Advice to commissioners and purchasers of modern substance misuse services

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This document provides advice and guidance to health and social care commissioners, drug action teams and other agencies involved in the planning and commissioning of modern substance misuse services.

It has been produced in the context of significantly increased recognition of the impact of substance misuse on individuals and society and the emergence of national strategies and standards for service and commissioning.

Services should be able to respond to a spectrum of need and should work closely with and in support of primary care, other secondary care services and non-statutory agencies. The special needs of young people are addressed in detail in a specific section in this document with key elements drawn from the Health Advisory Service 2000 guidance document (2001). The contribution of general psychiatry and other psychiatric specialities is acknowledged.

Alcohol services

Alcohol consumption in the UK continues to increase, with consequent adverse effects on physical, psychological and social (including community) well-being. When supported by specialists, effective interventions can occur in a variety of settings, including primary care, general hospitals, general psychiatry, social services and probation.

Multi-disciplinary, specialist treatment is effective and is needed to tackle complex alcohol problems, especially where there is psychiatric comorbidity. Non-statutory agencies provide invaluable facilities in both community and residential venues.

Specialist services must include a range of effective interventions, and have close links with other agencies, to provide 'stepped care'. The needs of special groups of patients also must be taken into account.

Alcohol services have a clear contribution to make in tackling the key health improvement areas: cancer, coronary heart disease and stroke, accidents, and mental illness.

Drug services

Drug misuse in the UK also continues to rise. Prevention of communicable diseases, especially hepatitis C, is being prioritised. There is increasing evidence supporting the provision of a range of services for drug users and indicating that these services are effective in reducing harm to individuals and society. Community care is the norm, with a greater emphasis on proper support for

treatments based in primary care. It is more important than ever to retain patients in services and there are more demands for treatment from the criminal justice system than hitherto.

Tobacco

Substance misuse services have a significant contribution to make to the planning and provision of smoking cessation services.

Levels of treatment

Three main levels are evolving:

1. Shared care with primary health care.
2. (a) Community treatment for more complex patients.
   (b) Liaison with general hospitals.
   (c) Liaison with, and response to, the criminal justice system.
   (d) Liaison with mental health and learning disability services for patients with substance misuse comorbidity.
3. High-intensity treatment as in-patients, out-patients or day patients for people with high levels of complex needs.

There is also extensive contact with social services and non-statutory organisations to provide appropriate treatment packages.

Services for young people also warrant a tiered approach, with a specific model to reflect the special issues surrounding this group.

Roles and responsibilities of psychiatrists

Because of the development of extended roles for other disciplines, psychiatrists have key roles in: diagnosis; medical and other treatments; training doctors and other professionals; management; and service planning. The rising demands within varying contexts indicate the provision of 0.9 whole-time equivalent (WTE) consultant psychiatrists per 100 000 population, with a further increase to 1.5 WTEs in more deprived, urban settings.

Background

This document aims to provide advice and guidance in context for the commissioning and purchasing of substance misuse services. Information will be provided separately for drug services and alcohol services, but can be applied to combined substance misuse services, reflecting the diversity of good practice strategically at a national level and operationally in the local context. It will focus on clinical treatment services while recognising fully the importance of other care and support agencies (e.g. voluntary counselling, supported housing and residential rehabilitation).

The health consequences of nicotine smoking, especially in general hospital and psychiatric patients, are recognised, although services to address this problem are not covered by this document. However, much of the expertise from alcohol and drug services is relevant to this area.

Services for young people are addressed separately, reflecting the special issues surrounding this group.

Introduction

In the past decade there has been a sea change in the appreciation of the impact of substance misuse in society generally, and in medical and psychiatric practice specifically. National drugs strategies are reflected in *Tackling Drugs Together* (Lord President's Office, 1995) and *Tackling Drugs to Build a Better Britain* (Cabinet Office, 1998) with the establishment of local drug action teams (DATs) with a developing responsibility for commissioning services as well as overseeing their planning. Complementary strategies exist for Scotland, Wales and Northern Ireland. A national alcohol strategy is likely to be published in 2002/2003. The special needs of young people are addressed, based on the Health Advisory Service 2000 review guidance published in 2001. The significant contribution of general psychiatrists to the management of patients with substance misuse is acknowledged.

Highly structured, criterion-based commissioning standards have been produced by the Substance Misuse Advisory Service (1999). Extensive operational standards are given in *Quality in Alcohol and Drug Services* (QuADS Team, 1999). Guidance on some aspects of drug treatment is given in *Drug Misuse and Dependence – Guidelines on Clinical Management* (Department of Health, 1999*a*).

