Adaptation and Implementation of TCU Mapping-Enhanced Counseling and Assessment Resources in the United Kingdom

Report on 2009 US Distinguished International Scientist Collaborators Award (USDISCA)

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The past 5 years have seen core changes in how addiction treatment is viewed by many of the service providers in Britain. A national initiative to increase *availability* of substance misuse treatment services in England and the *quality of care* has helped modify the widely-held concept that "methadone medication is treatment" towards a more comprehensive formulation. Heroin continues to be the primary drug of misuse being addressed by treatment providers in the UK, but there is growing clinical attention being given to the recovery process and better life skills. The International Treatment Effectiveness Project (ITEP) and Birmingham Treatment Effectiveness Initiative (BTEI) have been highly influential in reshaping addiction services, and endorsements of their manuals on the National Treatment Agency (NTA) Website this year has further elevated visibility of these innovations.

TCU Mapping-Enhanced Counseling and related tools are at the core of these innovations, adapted for UK service providers through close collaboration over several years between the Texas Institute of Behavioral Research (IBR) and a cadre of UK collaborators. A NIDA-funded International Scientist Award to Dwayne Simpson (and his primary collaborator, Dr. Ed Day, from the University of Birmingham, England) provided travel funds for visiting ITEP/BTEI implementation sites throughout the UK. This report summarizes progress made and challenges being faced by groups visited during September, October, and November of 2009.

Background for Simpson's Visit

A series of significant exchange visits between Texas and England addiction scientists and practitioners began informally with a small December 2004 meeting, arranged by Mike Ashton (Editor of Drug and Alcohol Findings) during a brief visit in London by Simpson. During a more formal visit to Texas in March 2005 by a senior UK leadership team representing addiction service providers, scientists, and policymakers, the focus narrowed to address strategies for enhancing engagement and recovery of addiction treatment service users in the UK. The operational initiative emerged from another visit to Texas (in November 2005) by treatment provider teams from the Greater Manchester area (NTA North West Region) and London for the purpose of adapting TCU mapping-based manuals and treatment assessments to use in the International Treatment Effectiveness Project (ITEP). Node-link mapping and decision-making tools were first selected for clinical applications in England. A related project was also soon mounted – the Birmingham Treatment Effectiveness Initiative (BTEI) – emphasizing the use of mapping for care planning and motivation enhancement. BTEI included an evaluation research component as well that adapted TCU client and organizational assessments for the UK.

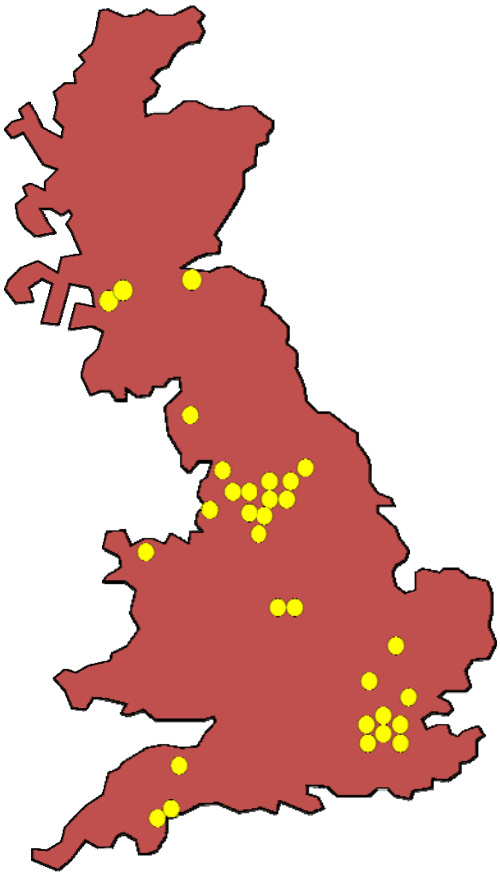
The TCU team provided training as requested to "UK trainers" on node-link mapping tools and assisted in the translations of clinical interventions and assessments. These efforts were

funded primarily under a NIDA grant (2004-2009) to Dwayne Simpson for "Implementation of Drug Abuse Treatment and Assessment Resources." Special approvals from NIDA allowed an expansion of this grant to include collaborative work in the UK. To date, over 2,000 drug service workers have been trained in the Manchester, Birmingham, and London regions for using ITEP and BTEI resources. Reports and publications (available on NTA and IBR Websites) provide documentation of this process and preliminary evidence of effectiveness.

Based on this record of progress, the NIDA International Program funded a USDISCA proposal by Simpson to conduct a series of leadership planning sessions and seminars that would emphasize the value of understanding (1) an adaptive treatment programming logic as represented by the TCU treatment process framework, (2) the functional and interdependent roles and applications of client assessments and intervention manuals, (3) core ingredients of recovery-oriented treatment services, their conceptual integration, and strengths and weaknesses as currently applied in the UK, and (4) the need for formulating a strategic planning approach in adopting and implementing innovations within the treatment systems represented. The original ITEP and BTEI project implementation leaders (i.e., Ed Day, David Best, and Phil Conley) were involved in planning, arranging, and conducting key meetings across the UK. Service provider networks from new "start-up" and "transplanted" projects requesting assistance also were scheduled for meetings as opportunities permitted.

Overview of Meetings in the UK

Simpson participated in a series of 30 meetings in England, North Wales, and Scotland during September, October, and November of 2009 (see list at the end of this report). Half were conducted with small leadership groups (usually under 10 persons) focused on strategic planning of innovation implementation. For instance, four of the seven "Systems Change Pilot Projects" funded in the past year for the purpose of pilot-testing innovative changes in UK services systems (including some focused specifically on CJ systems) were visited in relation to their intended use of TCU-based resources.



The other half of these meetings was conducted as seminars with formal presentations and group discussion. Of the approximately 500 drug workers and staff supervisors attending these seminars, there appeared to be three basic types of participants. At least one-third might be labeled as Implementers, comprised mainly of ITEP/BTEI trainers and experienced users of these materials. They were highly supportive, particularly of the mapping tools and related applications for enhancing the quality of care and service planning. *Service users* were especially vocal about the positive communication benefits of mapping-based interventions. Another third could be regarded as Adopters, comprised of service workers and supervisors already acquainted with the basics of ITEP/BTEI materials (e.g., via the manuals posted on the NTA Website). They tended to be keen for implementation training. Enthusiasm was generally high, even though their understanding of "ITEP

Training" and its broader context was often limited. Responses of these participants to seminar presentations were highly favorable, especially by those who gained in understanding and appreciation for the interdependence and comprehensive evidence base that exists for the ITEP/BTEI innovation resources.

