DrugScope

Bitesized briefing

Models of care and building recoveries in communities

What is *Models of Care*?

Models of Care – or to give its full title *Models of Care for Treatment of Adult Drug Misusers* – has played a critical role in shaping the unprecedented expansion and development of specialist drug treatment in England in the last decade. When the *Models of Care* document appeared in 2002 (it was subsequently updated in 2006) it provided the first national framework to guide the commissioning of drug services, and reflected the prevailing professional consensus on 'what works best ' in the treatment of adult drug users. By providing a national framework, it also helped to ensure equity and consistency in commissioning and provision of treatment across the country. (*Models of Care* is not a clinical guidance document; clinical guidance is dealt with in the Department of Health's 'Orange book' - which is also being updated.)

In a nutshell, what were the main themes of *Models of Care*?

The 2002 version of *Models of Care* set out for the first time a 'four-tiered' model of service provision, with increasing levels of intervention at each tier. This is now part of the common language of drug treatment – for example, residential services are often called 'Tier 4 services'. This framework also covered local screening and assessment systems, care planning and integrated care pathways. The 2006 update of *Models of Care* was not intended to replace the original version, but to build on it. It advocated a greater focus on harm reduction at all stages and levels of intervention, while at the same time stressing the need for client centred care plans and a greater focus on 'social reintegration' and on moving people through and out of treatment.

So why is it topical now?

When the 2010 Drug Strategy was published in December it suggested that *Models of Care* needed updating. On 2 February, the National Treatment Agency launched a consultation on the design of a new service framework to replace *Models of Care* and to support local areas to deliver the new drug strategy. This new approach is (significantly) called *Building Recovery in Communities (BRIC)*. It is no great surprise that a Government that has been critical of aspects of current drug treatment provision has encouraged the NTA to embark on a root and branch revision of the document that guided commissioning under the previous Government.

With so much else going on at the moment, how important is the *BRIC* consultation?

Pretty important. The document that emerges from the *BRIC* consultation will be used by commissioners to shape and inform the investment in local drug and alcohol treatment for years ahead. The 2010 Drug Strategy was (deliberately) short on implementational detail. It was more about setting out a direction of travel than describing how local services would get to the destination and deliver the improved outcomes the Government wants to see. The *BRIC* document is the first attempt by this Government to develop detailed guidance for drug and alcohol treatment. It should address some of the confusion and anxiety many people currently have about future commissioning and expectations of treatment services. The launch of the *BRIC* consultation was originally expected before Christmas, and was apparently delayed due to discussions at ministerial level about its tone, content and direction – this suggests that it is considered to be a significant document by the Government.

What does the BRIC document look like?

It would be fair to say that it raises more questions than it answers, which is not unreasonable as it is presented as a Consultation Questionnaire. It starts with a brief introduction setting out *BRIC's* broad aims and purposes within the context of the 2010 Drug Strategy. The document is then set out in sections, beginning with a quotation from the drug strategy and followed by a number of questions. The sections include areas such as the integration of drug and alcohol treatment, treatment in prisons, treatment outcomes, recovery champions and communities and barriers to employment.

What are some of the main differences to the earlier Models of Care documents?

To start with, there is a change in the language – evident from their respective titles. The organising question for the *BRIC* document is how existing practices can become more 'recovery orientated' (although it also recognises the role of harm reduction). The *BRIC* questionnaire uses the word recovery no fewer than ninety times, in comparison *Models of Care* uses the word 'recovery' only once. This focus on the term recovery is in line with the Drug Strategy's intention to 'rebalance the system'.

Similarly in *Models of Care* there are only a handful of references to mutual aid groups, and predominantly in the context of aftercare. In *BRIC* there is a whole section entitled, 'Active promotion of mutual aid networks

will be essential' and direct questions about how both mutual aid and peer support can be better integrated into treatment.

Models of Care was explicit that alcohol and prescription drugs were not given 'detailed consideration'. *BRIC* – like the Drug Strategy – states that the focus should be on individuals and their needs and not the substance as such, which is a welcome change. In practical terms, this means that alcohol, 'legal highs', over-the-counter and prescribed medications are introduced into the mainstream of the drug treatment framework for the first time.

Another first is that *BRIC* incorporates drug treatment in prisons as well as community provision. When Models of Care was produced, the Department of Health did not have responsibility for prisons. The 2010 Drug Strategy announced a transfer of responsibility for prison treatment from the Ministry of Justice to the Department of Health, which means a greater emphasis on shared outcomes and co-commissioning.

The *BRIC* consultation also seeks views on the value of a four-tier model (see above), which some argue has created barriers to recovery, by encouraging a view of treatment journeys as sequential and linear.

Any concerns?

As discussed above there are a lot of potential positives about the move towards a more recovery-orientated approach, and the *BRIC* consultation is welcome. It is important that *BRIC* continues to be informed by a balanced and realistic conception of recovery. In addition, it states that 'if the system is to be truly recovery-focused we must enter territory that is relatively uncharted in terms of what is effective after people leave treatment – learning from experience and gaining new evidence as we progress.' This echoes the conclusions of the National Audit Office's 2010 report *Tackling Problem Drug Use*, which commented on the lack of evidence on the effectiveness of interventions to move service users into employment and housing, for example.

In addition, *BRIC* will be setting out the constituents of a recovery-orientated drug treatment system during a period of profound policy and structural change. By the time the *BRIC* guidance is published drug and alcohol services will be adjusting to a whole new landscape, including reform to the health service, the absorption of the functions of the NTA into the new Public Health Service, greater localism, welfare reform, the 'rehabilitation revolution' in the criminal justice system and six pilots of payment by results for recovery. There is also a real risk of local disinvestment in drug and alcohol services – as well as in other things that are vital to recovery, such as housing, training and employment services.

BRIC also provided an opportunity for a greater focus on equality issues. In fact, there is only one question that is concerned with the diverse treatment population, and it asks about all the relevant groups in one go, covering ethnicity, gender, gender reassignment, disability, age, sexual orientation, religion/belief, pregnancy and maternity. Each of these factors will have a unique and significant impact on access to and success in drug treatment (for example, the issues around pregnancy and maternity will tend to be different to those around, say, ethnicity or religion).

What is DrugScope doing and how can members get involved?

The success of the *BRIC* guidance will depend on the responsiveness of the consultation process to the views, concerns and experiences of people who are directly involved in commissioning, managing and providing drug and alcohol services. It is important to ensure that your voice is heard.

One way of getting involved is to help to shape DrugScope's response to the consultation. We have created an online survey picking up some key themes from *BRIC*, and we would encourage you to follow the link below and complete our survey. It should not take any more than 10-15 minutes. The consultation document actively encourages individual responses, with a deadline of 4 May, so we would encourage you to submit your own response too. You can answer as many or as few questions as you want, so don't be dissuaded from participating because you want to focus on just one or two issues in what is a fairly long and complicated consultation document. In addition, the NTA is holding a series of regional consultation events – so you may want to check out what is happening in your locality.

Please complete Drug Scope's online survey at
https://www.surveymonkey.com/s/R5ZFV6Y

For more information on the *BRIC* consultation, including a link to the full consultation document, go to www.nta.nhs.uk/recovery-consultation.aspx