The plethora of guidance is invaluable to commissioners and purchasers increasingly moving towards joint commissioning. However, there is no clear and cohesive outline of what services should look like within the breadth of good practice. Hitherto, there has been limited emphasis on the need to provide a spectrum of care as a mixed economy of services. Clinically, there is an artificial but nevertheless useful distinction between in-patient and community services: in-patient services should be seen as an intensive phase on the continuum of treatment based on the current needs of the individual. There is an apparent paradox: although there is no suggestion that substance misuse *per se* should be addressed by long-term hospital care, the value of longer-term (6 months to 2 years) residential care under the auspices of community care placements is also acknowledged.

The range of substance misusers extends from those whose drug or alcohol use is likely to cause harm in the future to individuals who are dependent or very severely damaged. A proper service should respond to this spectrum of needs and, where possible, emphasise the earliest, simplest, effective interventions.

It is recognised that specialist clinical teams are best placed to deal with people at the more complex end of the spectrum, although those with less complex substance misuse also require intervention. The clinical guidelines (Department of Health, 1999*a*) emphasise that it is not good practice for primary care teams to treat drug misusers without the support of a specialist team.

There is chronic awareness that, as with most health and social care issues, substance misuse is ongoing, with a pattern of lapse and relapse occurring before there is a more permanent resolution of the problem. This pattern is not usually due to an intrinsic 'failure' of treatment, as there is often partial or temporary remission, but should be seen as part of the natural progression of the disorder in some patients.

Services should be available, accessible and acceptable to consumers' needs. Whenever possible, services should incorporate and build on natural support systems and networks, and be integrated within the community. They also need to be efficient, effective and properly coordinated, while retaining sufficient flexibility to adapt to changing circumstances. As well as the demography and socio-economic conditions, the character, quality and extent of primary level and specialist services vary enormously throughout the country, and all these factors must be addressed in assessing needs.

The QuADS Team (1999) rightly emphasises these values at the operational level and, locally, DATs in particular have a responsibility for ensuring an overview of provision.

Flexibility and responsiveness are key features of good services. There are a number of essential facets (see Fig. 1). All these facets have developed in terms of both strategic priority and volume of need over the past decade.

This document does not advise for or against combined services for drug problems and alcohol problems. For the sake of simplicity, alcohol and drugs are considered separately, with a short section about tobacco.

