Co-ordination and continuity of care in substance abuse treatment:

an evaluation study in Belgium

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Abstract
Considering the complexity of drug dependence and the multiplicity of services for substance abusers, co-ordination and continuity of care are important prerequisites for the quality of substance abuse treatment. However, several shortcomings concerning co-operation, communication and co-ordination have been reported in most European countries.
In this study, different aspects of co-ordination and continuity (e.g. first contact, intake, referral, follow-up) have been studied among all services (n=27) that are addressed by substance abusers in a clear-cut region in Belgium. Structured interviews with key informants show a lack of systematic communication between services and a lack of follow-up of clients. A study of 57 client records in 12 of these 27 centres illustrates that relatively little information is registered concerning the course of the treatment process and that only 10% of all client files contain a treatment plan.
Following the introduction of a formalised plan that was regarded as a precondition for systematising and optimising communication between services, key informants considered the implementation of a model of case management an appropriate way of improving co-ordination and continuity of care in this region.

Introduction
Substance abuse and treatment in Belgium
Although few valid and reliable epidemiological data are available on the extent and evolution of drug use in Belgium [1], empirical findings from population and utilisation studies illustrate some key aspects of substance use. Population studies show that cannabis is the most popular illicit drug, and the use of amphetamines among youngsters has increased considerably in recent years [2]. As in most European countries, heroin is recorded as being the main substance of problem drug use [3], and most treatment demands in some large Belgian cities (Brussels and Liège) are related to problems with heroin and to a lesser extent with cocaine [4].

Problematic drug use dates back to the beginning of the 1970s, when Belgium was confronted with a growing amount of young adults who abused illicit drugs (mainly heroin). As most services in traditional mental health care were at that time rather reluctant to deal with the emerging drug problems, two drug-free therapeutic communities were started during the period 1972-1975 [5]. Over the next few years, while the availability of illicit drugs and the consequent problems grew, other specialised services were established including day-care centres, crisis centres, short-term therapeutic programmes and therapeutic communities [6].
The lack of governmental initiatives, the involvement of more than 10 ministries and the fact that substance abuse quickly emerged as an important health issue stimulated the establishment of a number of specific and specialised initiatives for substance abusers. Recently, street-corner work, social workplaces and medical-social centres for drug abusers have completed the range of treatment, adding outreaching, training and employment, and low threshold facilities, methadone treatment and harm-reduction initiatives (e.g. needle exchange) respectively. Other harm-reduction initiatives such as controlled heroin trials are still being discussed.
From the 1980s on, traditional (mental) health care gradually opened its doors to drug addicts: many substance abusers detoxify in emergency wards at general and psychiatric hospitals [7],...
some psychiatric and general hospitals started special wards for drug addicts and some mental health care centres specialised in substance abuse treatment. Only a few general practitioners – especially in the French-speaking part of Belgium – are involved in the (methadone) treatment of drug abusers, since most of them are reluctant or feel incompetent to work with these patients [1].

These changes led to an extended and differentiated quantity of services for substance abusers, including specialised and general care centres (cf. Table 1). Specialised centres exclusively address substance abusers, while general care centres have regular contacts with or a specific approach towards substance abusers besides treatment for other target groups. Due to a lack of co-ordination between these services, substance abuse treatment resembles a patchwork rather than a network. Recently, co-ordination and co-operation between all levels (e.g. local, regional, national, European) and partners involved in the drug policy (e.g. health care, educational system, social welfare, judicial system, specialised substance abuse treatment) has been promoted to overcome this situation [8].

Insert Table 1

In the past decade, in accordance with EU agreements, Belgian drug policy has been basically aimed at the prevention and reduction of any drug use, reduction in the number of new users, protection of society and its members, care for drug users and improvement of the quality of their lives [2]. Since 1998, dealing with the possession of small amounts of cannabis has been given ‘least priority’ by the prosecuting authorities [9]. Recently, the federal government approved of the new policy note on drug problems, which introduces several innovations such as not prosecuting non-problematic use of cannabis, establishing epidemiological and evaluation-research and expanding resources for treatment, harm reduction and reintegration [9a]. Substance abuse is regarded as a public health problem and the associated policy focuses on ‘normalisation’ as an alternative for a strictly repressive or a full tolerance policy, aiming at controlling and reducing drug-related risks. Priority should be given to more and better co-operation in order to realise an integrated drug policy, including prevention of (non-)problematic drug use; treatment, (re-)integration and harm reduction for problem drug users; repression of dealers and producers [10].