Finally, there was a group of Watchers, comprised of staff members with cautious reservations about how ITEP/BTEI training might impact their services (but expressed outright in only 1 of the 30 sessions). Not surprisingly, this response seemed to be more related to concerns about impending system changes and funding prospects (due to new commissioning practices) than to the innovation contents per se. With proper orientation, they could become "late adopters."

Meetings typically included a 20 to 75 minute presentation using PowerPoint charts, with content and emphasis adjusted to the audience and purpose of the session. Background and context for the work leading up to the TCU "adaptive treatment" paradigm were explained, along with overviews of the conceptual models for representing effective therapeutic process and innovation implementation dynamics. Early in the course of these meetings, however, it became clear that views of the ITEP/BTEI project manuals were often limited and insular. For instance, "ITEP Training" was commonly perceived as *the singular innovation goal* for providers.

Modifications were therefore made in an effort to help communicate more directly how the ITEP, BTEI, and organizational functioning (ORC) applications fit together to form an integrated treatment approach. Rather than being seen as independent "silos" of tools and strategies, it was suggested that leadership teams and front-line providers should emphasize the broader landscape and inter-dependences among the protocol elements. This was approached primarily by recasting the ITEP, BTEI, and organizational change (ORC) components as being interconnecting parts of a basic "**Recovery Engagement and Life Skills**" initiative.

Further attention is required to tackle this issue, ideally in a coordinated fashion involving the collection of ITEP/BTEI project training teams. Another related complication seems to be emerging from a growing number of "ITEP Training Providers" who have no previous ties to these projects or infrastructure. The lack of a coordinated steering group sanctioned to unify and guide core UK innovation protocols is a contributing factor to these challenges.

Reports of Activities and Progress by Regional Collaborating Teams

North West England:
By Phil Conley (Deputy Regional Manager for North West NTA)

The value of Professors Simpson's visit to the UK and the North West in particular is difficult to overstate. It strengthened the very fruitful ties previously established between the NTA and the TCU Institute of Behavioural Research (IBR) over the last 5 years. Delegations from the NW have made two visits to the Texas IBR, and each trip has expanded our knowledge of the TCU approach and has acted as a profound stimulus to aid implementation here in the UK. This most recent UK visit by Professor Simpson has had exactly the same effect, but on a much larger scale. The extent of the knowledge transfer to such a wide and varied audience has been remarkable and the consequences are already becoming self-evident as the national level of interest in the TCU model of treatment and associated tools and techniques has mushroomed.

Aside from raising the general level of awareness, very important relationships have been established between the IBR and a number of UK-based early adopter projects that are proceeding with the TCU approach. In addition to the input that has taken place whilst

Professor Simpson was in residence – assisting with project designs, advising on bespoke application of TCU tools etc. – these relationships are vital to ensuring the continued sustainability of many of these projects. In short, having such access to IBR expertise in the future as a result of this visit will ensure proper standards for implementation are maintained.

There has been much debate in the UK amongst academics, practitioners, and the NTA alike as to how best to advance the various ITEP/BTEI initiatives that have grown organically across the UK, and how best to realise the potential synergies of bringing these together systematically (data sharing, for example). Professor Simpson's visit has acted as a focal point in this respect and a number of meetings have taken place whilst in residence to this effect. These communications will continue and hopefully the benefits of a more consistent approach to this work will ensue. Again, his role here cannot be overstated. Ironically, it is Professor Simpson – an overseas visitor – who has the best bird's eye view of these UK activities and the key contacts that go with them. He has used this knowledge to nudge his UK colleagues to move in the right direction, making the crucial links needed and providing the strategic steer that only he was able to provide. Action reports collected from several of the NW regional teams he visited are summarized below.

Dr Louise Sell (FRCPsych Consultant Addictions Psychiatrist/Service Director Alcohol and Drugs Directorate, Greater Manchester West Mental Health NHS Foundation Trust) stated "Professor Simpson's visit served to move our thinking about the implementation of the TCU materials in our services onto the next level. We have recently re-launched the mapping tools as "North West Maps". Two of our services are undergoing reconfiguration and will implement the TCU short-form assessments as part of the change programme. Following his visit our senior managers are engaged in using evermore of these tools in delivering service improvement."

Dr. Linda Harris (Clinical Director, WISMS) said "I had the opportunity to hear Professor Simpson speak at the Royal College of General Practitioners Continual Professional Development event in the Autumn. Whilst I had read information on ITEP and perused the IBR Website, nothing could replace the massive impact on me of hearing Professor Simpson's "story" first hand from the man himself. His passion, openness, and willingness to support other organisations keen to benefit from implementing ITEP was apparent and it inspired me to kick-start a new project for a managed approach to organisational implementation across the Wakefield Integrated Substance Misuse System (WISMS) Integrated Care Organisation pilot. Work has progressed already with a draft PID survey in circulation, plans to undertake organisational checklists and CESTs from clients, and commitments across the key stakeholders of the national Integrated care pilot to introduce ITEP as part of a wider integrated workforce strategy and systems change process. Thank you Dwayne, I feel I have joined a large and growing family of early adopters."

Dr. Michael Taylor (Adelaide Street General Practice, Rochdale) adds that "Professor Simpson's visit gave us the rare pleasure of exchanging views with a very experienced, internationally respected colleague. His views on psychosocial recovery, on the use of psychometric evaluation, on treating patients based on their whereabouts on the road to recovery, all confirmed that we were travelling in the right direction with our patient treatment plans. This inspiration refreshed our enthusiasm to continue improving the service we provide to people with problems of addiction."

Keith Owen (Senior Manager, Lifeline) noted that "On the 21st of September Professor Simpson visited Preston in Lancashire to meet with colleagues from the National Treatment Agency, the National Offender Management Service, and Lifeline Project. Lifeline CARAT workers and managers had recently begun to pilot the use of ITEP tools for use with drug using offenders in

custody and were keen to meet Professor Simpson at an early stage in this work. His input to the design of this pilot project has proved to be invaluable, furthermore his continued interest will I am sure help to maintain high standards."