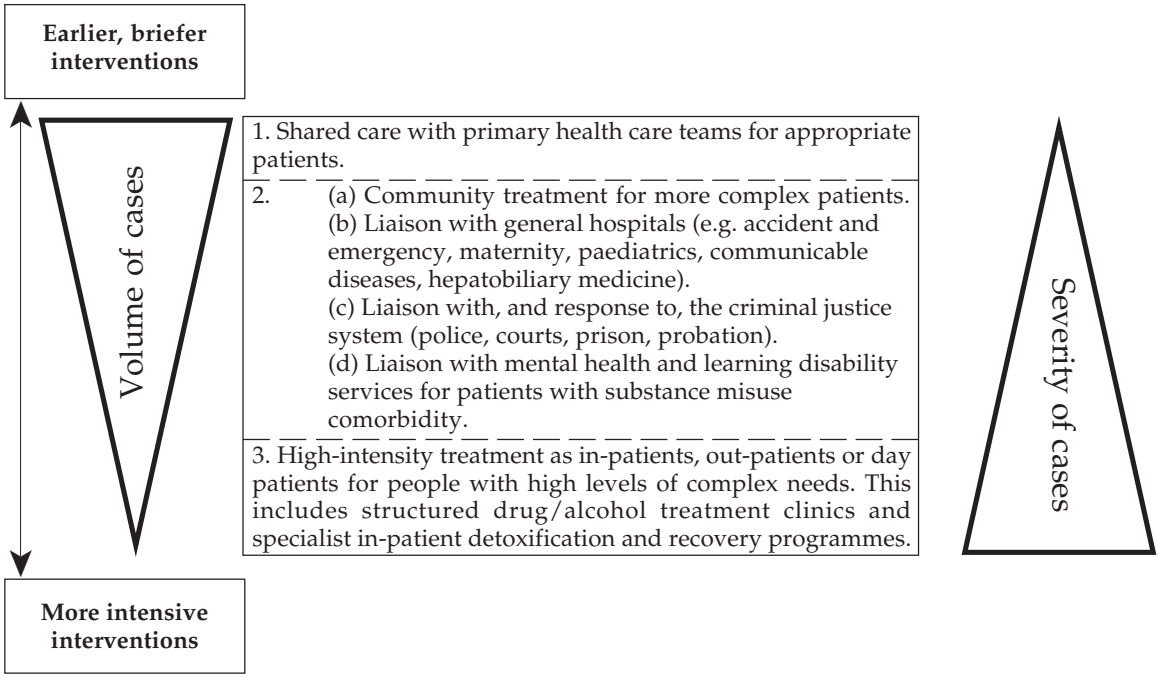

Fig. 1 Essential facets of a good substance misuse service

Alcohol services

Prevalence

The forthcoming national alcohol strategy contains extensive statistical information on the changing patterns of alcohol consumption in the UK. There is evidence of continuing increase in consumption between 1993 and 1998. There is a positive correlation between the affordability of alcohol and consumption, showing a marked rise (50% increase per capita) between 1960 and 1991 (Harkin *et al*, 1995). Accessibility to alcohol has increased in terms of outlets and opening hours, supermarket sales being a prime example. Changing cultural norms in the UK, especially the increase in wine-drinking with meals, has contributed to the rise in consumption. Women consume more alcohol and there has been a rise in the proportion drinking more than 14 units per week from 9% in 1984 to 14% in 1996 (Office for National Statistics, 1998). The preponderance of younger people drinking excessively continues and there has been an increase in regular drinkers aged 11–15 years from 13% in 1988 to 20% in 1996 (Goddard, 1997). Alcohol dependence occurs in 4.7% of the population aged 16–64 (6.8% of men, 2.8% of women) (Meltzer *et al*, 1995).

Alcohol misuse causes, or significantly contributes to, a wide array of physical, psychological and social problems. Deaths directly attributable to alcohol have continued to increase, as have deaths where alcohol is involved. Alcohol misuse significantly contributes to cancer, vascular disease, mental illness, accidents, complications in pregnancy, and violence and other crimes. It is commonly associated with physical, sexual and emotional abuse of children.

Simplistic approaches to tackling alcohol-related problems are inappropriate. The response must be multi-faceted. There are many opportunities to identify alcohol problems in health care settings but they may not be realised. In primary care, patients with alcohol problems consult approximately twice as often as the average patient. There is considerable evidence that earlier intervention can help to reduce progression of alcohol problems (Holder, 1987).

Moderate drinkers

These can be defined as people drinking at or below the identified limits in a safe pattern (21 units per week for men and 14 units per week for women, spread over the course of the week). Screening and monitoring in primary care, and health education and health promotion are key elements. General practitioners are in an ideal position to perform many of these functions.

Hazardous drinkers

These are people drinking above the safe limits without the occurrence of problems or dependence. Brief interventions are effective for a significant minority

of hazardous drinkers in primary care and general hospital settings (Bien *et al*, 1993). However, such interventions might not occur, unless supported by specialist practitioners (Ghodse *et al*, 1997).

Harmful drinkers

These are people drinking above the safe limits with the occurrence of problems but without established dependence. Even though such patients use health services more frequently than other patients, appropriate assessment, brief intervention and specialist referral might not occur. People presenting to social services and the criminal justice system can fall through the net because of patchy collaboration between these teams and specialist substance misuse services.

Dependent drinkers

These are people drinking above the safe limits, with problems and dependence. Such patients have an increased likelihood of significant social, psychiatric and physical complications. Specialist intervention is needed more frequently than for other groups.

Effective services

Raistrick *et al* (1999) divide treatment into generalist and specialist. Effective generalist interventions can occur in a variety of settings, including primary care (general practice), general hospital services (including accident and emergency departments), general psychiatry, social services and probation. These services must be supported by specialists and require extensive training input.

Specialist treatment may be seen as expensive but it is effective. Whatever the main thrust of generalist intervention, specialists are needed to tackle complex alcohol-related problems, especially where there is psychiatric comorbidity. Non-statutory agencies provide invaluable facilities in both community and residential venues. Alcoholics Anonymous has about 2900 meetings per week in England and Wales. Understandably, commissioning standards cannot be too prescriptive in defining the levels and types of specialist alcohol services, but inclusion of alcohol within the remit of DATs will focus attention on inequality of provision across a given area. The activities of specialist services will need to complement other services in contact with alcohol misusers. National Health Service alcohol teams have core roles in supporting developments in, and delivery of, alcohol interventions, wherever appropriate patients are encountered.