Specific characteristics of drug abusers

Drug dependence can be described as a maladaptive pattern of substance use leading to clinically significant impairment or distress [11]. In order to meet the DSM IV-criteria for dependence at least 3 of the following 7 criteria should occur at any time in the same 12 month period: “tolerance; withdrawal; substance often taken in larger amounts or longer than intended, reinstatement liability; much time spent in activities necessary to obtain or use the substance or to recover; important social, recreational and occupational activities are abandoned or reduced due to drug use; continued substance abuse despite physical or psychological problems caused or exacerbated by drug use”.

Dependence is a complex and multiple problem often including several related problems, e.g. unemployment, problems with the courts, infectious diseases (HIV, HCV, etc.), social exclusion, relationship problems, co-morbid psychopathology, accommodation problems. Moreover, the use of multiple substances is the rule rather than the exception [12]. Drug abusers are often reluctant about treatment, and their motivation for change is often low. According to Prochaska & DiClemente [13], change is a prolonged and cyclical process including several stages with maintenance as a final stage, but often followed by lapses and
relapses. Early drop-out and relapse after treatment are known to be relatively high among drug abusers [14]. Although survey-research shows that only few substance abusers enter treatment [15], many drug abusers have a long drug treatment career and some of them are known to be ‘drug treatment tourists’ [16]. Due to the nature of dependence, treatment objectives cannot be exclusively ‘cure’-oriented, but should also be ‘care’-oriented.

Consequently, substance abuse treatment should not be limited to one single treatment [17], but instead consist of different treatment episodes and modalities with continuity of care as an important challenge [18]. Integrated and individualised services are needed to address these complex and diverse problems and to improve the quality of care.

Quality of substance abuse treatment
During the past decade, evaluation of substance abuse treatment and several of its components has been an important research topic in most EU countries [19]. In Belgium, evaluation-research has mainly been limited to therapeutic communities [20]. This tendency towards evaluation has been inspired by the introduction of economic thinking in all social sectors, including the non-profit sector. One of the major goals of treatment evaluation is to improve the quality of treatment services [21]. Due to the competitive marketplace, the demand for accountability, the desire to assess return on investments and the need to allocate resources as wisely as possible, the economic (cost-effectiveness) aspect has also been integrated into this evaluation [22]. Monteiro [23] describes quality of treatment as the cost, delivery and effectiveness of treatment services. According to de Weert-van Oene & Schrijvers [24], co-ordination, continuity, effectiveness and efficiency can be distinguished within quality of care. Effectiveness refers to the relationship between achievements and resources, while efficiency is the relationship between effects and resources.

In Belgium, the issue of quality of care has been introduced into the field of social welfare and (mental) health care during the mid-1990s [25]. In a recent advice, the National Council for Hospital Facilities (Nationale Raad voor Ziekenhuisvoorzieningen, NRZV) recommended to reorganise the field of mental health care, based on the treatment demand of clients and the establishment of integrated treatment systems for some specific target groups, including substance abusers [26]. This reorganisation not only aims at more continuity of care and more individualised treatment, but also at better co-ordination and co-operation. The proposal of the NRZV has recently been further elaborated and concretised in a policy note by the minister of mental health care [27].

The quality of the delivery of services within substance abuse treatment has been discussed in several European countries. Koller [28] refers to the fragmentation and lack of co-ordination in German substance abuse treatment, which leads to institution-related thought and action. Nizzoli [29] criticised the lack of standardised clinical forms in this sector in Reggio Emilia, Italy. Research concerning intake and assessment in Rotterdam (the Netherlands) revealed widely divergent intake and assessment procedures, resulting in duplicated work and redundant information [30]. Also in the Netherlands (Utrecht), a lack of co-ordination, co-operation and communication between treatment centres for drug abusers has been observed [24].