West Midlands England:
By Ed Day (Senior Lecturer in Addiction Psychiatry, University of Birmingham)

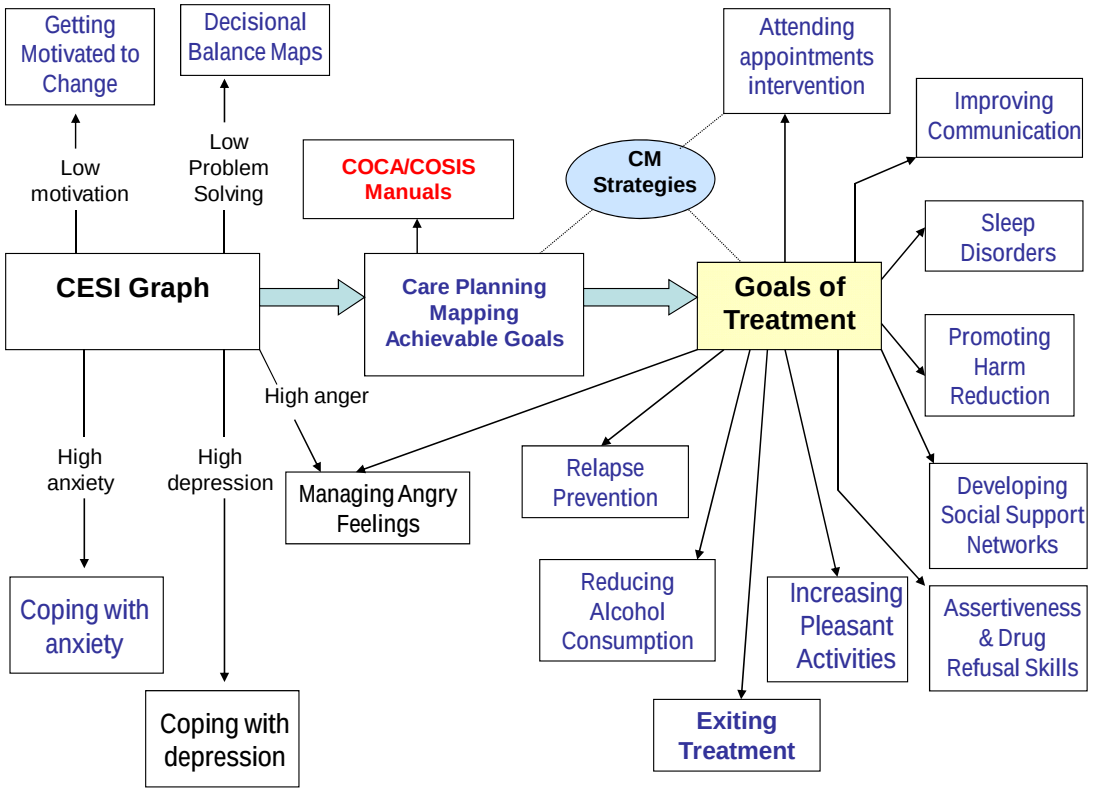
The Birmingham Treatment Effectiveness Initiative (BTEI) began in late 2006 to –

1. improve the assessment of service users problems by making the assessment and care planning process more comprehensive and client-centred,
2. use the information gained from improved assessment to tailor better interventions to client problems, and
3. understand the organisational barriers to implementing client-focussed assessments and interventions into clinical practice.

A common comprehensive assessment document was developed collaboratively with Dr. David Best (BTEI Co-Director) and the TCU team for use by all agencies across the city of Birmingham, and a simple scoring programme was used to allow the CESI to be completed at initial assessment by all new clients. An initial 'training the trainers' approach helped to disseminate these new tools alongside a manual aimed at improving Care Planning. A clinical audit process 6 months into the project led to a re-working of the Care Planning manual based on worker and client feedback.

Subsequent training within the BTEI project has emphasized the Care Planning process, which when combined with the easy-to-read graphs from the CESI administered during intake assessment, has helped workers understand client problems and needs in more detail. In parallel with this process, a comprehensive set of clinical tools has evolved based on the principle of node-link mapping. Workers are offered a choice of using collections of maps aimed at tackling a particular problem area (see map below), or more complete therapy manuals (either written during the BTEI project or signposted from within the IBR collection). For example the 'map book' is a large collection of maps to expedite the treatment planning and delivery process. All of this is embedded in the stage-based Treatment Process Model developed by Professor Simpson and his Texas team. Thus, the BTEI training shifts its focus more explicitly towards interactive use of assessment and intervention tools. Strategically, it differs somewhat from ITEP, which uses a single manual containing materials on 'Mapping' skills (i.e. maps that help someone to problem solve, similar to our care planning manual or our map book) and on 'Changing Your Thinking Patterns' (i.e., a cognitive intervention).

BTEI training in Prisons: Training recently initiated in the East region is being designed to introduce some of these materials into six 'pilot' prisons. Such efforts require making adaptations, possibly including a session-by-session guide like the Care Planning manual or one of the TCU manuals. Another option is to create a sequential collection of useful tools, rather like the ITEP manual. Ideally, prison staff delivering these services should be involved in developing these innovations, but closer examination of their existing tools is needed first. Indeed, it might be feasible to convert some or all of the materials already in use to a mapped format. Otherwise, this effort will require a bit of time and effort. Materials based directly on BTEI manuals can be relatively easy, but starting topics from scratch (i.e. family work and BME issues) will be more labour-intensive. Tactical details are being addressed, including training date timelines and locations, specific materials to be developed, labor expenses, "ownership" of newly-created materials for future distribution, and so forth.



North Wales, Scotland, and North England:
By David Best (Reader in Criminal Justice, University of the West of Scotland)

The key purpose of Professor Simpson's visit was to assist in the design of two projects externally funded for merging treatment effectiveness and recovery focused work. In both North Wales and Worcestershire, the commissioning bodies for alcohol and drug treatment had agreed to support the development of new manuals and the implementation of treatment effectiveness evaluation methods. He provided key input into the research design for these parallel studies – each will run for the calendar year 2010, involving around 400 clinical staff and 4,500 clients. This included instrument design, advice on an evaluation strategy, and in the case of North Wales, a visit to the coordinating centre for delivering a presentation to approximately 50 key players and informal meetings with a number of key early adopters of the programme.