Specialist services must be multi-disciplinary, include a range of effective interventions, and have close links with social services and the non-statutory sector. Social work input is particularly valuable because of the range of social problems presenting to alcohol teams – including child protection issues. It is

particularly important that patients have access to the full range of therapeutic modalities:

- psychiatry
- clinical psychology
- nursing
- occupational therapy
- social work
- alcohol counselling (accredited)
- music, art and drama therapies
- physiotherapy
- dietetics
- alternative therapies (accredited)

Pharmacy support is important in the light of emergent pharmacotherapies for alcohol problems and the need for rational prescribing.

Local coordination is crucial and should be encouraged by drug reference groups, DATs and other multi-agency groups.

National Health Service specialist alcohol services

The nature of services will be determined by a number of factors, including population needs assessment, strategic planning and service agreement and contract setting/management/monitoring (Substance Misuse Advisory Service, 1999). The importance of established local services should be recognised: evolution of services is preferable to radical change.

Local planning should take into account the needs of young people, women and ethnic minorities. Partnerships between statutory and non-statutory sectors should be fostered to allow for suitable levels of 'stepped care', focusing scarce resources appropriately. It is crucial to deal with the fallacy that all problems can be addressed completely, at either end of the spectrum of intensity of care. Generally, the level of assessment, treatment and after-care should reflect the complexity of cases. However, it is not being suggested that alcohol services should have sole care for complex cases – rather that they should be able to complement other services involved in collaborative care arrangements. Similarly, alcohol services cannot focus on straightforward cases, but increasingly provide consultancy, liaison and advice to the whole range of agencies likely to come into contact with people with alcohol problems. In order to do this, they should be resourced according to expectations from commissioners, other health and social care providers and the community at large.

National Health Service alcohol teams should be community-based, and supported by adequate detoxification and early treatment facilities for patients with a full-blown dependence syndrome, especially associated with significant medical and psychosocial complications. A relatively small but significant number

of patients requires intensive, sometimes prolonged in-patient treatment/ residential care in order to recover. Otherwise, their needs will not be met and they will continue to make numerous demands on the whole range of health and social services, have increased contact with the criminal justice system and suffer harm to themselves and those around them. As far as possible, such interventions should be community-based, because the intention is to return them to a normal lifestyle.

Audit, evaluation, monitoring and research

These are essential to promote developments in this field and to establish the most effective range of interventions, bearing in mind the diversity of contexts within which alcohol problems present. Findings from one area may not be generalisable to another without an awareness of the limitations.

In relation to public health issues, although many of the measures will be based on health education, alcohol services can have a significant impact on the targets contained in the Government's national strategy, *Saving Lives: Our Healthier Nation* (Department of Health, 1999*b*). The four key areas are:

- cancer
- coronary heart disease and stroke
- accidents
- mental illness.

Alcohol misuse contributes to mortality in all these areas and is susceptible to appropriate intervention. When addressing public health, a balance must be struck between population needs and the needs of individuals and particular groups of patients. Clearly, the four key areas cannot be addressed by early prevention alone. Indeed, national policy addresses the need to intervene in advanced as well as in early disease.

Training

High-quality services can only be delivered by appropriately trained and supervised personnel. In particular, the increasing requirements on consultant psychiatrists in substance misuse necessitate the provision of more posts for trainees at both senior house officer and specialist registrar levels. The prevalence of alcohol problems demands a higher profile for training all professions at all levels, especially at undergraduate level, when professional attitudes are established. Specialists have a key role in contributing to this.

Drug services

Prevalence

Tackling Drugs to Build a Better Britain (Cabinet Office, 1998) outlines the Government's 10-year strategy and has four key target domains:

- to help young people resist drug use
- to protect communities from drug-related antisocial and criminal behaviour
- to enable people with drug problems to overcome them and live healthy and crime-free lives
- to stifle the availability of illegal drugs.

Drug treatment has a central role in reducing drug misuse and its attendant problems. Increasingly, the criminal justice system is looking to treatment services to provide a therapeutic framework to complement the legal constraints on drug users. The Crime and Disorder Act 1998 requires the establishment of youth offending teams and strengthens the powers to deal with drug offenders by the use of drug treatment and testing orders (DTTOs). Also, approaches such as arrest referral and counselling, advice, referral, assessment and throughcare services (CARATS) appropriately demand prompt and targeted responses from drug services. However, the whole range of services must be enhanced to cope with the extra workload. Drug misuse continues to increase (Institute for the Study of Drug Dependence, 1999), although there is some evidence that the rate of increase is abating in younger people. While the HIV seroconversion rate is falling in the UK, rates for hepatitis B and C are continuing to rise in some areas.

