



Executive Summary

Report of a National Study of Care Co-ordination in
Drug Treatment Services (NatSOCC)

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REPORT OF A NATIONAL STUDY OF CARE CO-ORDINATION IN DRUG TREATMENT SERVICES (NATSOCC)

EXECUTIVE SUMMARY

ES1 - BACKGROUND

Drug misuse is a chronic relapsing condition (Gossop et al, 1998) commonly complicated by social problems and physical and psychiatric co-morbidities (Home Office, 2002; Weaver et al, 2003). Addressing the problems associated with drug misuse is a priority for the UK Government.

Care co-ordination, a form of case management, was introduced to drug treatment services to enable a 'joined-up' response to the multiple and complex needs of individual drug users (NTA, 2002). The introduction of care co-ordination was novel in UK drug treatment services, although forms of case management had been applied in other treatment settings.

The generic aims of case management are (a) to maintain client's engagement with services and, (b) to improve defined measures of health status and social functioning. In the drug treatment context, care co-ordination is intended to be 'needs-led' so the intensity of care co-ordination will depend on the range and complexity of individual presentation. However the fundamental objective of case management is to enhance patient outcomes by improving the co-ordination of service delivery and increasing access to needed services (Onyett, 1992). Assessment and care planning are key elements of a longitudinal care co-ordination process that involves;

- identification of a named care co-ordinator to organise care across health and social care agencies and maintain contact with the client;
- systematic and ongoing assessment of health and social care needs;
- care planning which responds to these needs; and,
- regular reviews

ES2 - METHOD

ES2.1 - STUDY AIMS

The evidence base supporting the implementation of care coordination in UK drug treatment services is minimal. Against this background we were commissioned:

- To examine the current implementation of care co-ordination (case management) within drug treatment services (statutory & non-statutory).
- To describe emerging models of case management practice.
- To identify how the case management process potentially impacts upon;
 - the attainment of improved engagement, retention and follow-up of service users; and,
 - improved co-ordination across the substance misuse services and key partner agencies (i.e. the mental health service and criminal justice agencies).
- To use the findings to identify models or approaches to case management practice with potential to enhance treatment outcomes that can be subject to formal evaluation.

ES2.2 - DESIGN

To achieve these aims we implemented a two-phase investigation:

Phase I involved a national postal survey of services providing tier 3 interventions across all English DATs. This was designed to describe service characteristics, measure the extent to which case management had been implemented and describe emerging models of case management practice.

Phase II involved multi-method studies of care co-ordination in 8 sites sampled to reflect variation in service type and team composition. We completed a survey of keyworkers to obtain data about the time they spent on different case management tasks, observed the case management provided to a cohort of new referrals over a 90 day period and described the management of clients jointly managed by drug treatment and adult mental health services.

ES3 - RESPONSE RATES

Phase I survey: We received completed questionnaires from 337 (74%) of the 455 services eligible to take part in the survey. Nine respondents did not meet inclusion criteria. Hence our main analysis was undertaken using data from 328 services.

Phase II Case studies: The case study sites comprised four prescribing services and four non-prescribing services.

- We received completed questionnaires and diaries from 103 of the 119 keyworkers employed at these services (87%).
- Ninety-day longitudinal case records were completed for 168 clients who started treatment during the study period.
- Case-based interviews were completed with care coordinators of 52 jointly clients jointly managed with mental health services.

ES4 - NATIONAL PROFILE OF TIER 3 DRUG TREATMENT SERVICES

Findings from the Phase I survey:

ES4.1 - SERVICE TYPES

Respondent services exhibited marked heterogeneity in configuration, interventions provided and team composition. We developed a typology which was used in subsequent analysis and to report findings. Services were described in terms of a dichotomy between prescribing and non-prescribing services and further differentiated as follows:

- Structured prescribing services with or without a structured counselling service but NO structured day programme (n=174, 53%). These are referred to hereafter as prescribing services without a day programme.
- Structured prescribing services with or without a structured counselling service but with a structured day programme (n=44, 13%). These are referred to hereafter as prescribing day programmes.
- Non prescribing services providing structured counselling without a day programme (n=46, 14%). Referred to hereafter as non-prescribing counselling services.
- Non prescribing services providing structured day programmes with or without structured counselling (64, 20%). Referred to hereafter as non-prescribing day programme.
- The vast majority of prescribing services are managed by a statutory provider (187/219, 85%). Non-statutory agencies are the main providers of non-prescribing services (100/110, 91%).