Additionally, Professor Simpson visited several centres and individuals with DB to help promote the treatment effectiveness model and to support innovative research thinking and planning in each location. This included:

- Meeting with Fraser Shaw, consultant psychiatrist about planning a funding bid to the Chief Scientist Office in Scotland to run a technology transfer study
- Meeting with David McCartney, clinical lead for the Lothian and Edinburgh Abstinence Project (LEAP) about designing a 12-step manual for use with aftercare groups and to engage local communities in recovery thinking

Finally, Professor Simpson provided academic mentorship to DB around existing data collected on treatment effectiveness and around research planning and strategy for managing new and existing workloads. Ongoing discussions will help to link those involved across the UK and to attempt to generate a UK-wide core dataset for treatment effectiveness databases.

North England (Bradford):
By Liz Barry (Joint Commissioning Manager Substance Misuse), Ian Wallace (Head of Commissioning, Substance Misuse), and Tracey Hogan (Director of Operations, Bridge)

The starting point for considering applications from ITEP/BTEI in Bradford came though a needs assessment and treatment planning process for 2008/09 which gave a clear indications that the Bradford treatment system needed to focus more on recovery, successful social reintegration, and positive sustainable outcomes for service users and their families.

In close succession, all national Drug Action Teams (DATs) and Crime and Disorder Reduction Partnerships (CDRPs) in England were given the opportunity to tender to be a Drug System Change (DSC) Pilot site, the purpose being to work innovatively to deliver against the National Drug Strategy 2008, make efficiencies, and improve the service user journey. Bradford successfully tendered with the proposal to bring a high number of existing providers together to work effectively as one unified treatment system under one overarching contract for reducing barriers to service users/providers and streamlining the treatment journey. In addition, the Bradford model aims to reduce the number of treatment steps taken by service users and reduce the length of time in care by ensuring the right service is utilised at the point of assessment and throughout treatment.

In order to achieve the above, Bradford Safer Communities Partnership has adopted strategies from the ITEP and BTEI models in order to make both strategic change and improve ground-level practice. To start, the Organisational Readiness to Change (ORC) has been completed by all 205 treatment staff within 15 treatment services in the district and this will define organisational functioning and readiness to change. The next stage of the process is the application of Client Evaluation of Self and Treatment questionnaires (CEST) to 10% of Service Users (350). Through this process an understanding of service user views of the treatment system as a whole will be gained. This detail, combined with that obtained through the ORC, will give a baseline assessment of current position for Bradford from which improvement plans will be developed and monitored.

Linked to the above, a third stage will see staff across the treatment system receive training in the node-link mapping techniques and it is anticipated that this ground-level work will give direct improvements for service users and the treatment system as a whole thus impacting operationally and strategically. The training plan for rollout of node-link mapping techniques was developed in conjunction with TCU, where four Bradford trainers attended intensive training delivered by TCU staff in Texas last summer.

Professor Simpson visited Bradford for 3 days in September and during this time was instrumental in providing strategic mentorship, technical advice. and practical assistance in adapting all aspects of the TCU tool kit to meet local requirements. This assistance was significant in enabling the DSC project plan to remain on target and importantly, in obtaining support from a number of stakeholders including:

- The Drug System Change Contract Management Board, comprising of the senior member of all key partner treatment agencies
- The Bradford Substance Misuse Governance Planning Group, comprising of senior managers from all treatment and associated services
- The ORC and CEST project planning group, comprising of commissioners, providers, and NTA representatives
- Yorkshire and Humber regional commissioning managers and senior police and probation services

The Bradford DSC pilot intends to make changes that will directly impact on local district targets and ultimately meet national priorities. This is expected to be shown through data collected via standard routes but also through baseline and follow up assessment via the ORC and CEST. The impetus of ORC, CEST, and the rollout of node-link mapping is considered fundamental to making system change for Bradford and is felt to be a critical factor in the ultimate success of the pilot.

North England:
By Nat Wright (Clinical Director Vulnerable Groups, HMP Leeds)

It was a great privilege to welcome Professor Simpson to provide a lunchtime training session on 9th October for the Leeds prison cluster treatment staff and with invited visitors from the University of Leeds. Dwayne has a long and illustrious career studying what works in treatment for drug users. After a visit with the Prison Governor, about 40 staff members gathered for his seminar.

There was much food for thought (as well as food to eat!) as we were presented with ideas on how we can better assess and support drug users. Many of us felt reinvigorated to consider how we can better support our patients so they don't just get stuck in treatment. HIs talk encouraged us to think beyond simply the provision of maintenance therapy to consider how psychological treatment is an important part of their recovery. He encouraged us to consider the values and culture of our own service as to how the organisation can either support or prevent drug users in their efforts to make lasting change. Perhaps most importantly, his talk encouraged us to look up and beyond our "small corner of the world" to learn from others. Information technology has made the world a shrinking place such that the experience from others who work in different countries is actually on our doorstep. We are grateful to Dwayne for stepping across our doorstep to aid our professional development.

East England:
By Emma Pawson (IDTS Regional Development Manager for Eastern NTA)

The support provided by Professor Simpson was invaluable and his influence has facilitated our development of the recovery and reintegration programme across several DAAT areas in the Eastern NTA Region. He met with the NTA Regional team in Cambridge and also provided support to our two pilot system change projects, meeting with commissioners and service managers to explain the TCU/ITEP programme and conceptual background. Following these visits I now have agreed action plans with three DAAT areas to focus on taking this programme forward. In addition, Dwayne has supported the Eastern Region's drug using offending project from an external advisory role by liaising both with Dr Ed Day and Emma Pawson.

South West England:
By Graham Shiels (Service Manager Torbay Primary Care Drug and Alcohol Services, and chair of the Devon and Torbay ITEP Implementation Steering Group)

Professor Simpson's visit encompassed two important and distinct events, one focussing on the work undertaken in the Devon and Torbay areas to date. The other was set at a Regional level, which was concerned with discussion/awareness of the model and possible implementation in partnership areas.

Devon and Torbay implemented the IBR/ITEP model in all of its tier 3 drug treatment services in October 2008. A phased approach was adopted with new clients presenting for treatment, with full caseload implementation achieved from April 2009. HIs visit to the area included a briefing

with commissioners and senior managers in the morning followed by a visit to a local drug treatment agency including an arranged "open floor" forum with staff and service users. The conclusion of the day was a meeting with our "ITEP champions group".

The regional conference held in Taunton was attended by over 90 delegates from all partnership areas across the South West region, and included a wide array of disciplines. Commissioners, providers, service users, carers, and front-line workers were all represented. The focus of the day was to explain the model to delegates and describe the implementation process from an international, national and regional level, with presentations from both Professor Simpson and Phil Conley. The day ended with "round table" workshops split into partnership areas to discuss the potential implications of wider implementation, and to learn from areas where the model is already established.