Drug-related mortality continues to increase, especially for prescribed opioids and cocaine. There have been a number of reports of increasing availability of methadone being associated with an increase in opioid-related deaths, indicating the importance of rational prescribing and monitoring.

There are many problems associated with the misuse of different classes of drug. Substitute prescribing cannot deal with non-opioid drug misuse, although the prescription of amphetamines is practised in certain services. Therefore, it is crucial that the responses to drug problems reflect the heterogeneity of the issues. Drug misuse can be identified in a number of health and non-health care settings and the task force review indicates that treatment interventions are effective in reducing harm (Department of Health, 1996).

Effective services

All the evidence points towards the need to maintain a range of therapeutic options. The Department of Health (1999*b*) recommends reasonable access to

in-patient drug detoxification and recognises that the need for hospital treatment does not imply a failure of community care, rather an understandable requirement for any intervention to be matched to the level of severity and complexity of drug misuse. Many factors contribute to the susceptibility to drug misuse: lifestyle is a key maintaining factor (Working Party of the Royal College of Psychiatrists and the Royal College of Physicians, 2000). A lot of attention is now focused on criminality and drug misuse. The evidence for effective treatment on a compulsory basis is mixed. It is likely that a small number of drug misusers will continue to benefit from treatment under a degree of coercion from the criminal justice system. However, this approach is not a panacea. To be put into effect, DTTOs require the consent of the drug misuser, and are targeted at a small number of offenders, particularly those who have committed many crimes to support drug misuse. Arrest referral schemes can divert drug misusers into treatment services but require a rapid response to be effective.

Harm reduction/minimisation remains an essential component of effective services for drug misusers, especially in the light of the rising tide of hepatitis C infection. The prevalence among drug injectors varies (e.g. London 85%, Glasgow 77%, East Anglia 59%; Working Party of the Royal College of Psychiatrists and the Royal College of Physicians, 2000) but has significant implications for all health and social care services.

Many drug misusers have complex problems that are not amenable to rapid resolution. Physical health problems as well as psychosocial issues may benefit from longer-term rehabilitation This usually lasts 6–12 months on a residential basis, but it is essential that there is adequate follow-up, ranging from self-help (e.g. Narcotics Anonymous) to continuing relapse prevention strategies supported by a community drug team. It is also very clear that good housing and training/employment opportunities contribute to a better prognosis.

National Health Service specialist drug teams

As for alcohol misuse, the array of services will be determined by a number of factors, including needs assessment, strategic planning and service/contract management. Well-established local services should be used as the basis for service development.

Effective local planning should include the special needs of young people, women and ethnic minorities. It is essential that partnerships between statutory and non-statutory sectors should be encouraged to generate a coherent, mixed economy of care. A realistic compromise should be struck between services for people with severe and complex problems and those for people with less complex treatment issues: the level of assessment, treatment and after-care should mirror the complexity of cases. Drug services should complement other services when addressing complex problems. Specialist drug services cannot focus on simple cases, but should provide extensive liaison and advice to other agencies. Both

liaison and direct care must be provided in a balanced way and should be resourced appropriately. Increasing demand for rapid service from the criminal justice system cannot be ignored. Although there is an argument that some of this demand is not from drug misusers new to services, the level of intervention, monitoring and follow-up is certainly significantly higher.

National Health Service drug teams should be community-based, although effective community treatment of drug misusers with complex problems may require a clinic setting. Throughput can be maintained only with the support of adequate in-patient detoxification, especially for people with associated significant medical and psychosocial complications. A small but significant number of patients requires intensive, sometimes prolonged in-patient treatment/residential care. It is often this small number of drug misusers with complex needs who will continue to come into contact with the criminal justice system, as well as health and social services. Nevertheless, the aim is to return all patients to reasonable community functioning as soon as possible. It is unlikely that many of the aims in *Tacking Drugs to Build a Better Britain* (Cabinet Office, 1998) can be substantially addressed without a significant increase in the number of drug misusers being treated in primary care, allowing specialist drug services to focus on people with more complex problems. However, good primary care support is time-consuming and might be best offered as a separate facet, perhaps with supervision and training provided by specialist services, although based in the community. Shared-care protocols need to be developed that address the level of complexity and treatment being offered in primary and specialist care. The particular needs of younger patients are often better addressed in the primary care setting, at least initially.

