special article

Psychiatric Bulletin (2001), **25**, 350–352

LAOFE OLADELE OGUNDIPE AND ROGER BLOOR

Service innovations: multi-agency standardised assessment schedule as a model of shared-care in managing drug misuse

Managing drug misuse is a challenge to health care workers because of the social, psychological and physical factors that contribute to drug use. Multi-disciplinary working beyond routine discharge and referral letter has been recommended but no single model of shared-care will be appropriate for all situations. We developed an innovative approach to collaborative working between agencies, which led to early access to treatment of people who misuse drugs and their greater satisfaction with the care provided. This seamless approach to sharing assessment data is reported in this article. It offers a model of 'shared-care', which improves services for people who misuse drugs, within current resource levels.

The magnitude of the problem of addiction needs no elaboration even if the question of how many people use drugs is notoriously difficult to answer. There are social, psychological and biological factors associated with drug use, the needs of the drug user are complex and it is unlikely that any one professional group will adequately meet these needs. The treatment of addiction is best delivered in a multi-disciplinary setting (Department of Health, 1999). The Drug Misuse and Dependence Guidelines on Clinical Management of substance misuse describe a multi-disciplinary approach as 'essential' and enjoin medical practitioners not to prescribe in isolation. The guidelines recommend 'shared-care'; viewed as any close cooperative work between agencies or services that directly improves the treatment of the drug misuser. Shared-care is defined as:

> "the joint participation of specialists and general practitioners (and other agencies as appropriate) in the planned delivery of care for patients with drug misuse problems informed by an enhanced information exchange beyond routine discharge and referral letter . . .".

This document (popularly called the 'orange book' and regarded as 'the bible' of drug management) suggests that no single model of shared-care is likely to be appropriate for all situations. Most districts have been establishing services following the principles of share-care (Beaumont & Janikiewicz, 1997). We therefore attempted to develop a local model of shared-care in the form of multi-agency assessment meetings. This paper describes our experience of a 10-week pilot run of this model of treating addiction.

Background to pilot project

The North Staffordshire area, like many areas in the UK, has a substantial number of people dependent on illicit drugs, particularly heroin. The magnitude of the problem of addiction in this area has been documented (Crome, *et al*, 1998). The specialist service for people who misuse drugs is based at the general hospital where detoxification treatment is carried out. Non-statutory services available locally include Staffordshire Alcohol Advisory Service and Druglink. They do an initial assessment of the drug use and engage the drug misusers in supportive relationships, pre-detoxification counselling, post-detoxification relapse prevention and needle exchange programmes.

These services appeared compartmentalised and despite the concerted efforts of all the professionals, the services became overwhelmed. The waiting-list grew to over 600 patients and waiting time lengthened to over 24 weeks. We thought that multi-disciplinary assessment meetings designed to increase collaboration between services would improve patient care and shorten the waiting-list and time.

The intervention: a seamless assessment schedule

The main problem was the amount of time expended on individual patient assessment. The general practitioner (GP) will usually refer the patient to the addiction unit or to Druglink, although drug misusers often approach Druglink directly. The patient is seen by a trained Druglink worker, who typically spends about 1 hour on assessment. The patient is then referred to the specialist addiction unit of the local hospital where a nurse spends

https://doi.org/10.1192/pb.25.9.350 Published online by Cambridge University Press

special article

another half an hour on assessment. This is followed by a doctor's assessment, which usually takes a further hour, before treatment begins. This cumulative time of over 2 and a half hours results in inefficiency because the assessment done by Druglink is not shared by the doctor or nurse because the information is not collected in a standard format. The nurse repeats the assessment, essentially collecting similar information as did the Druglink worker and although the nurse's assessment may be available to the doctor it may not be useful. The multi-agency meeting was designed to eliminate these repetitive assessments and to forge a seamless assessment approach whereby assessments by all agencies would be standardised and made available to all other professionals. A common assessment form, based on the Maudsley Addiction Profile (Marsden *et al*, 1998), was developed. The first person making professional contact with the patient collected the information required by the Druglink worker and the nurse, as well as most of the information required by the doctor. The doctor will only need to devote time to doing a mental state examination and physical examination, the bottle-neck to starting treatment.