Key messages and learning points included-

- Clarification of the next step for us here in Devon and Torbay. This will likely include taking a closer look at the work that has been undertaken in the NW region and how we might approach integrating the IBR model with the recovery agenda for the SW region.
- Support and assist a broader coordination of activities across the country into one central point as a repository of information, resources, and shared learning in the UK.

London/ Blenheim CDP:
By Laraine Start (ITEP Learning and Development Manager) and Jo Palmieri (Director of Learning and Development)

On the 21st October 2009, Dwayne Simpson visited Blenheim CDP to kindly give a presentation on mapping and recovery life skills. The meeting was attended by the senior management team, managers from a variety of treatment services throughout Blenheim CDP and ITEP trainers.

Martin Brown (Client Services Director) opened the meeting and spoke of his previous experience and involvement with Dwayne when Blenheim CDP first piloted the ITEP initiative in London. Brian Dalton (another Client Service Director) who had visited the TCU team in 2005 for project planning and experienced mapping training first-hand in Texas, co-chaired the meeting. Martin presented Dwayne with a trophy in recognition of his ITEP work and for enabling Blenheim CDP to use it as a tool for treatment effectiveness, including the training provided for over 775 people regionally and nationally in its use.

Dwayne gave a fantastic presentation on *Strategies for Change: Implementing Innovations for Integrated Services*. He summarized the matrix for the many mapping-based manuals we could download from the IBR Website. He shared the outline used for the 2.5 day training provided in Texas during July 2009, explaining how the first day was devoted to mapping techniques and the second to integration of mapping into care planning, special population issues (eg, gender and crack use), relapse, criminal justice, and exiting treatment. He also discussed the benefits of using small working groups rather than a single large group for improving training quality.

Further advice addressed ways we might move forward to evaluate the use of mapping from an organisational level, practitioner level, and service user level. He suggested that we consider broadening the way the ITEP and BTEI manuals are explained to trainees. That is, both are specific initiatives but part of a larger and conceptually robust strategy for "Recovery Engagement and Life Skills (RELS)" representing the core context for this work. After lunch, time was devoted to questions and discussions about staff experiences/practice of delivering the ITEP training.

For detailed training advice, Dwayne suggested that we contact Norma Bartholomew at TCU with our specific training questions around maps, mind traps, unhealthy ways of thinking, and behaviour cycles. The ITEP Coordinator did so and received a quick and very welcome response from Norma who was able to offer helpful recommendations. We also sent a copy of the current PowerPoint and outline of our present 2-day training structure and asked for her feedback. Norma has suggested that a few of our trainers might wish to visit TCU to attend advanced training on mapping, and she forwarded her "Teaching People to Map" presentation which we are looking to include as part of future training by Blenheim CPD.

Following Dwayne's visit the ITEP training group met to reflect on his key suggestions for us. Pending recommendations and proposals for Blenheim CDP training are as follows:

1. Senior management should look at how they can begin to evaluate the use of ITEP at organisational, practitioner, and service user levels.
2. The 2-day training we currently provide needs review – proposed changes noted above have already been sent to senior management and are awaiting action.
3. The Intranet will need to make all material and manuals from the TCU matrix readily accessible to all services within Blenheim CDP.
4. Some of the trainers should visit TCU and get first-hand experience in delivering ITEP.
5. Jo P. should meet with Phil Conley to discuss further exchanges involving London and Manchester-based trainers in an effort to better standardise training across the UK.
6. We should explore ways and implications of changing the name from ITEP to RELS.
7. We need to consider accreditation of ITEP via Open College Network so staff can gain a qualification demonstrating they are proficient in the use of ITEP.
8. Review mind-mapping software that is currently available to replace PowerPoint.

We felt very privileged and were grateful to have Dwayne visit us at Blenheim CDP, and wish to thank him very much for his time. Everyone present benefited so much and it was so interesting to hear about the years of work he and his team have put into this research. We were inspired and look to put all the above recommendations into action in the New Year.

London/NTA Staff for CJ Initiatives:
By Kieran Lynch (Programme Manager for Criminal Justice - National Treatment Agency (NTA) for Substance Misuse)

Professor Simpson has been involved in several aspects of work the NTA. He has played a key role in directing strategic activity across a new prison-based project being undertaken by the NTA and several other key Government and Health departments. It will serve as a test bed to allow materials developed by TCU/IBR and the subsequent ITEP and BTEI projects in the UK to guide and inspire new manuals for prison-based settings. Throughout his time in the UK he has provided well-reasoned support, expertise, and direction to all of the key senior managers, strategists, and workforce involved in this project.

Additionally Professor Simpson has:

- Undertaken several key visits to sites in the pilot regions.
- Reviewed some of the early materials and provided key indicators to ensure a successful outcome.
- Advised this project in how Organizational Readiness for Change (ORC) and the Client Evaluation of Self and Treatment (CEST) resources can be adopted to UK prison settings. With his input and the subsequent visits to other regions and to the 'voluntary sector', we at the NTA now have a better view and understanding of how the wider drugs placed workforce is engaging with this agenda.

- Co-chaired (with me) a key meeting at the NTA on “Setting the scene” and bringing together several of top academic, workforce, and NTA managers to link those involved across the UK to form a strategic delivery group.
- Gave a keynote presentation to the **Royal College of General Practitioners** (RCGP) at my request. The RCGP is the professional membership body for family doctors in the UK and abroad, and a key partner of the NTA in a drive to improving patient care, clinical standards, and GP training.

Finally, his support and mentoring to me and other colleagues at the NTA has not only provided us direct access to his considerable knowledge and experience but fostered a renewed and significantly more focused approach to individual projects that will have impact across the UK.

UK Feedback Report to NIDA International Programs Office in Washington DC:
By Mark Gilman (Regional Manager for North West NTA)

The purpose of the meeting (on 4 November 2009) in Washington DC was for Mark Gilman to update Dr Steven Gust and his colleagues on the progress of the international collaboration with the Texas IBR to transfer successful treatment models from the US to the UK. He reported on progress in the North West of England in particular and the UK in general, noting that Professor Simpson has helped guide two NTA-sponsored programs – the International Treatment Effectiveness Project (ITEP) and the Birmingham Treatment Effectiveness Initiative (BTEI) – in translating and implementing TCU-originated drug treatment resources to meet British service improvement needs.