The range of services should include in-patient drug detoxification and access to short-term recovery programmes, especially if psychiatric problems are present or suspected. As for alcohol services, it is particularly important to have access to the full range of therapeutic modalities (see p. 11). There should be effective contact with, and input into, drug reference groups, DATs and other multi-agency groups.

Audit, evaluation, monitoring and research

National Health Service teams are incorporating the tenets of clinical governance into their working practices and have a record of service improvement through research and clinical audit (MacLean Steel & Palmer, 2000). However, there is a dearth of good-quality outcome research (Working Party of the Royal College of Psychiatrists and the Royal College of Physicians, 2000).

Targets are being set nationally by the UK Anti-Drugs Coordination Unit and locally by DATs. However, data collection is poor, with variable use of the regional drug misuse databases. Although there is now no Home Office Addicts Index, studies of drug-related mortality are becoming a promising source of information.

Training

The increasing importance of dual diagnosis in mental health and social services makes it imperative that psychiatrists have accredited substance misuse training. More consultants will need to be trained to match the demands of specialist drug misuse treatment. The increasing profile of drug problems necessitates a higher profile for training in all professions at all levels, especially at undergraduate level, when professional attitudes are established. This is especially true in general practice, where there will have to be a major change in professional knowledge, skills and attitudes to meet the need for more primary-care-based treatment: at the moment many general practitioners are reluctant to treat substance misusers at all. Much of the training of medical and dental practitioners will be delivered by addiction psychiatrists.

Tobacco

Smoking is the largest cause of preventable illness and early death (Department of Health, 1998). Most smokers want to stop. Specialist substance misuse teams have the range of expertise and skills to make a significant contribution to the planning and provision of smoking cessation services. Evidence-based approaches draw heavily on treatment techniques used in drug and alcohol services.

Young people's services

In 1996 the Health Advisory Service published *Children and Young People's Substance Misuse Services: The Substance of Young Needs* (Avebury *et al*, 1996), which reviews the services available for young people who used and misused substances and makes recommendations on treatment systems. The recent report by the Health Advisory Service 2000 (2001) updates the changes in policy, commissioning, design and delivery of services and our knowledge of the effectiveness of preventive and treatment interventions. The report covers all substances, including tobacco and alcohol, inhalants and all drugs of potential misuse in young people, under the age of 19 years. It promotes integration and effective joint working both in children's services and young people's substance misuse plans (Department of Health, 2001*a*,*b*). Government intentions also note that:

> 'it is crucial to have a fully integrated approach to the development of young people's services…ministers…agreed to the implementation of an improved, integrated approach to substance misuse, education, prevention, and treatment services for children and young people, which aims to incorporate these services within existing children's services' (Department of Health, 2001*b*).

The Health Advisory Service 2000 report puts forward a vision of services, that of fostering social and emotional health and the reduction of harm within a developmental context. This vision emphasises the need for comprehensiveness and a view of substance use as one aspect of health and behaviour.

Key principles underpinning this vision include:

- The promotion of a view of child health that encompasses mental health and well-being and the absence of health-threatening risk-taking, including substance use and misuse, as a common goal of health and social agencies.
- Recognition of substance use and misuse as an essential and integral part of the challenge facing child health, education and social care agencies.
- The integration of family-, child- and youth-centred substance services into all systems that serve family and youth.
- The engagement of families and children in the planning, design and delivery of services.
- Universal access to services by eliminating barriers to appropriate assessment and interventions.
- Development and delivery of evidence-based prevention, early intervention and treatment systems.

The report recommends particular action steps:

- Promote public awareness of substance use and misuse.

- Develop, disseminate and implement evidence-based education and prevention programmes.
- Promote and improve the screening and assessment of substance use and misuse in children and young people.
- Develop, disseminate and implement evidence-based interventions.
- Ensure equality of access to services for all racial/ethnic and socio-economic and disadvantaged groups.

Each step contains numerous recommendations, sampled below.

Promote public awareness of substance use and misuse

The report recommends a broad approach to health and its promotion and, significantly, an understanding of child health that includes social and mental well-being as well as physical health. All substances should be recognised as potentially harmful, particularly tobacco and alcohol, with actions to address/ ameliorate these risks within the broad programmes that tackle health inequalities and social exclusion. The active involvement of children, young people and families in development and design of service, of health promotion campaigns and information programmes should be promoted.