The objective

This project is not designed to prove the efficacy of multi-agency working. The 'orange book' recommends multi-disciplinary management of addictions. This recommendation from a respected (quasi-legal) authority has not been contradicted by any randomised controlled trial and should, therefore, be accepted as the current evidence basis for clinical practice. Rather, we explored the logistical difficulties that might arise in our area should such a collaborative meeting be introduced. We envisaged that there might be problems with maintaining confidentiality and with maintaining a unified supervisory authority for a team of such a diverse membership, where each member is employed by a different authority with different line managers. We also explored the implications for extra resources that a multi-agency meeting forum might entail.

Team philosophy

Multi-agency teams can founder if members employ different philosophical stances. We therefore agreed a treatment approach based on the following principles (encapsulated in the acronym METHADONE):

- **M**oving people away from the crime and drug scene as soon as contact is made with them
- **E**ngaging drug addicts in therapeutic relationships
- **T**riggers to drug use must be explored individually
- **H**ealth education and health promotion practices
- **A**lternative activities to using drugs must be facilitated
- **D**angers and disadvantages of drug use personalised
- **O**ccupational rehabilitation and social reintegration are essential
- **N**egotiated reduction in substitution drug is at the core of treatment
- **E**mpowering the addict to avoid relapse is the ultimate goal.

The team believes that all components of 'Methadone' should be delivered by a team of professionals who are in regular contact with each other. The full discussion of the rationale for this philosophy is beyond the scope of this report but there is sufficient face validity or evidence base for each element. For example, there is evidence that adequate treatment of addiction substantially reduces the rates of criminal behaviour at 1-year follow-up (Gossop *et al*, 1998). A sustained therapeutic relationship leads to better outcome because frequent treatment sessions result in more abstinence (McLellan *et al*, 1981; DeLeon, 1991). The reasons why people use drugs are varied and complex and it is reasonable to assume that discussing temptations individually is an essential part of treatment.

Findings

A psychiatrist, social workers, nurses and drug workers from Druglink held about 10 meetings sharing assessments and jointly formulating management. The meetings provided a useful forum for assessing and treating drug addicts because all the required professional expertise is available to plan and pursue appropriate management. Our patients reported satisfaction with starting treatment earlier than would be required if they went onto a waiting-list. This pilot scheme showed that the initial assessment can be reduced to 1 hour per patient and can be done by one member of the team in a way that is useful to all members, thereby reducing unnecessary duplications. All professionals who took part were happy to be actively involved in discussions about treatment and progress of their 'clients'.

The issue of confidentiality was somewhat controversial but because all team members were health care workers we thought that they could share information based on 'the need to know'. We therefore informed the patients that any health care professional might have access to the information they provide, to facilitate treatment. Contrary to initial fears about diffusion of leadership authority within the team there was no problem with our non-hierarchical approach, although the psychiatrist took a leading role. We also found that it would be possible for such multi-agency meetings to operate with little extra resources (those needed to facilitate attendance at the weekly meetings). We believe that the extra cost of travel and the opportunity cost of the time spent at the meetings is likely to provide greater extra benefit, in health economics terms; the marginal benefit outweighs the marginal cost.

Discussion

The short life of this pilot scheme precludes any definitive conclusion but it demonstrates a multi-agency standardised assessment schedule can improve the care of patients who drug misuse, provide faster access to care and increase patient satisfaction. This shared-care approach has the potential to reduce substantially the waiting-list and time. The characteristic feature of this teamwork is a standardised assessment schedule used by

https://doi.org/10.1192/pb.25.9.350 Published online by Cambridge University Press

special article

all members of the team and shared by others. The scheme is capable of delivering a flexible service, utilising differing skills available locally in the most effective manner (Gask *et al*, 1997). A similar seamless approach in general psychiatry was reported to be useful locally as a model of working at the interface between primary and secondary care levels (Ogundipe, 1997).