It was noted that these programs have adapted the TCU Treatment Process Model, which uses a psychosocial mapping intervention for discussing issues with clients, as well as a process for assessing and improving organizational functioning and service management. More specifically, the ITEP and BTEI programs have shown these tools can be implemented effectively in the United Kingdom by following easy-to-use manuals that contribute to significant and lasting organizational improvements and patient/client outcomes.

Background: In March 2005 a delegation of NTA senior managers and partners (11 people in total, including Mark Gilman) spent 4 days with Dr. Simpson and his colleagues at TCU/IBR. The plans for ITEP were born during this initial meeting, with a focus initially on improving early induction and engagement into treatment services. The North West Region (one of the nine formal regions for planning and commissioning addiction services in England) enthusiastically embraced ITEP and Dr Simpson has provided a series of strategic implementation seminars across the North West (and other parts of the UK).

Impact of ITEP in the North West: It is customary in the UK for young men to celebrate passing their driving test by purchasing an old car and making immediate cosmetic changes. Expensive wheel trims and elaborate in-car audio systems are a must. However, it soon becomes clear that a better car is required. This is what has happened with the introduction of ITEP in the North West. Indeed, Dr Simpson’s work via ITEP has thrown the wider treatment systems into sharp relief and often found them wanting. The term “Recovery Engagement and Life Skills” (RELS) has been proposed by him to help service providers gain a wider system perspective for ITEP and expanded applications. To address this we also have drawn on a wide body of work including that of William White, George De Leon, and John McKnight.

Bio-Psycho-Social – revisited via ITEP: One of the key pieces of learning from ITEP is that some of our UK treatment systems based on Bio-Psycho-Social models were at risk of becoming “bio-bio-bio models” (as discussed further by Sharfstein). Our work with Dr Simpson

and his colleagues around ITEP alerted the North West region to this risk and enabled us to create system changes to counter with broader perspectives. Within this context, they have led to the development of a much broader strategic model, generally being referred to as ROIS (Recovery Oriented Integrated Systems).

Summary: I entered the world of drug treatment in the late 1970s and have worked in research, policy, and practice. In 1995, I was a guest of the United States Information Agency and made professional contacts that have remained to this day. However, the partnership with Dr. Simpson, TCU/IBR, and NIDA has been the most successful of its kind in my career. The benefits of this international collaboration will continue over the years to come and will be crucial as the financial investment in substance use disorder treatment realigns to the economic climate in England and beyond.

Concluding Observations and Recommendations:
By Dwayne Simpson

Training interests and requests for ITEP/BTEI innovations and mapping resources clearly are on the uptake in the UK. These are due largely to favorable comments and endorsements by frontline service workers, users, and managers. A particularly encouraging sign is that these include "transplanted" workers who have carried the concepts and materials to new services settings, in several cases to mental health or alcohol applications outside of their point of origin. Posting of these manuals on the NTA Website also has aroused interest and related training requests. Applications to newly-funded systems change pilot projects as well as other regionally-focused initiative are growing, along with adaptations for use in prison and other criminal justice (CJ) settings. The interests in CJ applications are drawn to the assessment tools especially, including the use of optical scanning and on-line scoring technology based on the TCU short forms focused on risks and criminal orientation measures. This parallels our work in the US, leading to a request to arrange and host a demonstration site visit for UK visitors in early 2010 (tentatively arranged to be held in the New Jersey prison system that has effectively implemented many of these resources).

Because of the occasional concerns expressed about taking on a "US export" such as the **TCU-Mapping Enhanced Counseling** materials for addiction treatment services, it has been helpful to explain to meeting participants that there have been no charges or profits made by the TCU team of scientists. In fact, in only a few exceptional cases were any IBR staff travel expenses to the UK reimbursed, and no consulting fees have been paid for ITEP/BTEI collaborations. Furthermore, working agreements as well as "copyright" stipulations (both in the UK and the US) preclude any direct charges or fees for TCU-based materials – although professional training consultancy fees may be allowed when justified. These declarations sometimes come as a surprise to meeting participants, and seem to give ITEP/BTEI resources better credibility with UK service providers.

Growing requests for ITEP/BTEI training in the UK, however, are creating pressures that are increasingly difficult to meet. The principal training teams for ITEP are located in the North West (lead by Jan Mooring and associates from the Greater Manchester West Trust) and in London (conducted by Blenheim CDP). Together, these two groups have trained over 2,000 drug workers on using ITEP in the UK during the past 3 years. In turn, several of the teams they trained (such as for the Torbay and Devon DAAT in the South West) have proceeded with further internal team training. The BTEI training which emphasizes care planning and client/systems assessments is lead by Ed Day (from U of Birmingham) and by David Best (U of the West of Scotland). All report growing numbers of training requests from outside their own

regions and which they are struggling to meet. In this context, some private for-profit training groups not officially involved in ITEP/BTEI are beginning to offer these training services.

Although the TCU team shares concerns about the "quality and fidelity" of training and field applications of these interventions in the UK, we have avoided the use of formal certification for trainers because these can become costly and difficult to manage. However, we have continued to offer advanced "TCU-Mapping Training Workshops" in Texas, and the latest one (conducted last July) included eight attendees from Britain. Workshop participant evaluations, using a standardized training assessment protocol (based our innovation implementation process model), have been summarized in an *IBR Newsletter* (Summer 2009, available on the IBR Website at www.ibr.tcu.edu). This represents a training evaluation process (including assessment tools) we recommend, and continuing conversations are underway about how best to manage skill training for UK drug workers.

While TCU/IBR serves as "home base" for users of its treatment intervention and assessment resources in the US, this management model has not been duplicated in the UK. Instead, the UK-adapted ITEP/BTEI innovations are non-centralized and lack coordination. This complicates systematic efforts for quality management as well as expansion of second-generation resources (i.e., mapping manuals and related resources) such as those now beginning to appear. Since one of the sustaining strengths of this UK initiative rests on the generation of new mapping materials and applications by providers across various regions, having a centralized collection and sharing point would have merits.