Develop, disseminate and implement evidence-based education and prevention programmes

A crucial question is 'what works?' and which programme should be implemented. Both commissioning and development of prevention programmes should be in keeping with a central strategic policy on universal and targeted programmes drawn from a central catalogue of evidence-based programmes. This should be integrally linked with the wider strategy for children and young people. Specific education programmes should evolve in keeping with the developing evidence base so that effectiveness is maximised. A systematic categorisation of existing targeted programmes and their effectiveness is recommended. The design of all prevention programmes should be governed by evidence-based techniques with strong academic support in their design and evaluation, commensurate with the particular programme. The Health Advisory Service 2000 (2001) report recognises that, at present, even internationally, there are few evaluated programmes. None of these has been evaluated in the UK and there remains great scope for the development of UK interventions, informed by the international evidence.

Promote and improve the screening and assessment of substance use and misuse in children and young people

Substance use and misuse screening should be an integral part of overall child health and social care. All practitioners working with young people should have

at least a generic level of training in substance issues; they should be able to screen for any substance use and/or misuse, and be aware of vulnerability and the need for child protection. Systematic screening of vulnerable children (e.g. homeless, truants, those within the criminal justice system) and children of parents who misuse substances should be actively encouraged. Assessment instruments that prompt more structured questions are being developed.

Develop, disseminate and implement evidence-based interventions

There is a dearth of evidence-based interventions. Intervention approaches should embrace validated techniques, including some adapted from the adult addiction or child health and social care literature. All practitioners should be competent to deliver the intervention(s) and work within a comprehensive care plan. Interventions delivered by multiple agencies should complement each other and be integrated into a comprehensive stepped care approach based on a comprehensive assessment.

Ensure equality of access to services for all racial/ethnic and socio-economic and disadvantaged groups

The principles of inclusion and accessibility, child protection and comprehensiveness of approach for all children and their families, regardless of issues such as race, gender and socio-economic background, should underpin all commissioning and provision of services. Competence of all practitioners on issues related to race, culture, religion and gender must be ensured. Innovative outreach programmes need development that seeks to increase access, engage and retain young people in services, especially disaffected and vulnerable young people.

Develop and implement a tiered model of services

A tiered model approach that is flexible and dynamic, and that can be used by providers and commissioners to conceptualise the service components needed in an integrated and comprehensive child service is recommended. Such a model offers a framework for cross-system collaboration and integrated care, describes the functions, roles and responsibilities of practitioners, facilitates inter-agency support for skills transfer, training and coordination and better integration of the many varied agencies for children and young people. The model should offer a basis for assessment and audit of current provision and gaps in service, and a range of information to guide effective planning, increase understanding of organisational relationships and support communication and coordination of services. The tiered model described corresponds to that adopted in children's services, particularly child and adolescent psychiatric teams and their commissioners, and accords with the model under consultation for adult addiction services.

Tier 1 services (for all young people): providing substance use education, information, screening and health promotion, and referral to other appropriate services.

Tier 2 services (for all young people who may be vulnerable): providing substance-related education and targeted prevention, support and advice, and assessment and interventions for those identified as at risk of developing problems with substance misuse. This tier will support Tier 1 and have close liaison with Tier 3.

Tier 3 services (for young people with substance misuse problems): providing multi-component, multi-faceted and multi-agency interventions for complex problems facing young people and their families.

Tier 4 services: providing very specialist forms of intervention or particular focused work for young drug misusers with complex care needs. These services are adjuncts to Tier 3 and may include specialist residential treatment. Continuity of care with other tiers is essential.

Develop and implement a plan of integration

The integration of substance misuse services within existing children's services is fundamental to the development of young people's substance misuse services (Health Advisory Service 2000, 2001). Such a 'joined-up' approach will first require children's commissioning groups to review their structures alongside DATs to ensure adequate resources, both financially and in human terms, to begin this integration. It may be that the DAT will initially lead the collaboration, partly because of its current structures and involvement. However, the aim should be to embed substance misuse services within children's services, led by the children's systems supported by DATs. Considerable involvement from addiction services and DATs will continue to be required.