ES4.2 - STAFFING AND TEAM COMPOSITION

Keyworkers were recruited from a wide range of professional backgrounds, most commonly nursing (n=1402, 38%), social work (n=518, 14%), community work (n=319, 9%), counselling (n=281, 8%), criminal justice work (n=246, 7%) and psychology (n=198, 5%). Keyworkers with no healthcare related qualifications made up 16% of the workforce.

The disciplinary composition of teams varied markedly. All prescribing services were medically led and included nursing staff. However, there were three variants on these medically led teams:

- Comprehensive Teams consists of doctors, nurses plus staff from a social care background and staff delivering psychosocial interventions.
- Medical team, no social care professionals. These teams included other allied health professions usually delivering psychosocial interventions, but did not include staff with social care qualifications.
- Medical team + social care professionals. These teams included staff from social care professions.

Non prescribing services either had:

- Social care teams comprising staff from a social care background.
- Psychosocial teams consisting of staff trained in counselling, psychology and psychotherapy.

ES4.3 - PROFILE OF INTERVENTIONS PROVIDED

Prescribing services provided the widest range of tier 3 interventions while the majority of counselling services and non-prescribing day programmes concentrated on their defining mode of intervention.

A small proportion of tier 3 drug treatment services also provide tier 4 services (n=46, 14%) and the majority (including at least half of the services in each service type classification group) offer clients tier 2 interventions (n=219, 67%).

ESS - ORGANISATIONAL ASPECTS OF CASE MANAGEMENT WITHIN TEAMS

Findings from the Phase I survey:

ESS.1 - CASELOADS

The Phase I survey showed that there was substantial variation in team size, aggregate caseload and mean caseload per wte keyworker between and within sub-groups of service types.

The mean caseload per wte keyworker was highest in prescribing services without a day programme (28 drug clients, 31.5 drug and alcohol clients; range: 5-230).

The median caseloads per wte keyworker in prescribing day programmes was 16 drug clients, rising to 18.6 when alcohol clients were also included. (Range: 8 - 158).

Keyworker caseloads in non-prescribing services were typically smaller than in prescribing services. The median caseloads per wte keyworker in counselling services was 9.7 drug clients (range 2-33), rising to 14.2 (2-33) when alcohol clients were also included.

The median caseloads per wte keyworker in non-prescribing day programmes was 6.6 drug clients (range 2-55), rising to 8.8 (range 4-55) when alcohol clients were also included.

Some services treat a small number of clients relative to the number of keyworkers and some services treat a very high number of clients with relatively few keyworkers. Services with keyworker caseloads of fewer than 5 were either non-prescribing day programmes (n=14) or a small counselling service (n=1).

In contrast there were 9 services where these caseloads exceeded 70 clients per wte keyworker. These were all prescribing services without day programmes with large aggregate caseloads (> 250 clients). In each team doctors keyworked clients and provided medical management to non-comprehensive teams of nurses but no social care staff.

ESS.2 - ALLOCATION OF CASE MANAGEMENT RESPONSIBILITY

The vast majority of services (n=318, 97%) reported that keyworkers were allocated a personal caseload of clients. There were 79 services (24%) in which the allocated keyworker was described as having sole responsibility for case management of the clients allocated to them. Nearly three-quarters of services (n=239, 73%) reported that these keyworkers also shared responsibility for a proportion of cases with the team. In contrast, a small number of services (n=10, 3%) reported that keyworkers were not personally allocated a caseload and that there was a responsibility for all cases shared by the whole team.

Services reporting each of the above arrangements were distributed across different service types and between differently composed teams and there was no significant relationship between service type and model of case management responsibility.

Amongst the 318 services in which keyworkers were allocated a personal caseload of clients, two-thirds of services (217/318, 68%) reported that some form of internal brokerage operated within the team. Prescribing services with a comprehensive team were more likely to report internal brokerage than those with non-comprehensive teams.