On the basis of discussions with UK collaborators throughout this visit (including with Mike Ashton in the closing two weeks spent in London), the following recommendations are offered for establishing a not-for-profit agency that could coordinate, consolidate, and facilitate the on-going ITEP/BTEI activities. Its broad mission would focus on "Recovery Engagement and Life Skills," particularly evaluation and implementation of evidence-based resources for addiction and mental health services. Its initial strategy would be to –

1. collect and disseminate intervention and assessment resources (including the mapping-based and related materials from TCU, ITEP, BTEI, and new ones being developed), especially via a dedicated Website with some of the same features of the IBR Website,
2. address organizational implementation tactics (with ORC related materials),
3. address staff skills and training via coordinated UK-based workshops (and calling on the TCU-based trainers and developers if needed),
4. promote the blending and applications of mapping-based tools across the specialty areas of addiction (drugs and alcohol), mental health, co-morbidity, etc., and
5. provide technical and financial support for centralized data gathering and evaluation research.

Ideally, it would operate under a highly strategic advisory board that is small and congealed in purpose. In practice, this could become the UK partner to TCU/IBR and have direct access to our IBR team and resources. Lead UK research operatives should include David Best and Ed Day (possibly adding alcohol and mental health leads over time). Collaborative research and preliminary publications by Drs. Best and Day with the TCU team have been carried out under partial support from a NIDA grant, but this funding expired in the Fall of 2009. Widespread willingness and enthusiasm have been expressed in the past 3 months by ITEP/BTEI implementation teams in the UK towards sharing data for research and evaluation. This requires considerable effort in preparing and carrying out protocols for data gathering and analysis, of course, as well as scientific coordination of the overall enterprise. On the US side, the IBR has a similar nation-wide line-up of collaborators from CJ/prison systems and treatment providers as well as residential treatment systems.

In recognizing the unique timing for starting several new projects with the goal of recovery engagement and life skills training, Dr. Best and other team leaders have already begun arranging "steering team meetings" with the goal of defining core data collection forms and intervention protocols. By following the same general approach used in IBR studies conducted in the US, several key issues are in need of being addressed using these data from the UK.

- Does better care planning yield better client engagement and retention in treatment?
- Are the client assessments reliable measures of their needs and change?
- Is more mapping related to better engagement and retention in treatment?
- Do brief interventions show measureable effectiveness?
- Can treatment organizations change their functioning and client performance levels?

The success of these efforts is likely to be pivotal for the sustainability of ITEP/BTEI-based accomplishments, so it will be important to find supportive strategies and mechanisms. In particular, these will need to focus on practical issues and ways to address the concerns already mentioned. With that in mind, Mike Ashton (who played an important role in originally seeding this collaborative project) has agreed to offer some closing comments on the future implications of this work.

Implications for Future Actions in the UK:
By Mike Ashton

First I'll declare an interest of a kind in having (at the December 2004 meeting Professor Simpson refers to) inadvertently initiated the processes which led to the impressive catalogue of progress described in this document. Why that meeting happened is relevant I think. It arose from the admiration I had for the unusually consistent and focused decades of research which brick by brick (and along with other research) cumulated in to the model of treatment described in: Simpson D.D. "A conceptual framework for drug treatment process and outcomes." *Journal of Substance Abuse Treatment*: 2004, 27(2), p. 99–121. Such a synthesis intelligently making sense of a corpus of work is highly unusual. I relayed to Professor Simpson my feeling that it was a "fabulous" piece of work. The review did not just describe and justify the model but identified opportunities for improving the processes involved – for making treatment better. Essentially that is what the work described in this report has been doing in the UK context, and it is work myself and others hope to see consolidated and supported.

The issue is not *whether* this work will continue, but how effectively. On the ground it *will* carry on and probably grow because it addresses the core reason why most people get in to the addiction treatment business – to form productive relationships with some of the most marginalised, stigmatised, and damaged people in our society. The enthusiasm of staff who find someone is talking not about targets and guidelines, but about the things they came in to this business to do, is obvious in this report and in other forums. The challenge now is to build on and extend this work by creating a central resource with the credibility only the Texas (TCU) link can provide, which can make the most of local initiatives by helping them evaluate and self-evaluate effectiveness, provide opportunities to develop and refine through contrast and comparison with other regions, and help extend the work across the country.

A personal and not very systematic account of the relevant context in the UK may help answer the questions – 'Why this?', and 'Why now?'

1. **Deep public sector cuts are in prospect for years to come**. Already the main treatment budget has been frozen and for years patient numbers have outpaced resources, meaning less and less money per patient. As Mark Gilman of the National Treatment Agency for Substance Misuse says in this report, "The benefits of this

international collaboration will ... be crucial as the financial investment in substance use disorder treatment realigns to the economic climate". One scenario is that quality will decline with quantity as resources tighten. Another, and far more preferable one, is that making the most of money we have will become even more of a priority, and will drive quality improvements as we critically examine our organisations, workforce, staff skill development, and what actually happens at the client-worker interface. The TCU suite of resources amended for the UK provides a uniquely comprehensive set of measurement and quality improvement tools systematically coordinated across all those levels.

2. **Emerging strongly now with some central support is a suppressed dissatisfaction with the current treatment offer as it faces many patients.** Methadone is no longer seen as good enough – we want to do something more therapeutic with the population coverage and client-worker contact-time methadone (and allied therapies) can provide. We want to develop that from a holding operation to more of a transformation of our patients' lives sufficiently robust for them to be able to exit intensive treatment. This ambition is partly there for its own humanitarian sake, and partly because of the issue addressed in the point above – we can no longer afford indefinitely extended treatment as the norm. The risks however are enormous unless the quality of that treatment and of aftercare and reintegration arrangements are strong enough to protect against relapse. The TCU model allows us to envisage how that might happen and offers treatment and workforce development tools which can help make it happen.
3. **Across Europe the heroin epidemic has been receding and cocaine has been gaining ground.** To an extent the same trends are apparent in the UK, fuelled partly by the expansion in access to treatment via the criminal justice system, which nets stimulant users who would otherwise have seen little reason to enter treatment. In the absence of recognised and effective medications for cocaine dependence, psychosocial work, therapeutic relationships, and promoting enduring lifestyle change become the inescapable core of adequately responding to the new cocaine/crack using caseloads. The key questions then become: how do you change clients' thinking patterns, form relationships which initiate patient recovery, recruit or develop the special people who can do this, foster healthy organisations to support these processes, and test whether all this is working? These are among the questions directly addressed by the work stimulated by Professor Simpson and his research colleagues in Britain.
4. **Developed in sectors well beyond addiction treatment (but coming its way too) is 'personalisation' in the delivery of public services.** However, people do not become fully aware 'out of the blue' of their individual needs, strengths, values and goals and preferred strategies sufficiently to make the most of the opportunities offered by client-led personalisation strategies. These understandings are reached in comparison, dialogue and interaction with other people. In turn this demands mutually understood communication vehicles intuitive enough to be used in 'real time' encounters between people with varying cognitive styles and abilities. The TCU suite of resources is particularly strong in this respect. Examples include the CEST tool enabling clients and workers to assess the client's needs and strengths across several domains, and to visualise these in comparison with say, the general run of patients at that clinic or in that type of treatment modality, and the node-link mapping counselling strategy, which through intuitive visual aids promotes a client-centred approach to care planning. These can be located within the wider TCU model's appreciation of the non-drug related dimensions of what counts as successful treatment. Such aids take us beyond the ambition to personalise service delivery, to how it can be done in very concrete terms.