Human resource strategy

Many services are severely hampered because of workforce and recruitment problems, complicated by competency and training issues. The availability of training is essential to building the capacity and competence in delivering services. Development and delivery of training in sufficient quantity and of the required standard represents a considerable challenge for government, commissioners and service providers. The current range and number of training initiatives specifically directed at young people is limited and of unknown quality. The National Treatment Agency human resource strategy should specifically address this issue and embark on liaison with professional bodies to assist in recruitment, training and dissemination of good practice. Child services (including child and adolescent mental health teams, social services and education) have considerable expertise in the understanding of child development but view the substance use

field as novel. It is critical that child practitioners should feel adequately trained, competent and supported in addressing not only the complex developmental needs of vulnerable young people, but also their substance use.

Evaluation

This is essential when services develop in a field where there is a dearth of evidence. It will require resources and must be supported by commissioners.

Sequential implementation and leadership

Change is essential and must be based on robust principles. The Health Advisory Service 2000 report (2001) suggests a set of sequential steps aimed at achieving improvements, establishing a culture of evaluation of services and achieving integration with children's systems. A national integrated implementation plan requires careful planning. Any implementation of these recommendations will require leadership and coordination across departments and organisations, those concerned not only with addiction but with all aspects of children's services. A subgroup of the group responsible for implementing the children's National Service Framework may be well placed to carry out this function in the longer term. Crucially, in the era of rapid developments of these services, careful evaluation and coordination of approach at all levels are required.

Maintaining links between child and adolescent and substance misuse services

These links should operate at all levels of the implementation of the young people's strategy. The development of such a systemic approach will have its roots in the training of psychiatrists, other doctors (e.g. paediatricians, general practitioners) and all relevant disciplines, and extend to all aspects of clinical governance and equivalent processes in other areas. Commissioning links are equally important, especially given the divergence of commissioning pathways within the emerging health and social care economy (i.e. the roles of strategic health authorities, DATs and primary care trusts must be clarified and they should collaborate effectively).

Roles and responsibilities of psychiatrists in substance misuse services[1]

No professional group is sacrosanct and each must be considered in terms of roles, responsibility and value for money. Referring to Fig. 1 (p. 8), medical responsibility must be held by a psychiatrist fully or partially at all levels apart from at level 1. The distinct specialised knowledge, skills and expertise of a psychiatrist in substance misuse are reflected by Faculty status within the Royal College of Psychiatrists. Psychiatry sessions should provide a number of aspects: essential medical aspects (diagnosis and treatment of physical and psychological conditions, and medical responsibility); psychiatric aspects (specialised diagnosis and treatment of psychiatric disorder within a biopsychosocial model); and substance misuse aspects (accredited, specialised expertise within this area of practice). In addition to these core roles, consultant psychiatrists contribute leadership, managerial and extended strategic skills, in keeping with their training and seniority.

The accepted, recommended level of consultant provision has been 0.6 whole-time equivalents (WTEs) per 100 000 population. However, this figure was based on the scope and priorities of substance misuse services in 1990. Extending the roles of other professional disciplines such as nursing, clinical psychology and social work can meet many of the responsibilities within the national strategic frameworks for drugs and alcohol, but the changes justify enhancing the provision to 0.9 WTEs per 100 000 population, with a further increase to 1.5 WTEs in more deprived, urban settings. This is reflected in the model job description for a consultant addiction psychiatrist. In addition to consultant time, training and/or non-consultant career grade time should be provided. Figure 1 illustrates the extending areas for direct service provision and liaison expected of modern substance misuse services. Consultant psychiatrists not only have to fulfil specific clinical duties but have increasingly also become involved in other activities such as:

- clinical governance, including audit, evaluation, research and monitoring
- continuing professional development
- management and clinical leadership responsibilities
- training doctors and other disciplines.

Enhancement in the provision of psychiatry sessions would also reduce professional isolation, and encourage peer review and scrutiny. It would also

1. This section formed the basis for the Substance Misuse Faculty's position statement on the role of consultants with responsibility for substance misuse, now published in full (Royal College of Psychiatrists, 2002).

reflect the increasing place that substance misuse has in health issues such as dual diagnosis and in social well-being, including the safety of communities where there is pressure to retain patients in active treatment. These issues are likely to be of more importance as joint commissioning plays a greater part in determining the configuration of substance misuse services.

Similar issues permeate the roles of child and adolescent psychiatrists where there is a substance misuse component, especially when this is highly specialised (e.g. responsibility for Tier 4 services). The expertise of psychiatrists is invaluable in the coherent commissioning and development of young-person-specific services.

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