As the development of substance abuse treatment in most EU countries first occurred without a great deal of co-ordination and deliberation, problems encountered in this sector in Belgium will – consequently – serve as examples for the challenges other European countries face or have faced. Since the establishment of services for substance abusers happened without governmental programming, it led to fragmentation and lack of co-ordination [26] and it
created a chaotic and unstructured network with overlapping and parallel structures and missing links [5]. In recent years, the range of treatment services has been growing as the amount and diversity of treatment demands increased [31]. Co-operation and communication between services is mainly based on personal choices and benevolence [2]. Due to the broad range of services and the free choice of the client, some clients are registered in different services at the same time as or shortly after they have been in another service [32]. The subsidising system, which pays per bed and consultation, unintentionally stimulates competition between services. Moreover, a lack of standardised intake procedures and follow-up of clients has been reported [33].

Besides these problems encountered in the organisation of substance abuse treatment, the multiple and complex problems of substance abusers – which elicit contacts with several caregivers – induce the need for co-ordination and continuity of care [34]. Alternatively, several solutions are suggested to improve the quality of substance abuse treatment. In several places in the United States, case management has been introduced in substance abuse treatment to address the needs of clients with multiple, complex and chronic problems [35] [36] and to deal with the lack of co-ordination of care [18]. According to a German study, services should no longer be regarded as separate institutions, but rather as a network of treatment modalities with clear functions to answer client’s needs [28]. Moreover, it was suggested that the demand for successful co-ordination and co-operation should be placed in a context of local monitoring and steering, in order to give the right help to the right person. Due to the differentiation in substance abuse treatment, the growing complexity of drug problems and the different effectiveness of treatment modalities, client matching has recently gained importance in the US [37] and in Europe [38]. Centralised intake procedures have been developed to facilitate access, co-ordination and continuity of treatment [39].

**Aims**

The aim of this study is – according to the advice of the NRZV – to evaluate two core aspects of quality of substance abuse treatment, i.e. co-ordination and continuity of care. Effectiveness and efficiency of treatment are not a primary focus, as these aspects are not the main incentives for the intended reorganisation of treatment and as these are more economic aspects of quality of treatment, closely related to accountability [21].

As some of the above-mentioned solutions might be good alternatives for the present-day situation, different aspects of the treatment process that are related to co-ordination and continuity of care will be studied. Based on the results, recommendations will be formulated to improve and optimise co-ordination and continuity of care. These recommendations might also be relevant to and applicable in other countries, as problems concerning the organisation of substance abuse treatment dealt with in Belgium are similar to those encountered in other European countries.

Although co-ordination is widely recognised as an important function in substance abuse treatment, only few researchers have focused on this aspect [18] [34]. Graham et al. [18] view co-ordination as an integral part of case management and define it as the giving and receiving of information regarding specific clients, such as informing other agencies, obtaining information from other agencies, exchange of information and case discussions involving other services. Co-ordination of care is clearly situated on the client-level rather than on the system-level. According to van Achterberg et al. [34] co-ordination consists of five basic tasks: introduction; making a care inventory; making a care plan; executing the care plan and monitoring care; evaluating the operationalisation of the care plan. Other authors state that co-
ordination of care can be derived from the functional co-operation between services [24]. In order to study co-ordination of care at the level of the individual, we will focus on several aspects of the referral process, exchange of information, registration, creation of client files and co-operation.

Several authors [40] [24] have stressed the importance of continuity of care in substance abuse treatment. However, relatively few information is available on how continuity of care can be operationalised. Bachrach’s 7 dimensions of continuity of care provide a useful theoretical framework for this operationalisation [40]: longitudinal approach, flexibility, individualisation, proximity, accessibility, communication and comprehensiveness. Several aspects related to these dimensions, i.e. intake procedure, treatment process, follow-up of clients and case management will be studied in this article.

Both theoretical frameworks illustrate that aspects of co-ordination and continuity of care cannot be strictly separated (e.g. communication, case management). However, for pragmatical reasons both dimensions will be distinguished in the chapters ‘results’ and ‘discussion’.

Methods
Sample
The sample for the structured interviews consisted of all 27 (general and specialised) services in the province of East Flanders, which has a relatively large group of substance abusers among its population. The level of the province was chosen, since the provinces are responsible for the co-ordination of substance abuse treatment. Services in the province of East Flanders were studied as this region has the most elaborated and differentiated network of services in Flanders. The following services were involved in the project: 3 drug-free therapeutic communities, 1 crisis centre, 1 day-care centre, 1 medical-social centre, 2 other specialised outpatient centres, 5 mental health care centres, 7 wards in psychiatric hospitals, 5 shelters for the homeless and 1 place for sheltered living.