There is another reason why the Texas-inspired ITEP/BTEI initiatives are timely. Particularly in England, the drug (not alcohol) treatment sector is emerging from a time when its focus was driven by national targets such as waiting times and numbers in treatment. Though perhaps a

necessary by-product of capacity expansion, for many years the drug treatment sector has felt dictated to via guidelines and targets, its professionalism and creativity undermined. In this climate, meaningful reflection on objectives, practice, and process have not flourished. Arguably now having done their job, national targets have been pared back to raising 'numbers in effective treatment'. There is at the same time a greater emphasis on effective treatment defined in terms of outcomes which matter to the client and the society, not just process indicators and standards. The effect may (already) be to free services up to meet objectives in new ways generated locally by professionals and service users; the ITEP/BTEI initiatives seem examples of this happening.

Professor Simpson's approach, as embedded in the TCU suite, is different. It offers tools and models and effectively says, 'Use these in ways which make sense to you to help do what you want to do better. We are not telling you what to do, just offering research-based support'. It is a change commonly remarked on and (I imagine) a large part of why the TCU's offerings have been so widely embraced and 'made their own' by treatment services. These tools also facilitate reflective practice by enabling services to see themselves and their clients in the context of other clients and services – effectively, offering up a mirror. When in this document Dr. Linda Harris refers to Professor Simpson's "passion, openness, and willingness to support other organisations," this is I think some of what she is responding to.

That is one element in the 'remoralisation' of the addiction treatment workforce which has been an important by-product of the TCU approach. Another element is the lift people feel from being given the hope and expectation that they really can effect positive change of the kinds now being forefronted in the policy changes described above. Remoralisation, self-efficacy, optimism that things can change, itself related to a clear and credible diagnosis and route forward, will be recognised as common factors in effecting therapeutic change in clients; there is no reason to believe that staff react any differently in principle. The TCU suite of resources and the supportive, empowering way these are offered to services and staff promote these factors.

It is clear from this report that great steps have already been taken, perhaps partly because of the fit with the context and needs of the treatment sector outlined above. Given this fit, there has been no need to incentivise, cajole, or set targets. The tally of workers trained and services affected (and the unnumbered tally of clients touched by this process) is remarkable. As Phil Conley of the North West NTA remarks, "the various ITEP/BTEI initiatives ... have grown organically across the UK". Now the issue is "how best to realise the potential synergies of bringing these together systematically", providing the basis for harvesting "the benefits of a more consistent approach to this work". The issue is also how to do all this without throwing the baby out with the bathwater and reproducing the top-down directiveness from which service providers in the UK are emerging. Professor Simpson already has an up and running US model for how this can be done, has suggested a similar model for the UK, and is prepared with colleagues to continue supporting such efforts. At his instigation, a meeting has been arranged on 12 January to see if this model seems feasible for the UK – and if so, to make a start at creating a resource to enhance the progress based on this service delivery strategy over the past 5 years.

The meetings held in the UK by Simpson and collaborating teams are listed below.

- Sept 7: National Treatment Agency (NTA), London
- Sept 8: National Addiction Center, Kings College, U of London
- Sept 9: RAPt and Phoenix Futures Training Workshop, Vauxhall, London
- Sept 10-16: Strategic Planning with Dr. Ed Day, U of Birmingham
- Sept 14: Leadership Team for West Midlands National Treatment Agency for Substance Misuse, Birmingham
- Sept 17: Leadership Team for North West National Treatment Agency for Substance Misuse (NW NTA), Manchester
- Sept 17: Leadership Team for Addictions Dependency Solutions, Manchester
- Sept 18: Bradford System Change Pilot Leadership Team, Bradford
- Sept 21: HMP Preston/Lifeline Leadership Team and Prison Staff, Preston
- Sept 22: Bolton Community Drug Team, Greater Manchester West Mental Health Foundation Trust, Bolton
- Sept 23-24: Bradford System Change Pilot, Governors Meeting, Bradford
- Sept 25: Royal College of General Practitioners, Substance Misuse Unit, Manchester
- Sept 28: Dr. M. Taylor GP, York House Surgery, Heywood, Rochdale
- Sept 29: Leadership Team for Sefton System Change Pilot, Sefton
- Sept 30-Oct 6: Strategic Planning with Dr. David Best, U of the West of Scotland
- Sept 30: Senior Managers for North Wales Treatment and Recovery Project, Colwyn Bay, North Wales
- Oct 1: Dr. Frazier Shaw, Consultant Psychiatrist for East Glasgow Services, Hamilton, Scotland
- Oct 1: Directors for Lothian and Edinburgh Abstinence Project (LEAP) and John Paul Getty Research Foundation, Edinburgh, Scotland
- Oct 8: HMP Leeds/Treatment Leadership Team and Prison Staff, Leeds
- Oct 16: HMP Lancaster/Lifeline CARAT Leadership Team, Lancaster
- Oct 21: Blenheim CDP Leadership and Trainers Team, London
- Oct 22: National Implementation Leaders for ITEP/BTEI Applications, NTA, London
- Oct 26: Leadership Team for Eastern National Treatment Agency for Substance Misuse, Cambridge
- Oct 26: Hertfordshire System Change Pilot Leadership Team, Stevenage
- Oct 27: Essex System Change Pilot Leadership Team, Chelmsford
- Nov 10: Southwest Regional ITEP Event for SW Implementation, Taunton
- Nov 16: Devon DAAT and Torbay ITEP Steering Group, Exeter
- Nov 16: Devon DAAT and Torbay ITEP Commissioners, Providers, and Service Users, Exeter
- Nov 16: ITEP Champions Team for Devon/Torbay ITEP Implementation, Exeter
- Nov 24: Report to NTA Leadership on ITEP/BTEI Implementation Uptake in UK, London