There were only 36 services (11%) where there was no sharing of casework in relation to individual cases within the team. This arrangement was reported at services of all types.

ESS.3 - POLICIES FOR THE MANAGEMENT OF KEYWORKER CASELOADS SIZE

A quarter of services (n=81, 26%) reported that they had no policy in relation to caseload size, while a third reported operating some form of caseload weighting system (n=98, 32). The remaining 42% (n=129) reported a team policy whereby a simple minimum and/or maximum number of cases that a wte keyworker could be allocated had been defined. These stated policies were often a poor guide to the actual caseloads which keyworkers carried. Mean keyworker caseloads fell within the range defined by a team policy in 6 out of 10 teams (60%).

ES6. - THE CASE MANAGEMENT PROCESS

Findings from the Phase I survey:

ES6.1 - ASSESSMENT & CARE PLANNING

The vast majority of services (96%) completed some form of clinical assessment, either triage or comprehensive, with more than 90% of their caseload.

Overall 93% of tier 3 clients were estimated to have received a risk assessment.

Overall, 89% of the total aggregate treatment population received either a brief or a comprehensive care plan. The proportion with a care plan was lowest at counselling services (84%) but did not differ markedly between other service types.

The duration of the assessment and the care planning processes were described by different respondents as 'open-ended', variable by client' or 'time limited'. Services of all types reported these differing practices and did not differ significantly in total aggregate caseload, or median individual keyworker caseload size.

ES6.2 - MONITORING OF THE CLIENT'S PROGRESS IN TREATMENT

A significant minority of drug treatment services reported that they would visit clients who fail to attend for assessment (n=105, 32%) or who miss treatment appointments (n=120, 37%).

For most services reporting the use of outreach, the mechanism was employed to maintain contact with clients irrespective of referral route. The use of outreach was not limited to criminal justice clients, but services are slightly

more likely to carry out home visits for clients if the service has a relationship with a local DIP team.

ES6.3 - REVIEW OF CARE PLANS

We estimated that at least one care plan review had been completed for 85.5% of the total aggregate tier 3 treatment population. The proportion receiving a review was lowest amongst counselling services (77%) and highest at structured prescribing services (87%) and non-prescribing day programmes (88%).

ES6.4 - THE ALLOCATION OF KEYWORKER TIME TO CASE MANAGEMENT ACTIVITIES

Findings from the staff diary completed at phase II case study sites:

Client contact represents 40% of keyworker time. Keyworkers at counselling services spent the largest proportion of work-time in client contact (45%), while keyworkers at prescribing services with non-comprehensive teams had the lowest level of contact (31%).

Care co-ordination represented 15% of keyworker activity overall. However, keyworkers at prescribing services with comprehensive teams spent 20% of their time in care co-ordination whereas those at counselling services spent just 6% of their time on this activity.

General administration was the second most time consuming activity after client contact, taking up a quarter of keyworker time. Time spent in business meetings, travel and supervision in aggregate represented less than 10% of total keyworker time.

ES7 - THE EARLY CASE MANAGEMENT PROCESS

Findings from referral data completed at phase II case study sites:

ES7.1 - RETENTION AND ATTRITION DURING ASSESSMENT AND THE FIRST THREE MONTHS OF TREATMENT

Across the 8 case study services 508 referred clients were offered a full assessment during a ten week recruitment period. 77% (n=389) attended a full assessment. The highest rates of non-attendance observed were at the non-prescribing day programmes (47%, n=73/154) and prescribing services with non-comprehensive staff teams (26%, n=31/119).

The vast majority of clients assessed were offered treatment (380/389, 98%) but of the clients offered treatment, 64% (n=323 / 380) subsequently started treatment. The observed proportions of clients starting treatment were highest at counselling services (87%, 83/87), and lowest at the non-prescribing day programmes (72%, n=73/154).

At non-prescribing day programmes, high rates of attrition pre- and post-assessment, meant that only 36% (n=55/154) of referred clients started treatment. Further attrition after starting treatment meant that overall only 18% of referred

clients (n=28/154) were retained in treatment at three months. The proportions of the referred populations retained in treatment for three months ranged between 53% and 64% at other service types.

