take place over time in the wider context of the patient's overall health and social situation. It is often more implicit than explicit as new issues arise between doctors and patients who know each other well – true for all patients, not just drug users.

They are also in danger of creating too much assessment and not enough treatment. The multi-hurdle assessment system does not recognise that competent GPs routinely carry out these levels simultaneously and start treating without a gap. This model is largely unrecognisable to those of us who work in primary care.

PAPERWORK

All patients need some care planning but endless paper completing exercises are not appropriate as GPs tend to maintain continuity of care with patients. GPs see patients on a long-term basis and develop care plans gradually with patients personally. It is clumsy and usually unhelpful to use a care plan drawn up by somebody else and GPs are unlikely to engage with this.

Care coordination is an essential part of good general practice. We already do much of this in primary care and there seems little advantage in

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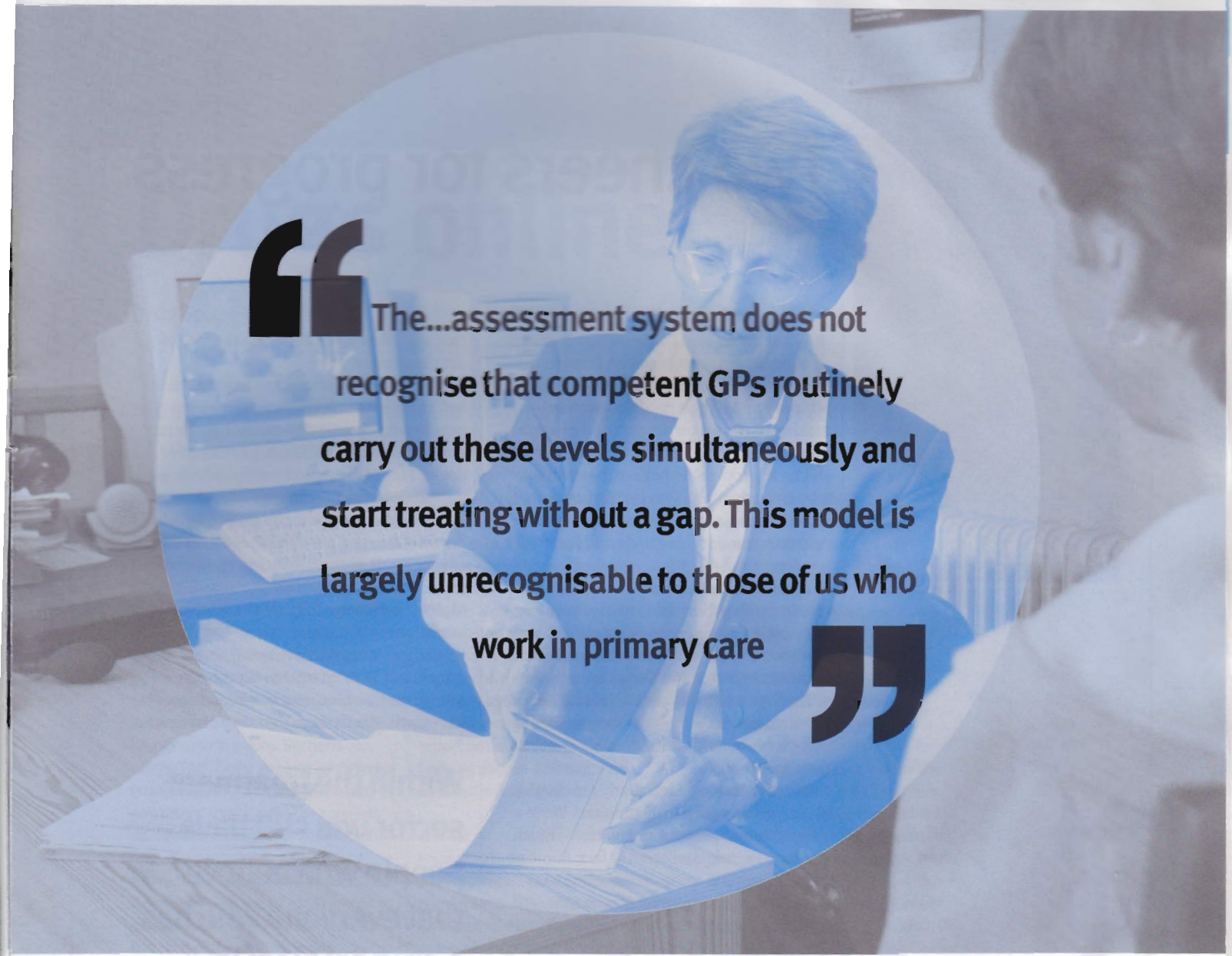

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formalising it. It could lead to highly defensive and clumsy practice. Whilst GPs are constantly and flexibly involved in care co-ordination, the formalised process is totally alien to primary care. One of the joys of working in primary care is the long-term relationship built up over time. Assessment and care coordination is done on the way. We tend to have high retention rates of drug users and other patients in primary care, we are used to managing many chronic relapsing conditions and we are open, non-stigmatising and used by most of the local population.

On the other hand most GPs can be put off by constant form-filling, complex care pathways involving too many agencies, artificial hoops to jump through, and the imposition of a top-down approach which devalues their skills. Sadly, MC characterises many of these aspects.

MISSED OPPORTUNITY

Ultimately, MC represents a missed opportunity. The involvement of GPs at various levels, the development of training and clinical governance and the enthusiasm of the RCGP have contributed to the growth of a vibrant network of GPs and GPSIs working in the field. MC fails to mention or take account of these developments. It is alien to GPs and to the many progressive primary care-led developments in the treatment of drug users. It presents as an old-fashioned, clumsy and hierarchical model and ignores the lively, varied & progressive service developments taking place in primary care which, in partnership with the users are moving the whole concept of treatment for drug users forward. ■

GPs sidelined: a prescription for failure

A GP says

'Reading these documents as a GP, I have to work hard to see how it is relevant to me and how primary care structures fit in . It's as though it was all developed with someone else in mind. Which of course it was, as there were no GPs among the people who wrote it – and it shows'.

A user says

'With the stated aim of the NTA of involving drug users at every level of our care, why wasn't there a user on the steering group? It feels as if Models of Care is yet another document and I have every faith that it will disappear, like so many more government documents before it'.