As a minimum the team should involve all the local voluntary agencies helping drug misusers, a social worker and a primary community psychiatric nurse (CPN). These primary care workers will administer the standard assessment protocol in their community-based clinics and present the cases at the weekly multi-agency meetings where a management plan is formulated. Some GPs interested in treating patients who drug misuse may find it useful to attend these meetings as 'specialised generalists'. A secondary CPN representing the specialist addiction units will also be involved, but a psychiatrist of specialist registrar/consultant grade (described as the 'specialist' by the orange book) must be available to lead the team. They have expertise in managing dual diagnosis, can prescribe controlled drugs and their training involved leading multi-disciplinary teams.

Conclusion

The failure of medical practitioners to work in a shared-care approach may be construed as not fulfilling standards and quality of care in the appropriate treatment of people who misuse drugs because the orange book describes shared-care as "essential". Multi-agency meetings provide a framework to fulfil this standard and ensure that no medical practitioner 'prescribes in isolation'. Multi-agency standardised assessment schedules can reduce duplications of assessments, improve efficient use of resources and provide greater utility to patients. An economic evaluation of multi-agency assessment meetings compared with the traditional approach is required.

Acknowledgements

We thank Dr Mike Jorsh, Consultant Psychiatrist, City General Hospital, Stoke-on-Trent; Mrs Sandra Summers, Ward Manager, Addiction Unit, City General Hospital; Mrs Sue Wise, Druglink, Hope Street, Stoke-on-Trent; and Ms Carol Burt, Druglink, Hope Street, Stoke-on-Trent, for their comments on earlier drafts of this paper.

References

BEAUMONT, B. & JANIKIEWICZ, S. (1997) *Working with Other Agencies*. Oxon: Radcliffe Medical Press Ltd.

CROME, B., CHRISTIAN, J. & GREEN, C. (1998) Tip of the iceberg? Profile of adolescent patients prescribed methadone in an innovative community drug service. *Drugs: Education Prevention and Policy*, **5**, 195–197.

DeLEON, G. (1991) *Retention in Drug-Free Therapeutic Communities*. Rockville: Department of Health and Human Services.

DEPARTMENT OF HEALTH (1999) *Drug Misuse and Dependence. Guidelines on Clinical Management*. London: Stationery Office.

GASK, L., SIBBARD, B. & CREED, F., *et al*, (1997) Evaluating models working at the interface between mental health services and primary care. *British Journal of Psychiatry*, **170**, 6–11.

GOSSOP, M., MARSDEN, J. & STEWART, D. (1998) *The National Treatment Outcome Research Study: Changes in Substance Use, Health and Criminal Behaviours at One Year After Intake*. Third Bulletin. London: Department of Health.

McLELLAN, A.T., LUBORSKY, L., WOODS, G. E., *et al*, (1981) Are the "addiction related" problems of substance abusers really related? *Journal of Nervous and Mental Disease*, **169**, 232–239.

MARSDEN, J., GOSSOP, M., STEWART, D., *et al* (1998) The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome. *Addiction*, **93**, 1857–1867.

OGUNDIPE, L. (1997) Community psychiatry in practice: experience of a registrar in community psychiatry. *Parapraxis*, **3**, 31–34.

Laofe Oladele Ogundipe Specialist Registrar in General Adult Psychiatry, Lyme Brook Mental Health Centre, Talke Road, Newcastle-under-Lyme **Address for correspondence** Deramore, Ercall Heath, Nr Newport, Shropshire TF10 8NQ, **Roger Bloor** Consultant Psychiatrist (Substance Misuse) and Medical Director, Edward Myers Addiction Unit, City General Hospital, Newcastle Road, Stoke-on-Trent

https://doi.org/10.1192/pb.25.9.350 Published online by Cambridge University Press