ES7.2 - SPEED OF SERVICE RESPONSE: REFERRAL, ASSESSMENT AND TREATMENT START DATE

The median number of days between the referral date and the first date offered for assessment was 3 (range 0-90). The interval between the start of assessment and the initiation of treatment was 7 days (range 0-153). For all cases the median interval between referral and the treatment start date was 11 days (range 0-171).

Statistically significant differences were observed for each of the above measures between service types. Prescribing services with comprehensive teams achieved the most rapid assessment and initiation into treatment, prescribing services with non-comprehensive teams were slowest.

ES7.3 - CASE MANAGEMENT OUTCOMES AT THREE MONTHS

Findings from longitudinal case records completed at phase II case study sites. (168 of 323 referred cases starting treatment)

For most clients assessment was reported to be completed at a single appointment. The most frequently identified drug treatment needs were for 'care planned prescribing' (n=83, 49%) and 'advice / information' (n=57, 34%). The most common community care needs were in relation to 'relationships / social skills' (n=79, 47%), physical or sexual health (n=64, 38%), work / employment (n=62, 37%) and mental health (n=53, 32%).

All clients were reported to either have a care plan or for it to be under development on the basis of their assessment. In two-thirds of cases at least one other clinician was involved in discussions about the development of the client's care plan (n=113, 67%). This was most commonly a co-worker within the team (n=57, 34%) or a psychiatrist (n=26, 16%). External care agencies were involved in just under half of all cases (n=79, 47%).

Keyworkers had contact with their client on 11% of their days in treatment. Care co-ordination tasks were completed on 3% of days in treatment. Keyworkers at non-prescribing day programmes recorded the most frequent sessions with clients (17% of treatment days) and the greater proportion of days on which care co-ordination tasks were undertaken (13%).

The proportion of treatment days in which the keyworker contacted the client and completed care co-ordination activity was comparable or higher amongst those clients who dropped out of treatment than those who were retained in treatment at 90 days.

An analysis of the degree of congruence between assessed need and the interventions provided at three month follow-up revealed numerous cases in which assessed drug treatment needs had not been matched by intervention.

Provision of interventions to address assessed community care needs was markedly lower. Between one and two-thirds of those clients with the four most commonly assessed community care needs had not received appropriate intervention at the 3 months follow-up.

ES8. - CARE CO-ORDINATION - WORKING WITH PARTNER AGENCIES

Findings from the Phase I survey:

ES8.1 - RELATIONSHIP WITH CRIMINAL JUSTICE SERVICES AND THE DRUG INTERVENTION PROGRAMME

The configuration of drug treatment services relative to criminal justice agencies (CJS) varied markedly. One fifth of services (n=67, 20%) had been merged to form a single combined drug treatment and DIP team. The large majority of services however reported being separate from the DIP or CJS team(s) in their catchment (n=261, 80%), though a third of these (84/261, 32%) reported having one or more joint posts with a DIP team. Those with joint posts represented a quarter of all treatment services (26%). There were no significant differences in the proportions of different service types reporting the above relationships to DIP teams (See table 8.1)

CJS keyworkers retained at least some responsibility for care planning, care co-ordination, monitoring or review in a large majority of cases referred to combined treatment teams (3680 / 4431, 83%) and teams with joint posts (1989 / 2618, 76%). In contrast, less than half of patients referred to teams with no formal links to DIP were subject to joint management (1705 / 3503, 49%)

ES8.2 - RELATIONSHIP WITH MENTAL HEALTH SERVICES

Findings from the Phase I survey:

At a small majority of services it was reported that the catchment mental health service had primary responsibility for care co-ordination work with clients with severe mental illness. Around a tenth of respondents (n=37, 12%) stated that the drug treatment keyworker was responsible for care co-ordination and a small number said lead responsibility for cases was divided approximately 50:50 between the two services (n=21, 7%). Some services were unclear which agency retained primary responsibility (n=53, 17%).

Findings from the study of jointly managed clients at Phase II:

Lead responsibility for the client's care co-ordination was reported to rest with mental health services in half of all cases (n=79, 50%), with the substance misuse team in 31% of the cases (n=49). Responsibility was reported to be shared in 11% of cases (n=17). Lead agency status was unclear or unknown in 13 cases (8%).

Findings from the study of jointly managed clients at Phase II case study sites (Interview study population, n=52)

Lead responsibility was reported to be held by the drug service in 19 cases (37%) and the mental health service in

17 cases (33%). Responsibility was reported to be shared in 9 cases (17%) but unknown in 7 cases (14%). Almost all clients (n=50, 96%) were reported to have a substance misuse treatment care plan. The median number of days in the preceding 90 days in which keyworkers reported some client contact was 5.5 (range: 0 – 36). The median number of days in the preceding 90 days in which keyworkers reported some care co-ordination with an external agency was 3 (range: 0 – 36). There was no statistical significance in the frequency of care co-ordination between cases where the lead agency for care co-ordination was, or was not, the drug services.

Irrespective of the overall lead agency identified, drug treatment keyworkers were mostly responsible for co-ordination with substance misuse agencies and mental health keyworkers were mostly responsible for co-ordination with mental health agencies. There was a high level of uncertainty about responsibility for co-ordination with some agencies – notably alcohol treatment services, social services, housing agencies or hostels and primary care teams.

All clients with a care plan (n=50, 96%) had been reviewed. Two-thirds of reviews were undertaken separately by drug treatment and mental health services (n=35, 67%), the remainder being completed jointly (n=15, 29%). Arrangements for joint reviews were variable.

Keyworkers experiences of the joint management arrangements in place for each sampled patient demonstrated that workers often had mixed experiences.

ES9. - DISCUSSION

The NatSOCC study provides important new evidence about the early development of case management in drug treatment settings.

Services have embraced case management principles and are undertaking assessments and developing care plans which they both monitor and review. However, beneath this positive finding, extreme variation in practice was observed. Possibly the most striking differences in case management practice that we observed related to caseload size. However, we have also seen diversity in workforce composition, keyworker responsibility, commitment to internal and external brokerage, case management process, outreach and inter-agency care co-ordination. With respect to each of these services report a variety of approaches. Moreover, services reporting these different arrangements are distributed across different service types and between differently composed teams. We found few, discernable or significant relationships between service type and practice in relation to any of the above. Many of the differences we observed were independent of the service typology or the professional composition of the teams described in the preceding section. Services providing the same range of interventions to similar client groups appear to be approaching case management in quite different ways.

Even though we found little evidence that outreach was a prominent activity, this is a clear area for development and further investigation. One further clear priority should be to establish more clearly an evidence base around appropriate caseload size. Beyond these tentative notions, when

reviewing the study findings it is difficult not to conclude that while the key components of case management have been established in drug treatment settings, practice is currently so variable that it is impossible to develop a useful typology of models. For these reasons, in order to describe the case management being implemented in any single treatment setting one needs to do so in terms of certain key dimensions.

Firstly, the organisational context needs to be considered (the services mode of intervention, target population and casemix)

Secondly, there are a range of professional issues which will have a bearing on the approach taken. These include team composition and skills mix, generic or specialist workers and commitment to brokerage.

Thirdly, the local case management policy framework pertaining to the service needs to be considered. (Caseload size and caseload management)

Fourth, how is the case management process managed? (Brokerage with partner agencies, Speed of response and intensity of casework, Duration of case management, monitoring, assertiveness & management of non-compliance.)

Our findings suggest that there is a lack of consensus and consistency around key aspects of case management practice. But the objective must not be to impose a homogeneous model onto the mixed economy of provision that is such a strength of the UK system. Rather we need an evidence-base which supports the appropriate application of different approaches. In order to refine models appropriate to the range of UK drug treatment settings and to provide guidance which can be flexible and context specific, research should begin focusing on investigating the practice, process and outcomes associated with the dimension of practice described above. Our study shows that interesting and potentially positive developments are in process. These need to be fostered and rigorously evaluated so that policy and practice guidance, and local DAT commissioning decisions can be guided by good outcome-based evidence.

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DISCLAIMER →

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