A total of 31 key informants have been interviewed, one at each service except 4 services where 2 key informants were interviewed as no single person could adequately answer all interview questions. A key informant was defined as ‘a person at a centre with most knowledge and experience concerning the different aspects of co-ordination and continuity of care’. Most key informants (n=16) had a supervisory function, while others were working as psychologist (n=6), social worker (n=6), psychiatrist (n=2) or drug counsellor (n=1).

For the study of the client files, those services (n=8) that only have a minority of substance (ab)users among their populations were removed from the interview sample. Moreover, if services were part of a larger organisation (n=3), information was thought to be redundant after the study of client files in 1 or 2 services. Since two services refused to participate in this second part of the research, the sample for the study of the client files consisted of 14 services. A random sample of 5 records was chosen from the first 10 clients in each service, who gave their informed consent to participate in this study. Due to a combination of reasons (small number of drug users among the client population, refusal of clients to participate and caregivers forgetting to ask clients to participate), in one service only two clients and in two services only one client agreed to participate in the project. The last two services were removed from the sample. In total, 57 client files have been studied in these 12 services (2 drug-free therapeutic communities, 1 crisis centre, 1 medical-social centre, 4 mental health care centres and 4 wards in psychiatric hospitals).
Instruments
A structured questionnaire, based on topics from existing questionnaires [41] [42] and literature concerning co-ordination [34] [18], continuity of care [40] and case management [43] [44] [45] was used for the structured interviews. This questionnaire consisted of open-ended and multiple-choice questions.

The first part of the questionnaire concerned descriptive information about the organisational and structural aspects of treatment (i.e. objectives, target group, treatment programme and accessibility), while the second part focused on important aspects of the treatment process (co-ordination and continuity of care) and on aspects of case management. Questions concerning case management were all open-ended questions, checking experiences, expectations, positions, feasibility and priorities. The prerequisites, strategies, partners involved and communication were questioned as important aspects of the treatment process (first contact, intake, dismissal, referral and co-operation), since these aspects are closely related to co-ordination and continuity of care. In order to understand how information is collected and recorded, some questions concerning registration and client files were integrated in the interview. Due to a lack of precise figures, frequencies were estimated using a 7-point scale from ‘always’ to ‘never’.

For the study of the client records, an interview scheme and a checklist were used. The interview scheme was based on a code for referral in mental health care [46] and covered feedback and communication at referral. The checklist consisted of 32 items concerning various aspects of the treatment process and were based on criteria for ‘good quality’ client files [44]. Items can be scored positive or negative (present or absent in the records). The items were grouped into 8 categories: first contact, assessment, planning, intervention, evaluation, referral, dismissal and registration. The first category concerned information gathered at the first contact or admittance (e.g. treatment demand, name and address of the referring agency), while categories 6 and 7 concern information registered at referral or dismissal (e.g. reason for referral, notice of dismissal). Categories 2 to 5 refer to the core functions of case management [43], e.g. assessment of current and past problems, goals of treatment, treatment planning, description of various interventions, evaluation of interventions. The last category contains residual items (e.g. informed consent).

Procedure
The evaluation study was conducted between January 1998 and June 1999. Key informants were interviewed at their workplace between June and October 1998. The duration of the interviews varied between 70 and 120 minutes, with 90 minutes as the average duration. All interviews were tape-recorded and transcribed and then returned to the key informants for a final check. Client files were studied from 15 December 1998 to 31 January 1999. A short interview with the person responsible for the registration at each centre preceded the study of the records. The client files were scored on the presence or absence of the checklist items. Moreover, the researcher noted his findings and remarks concerning the records at the end of the interview.

Data analysis
The data from the semi-structured interviews and the study of the client files were analysed by both qualitative and quantitative methods. Multiple-choice questions in the interviews and checklist items in the files study were coded and analysed using the statistical software package SPSS. Due to the nominal and ordinal level of the variables, analyses were limited to frequency
tables and crosstabs. Answers to open-ended questions and additional remarks from key informants during the interviews were grouped according to themes. Comparison of these themes in the total sample led to a more in-depth analysis of the interviews. The remarks of the interviewees and the researcher’s notes during the study of the client files were analysed similarly. During the data analysis we distinguished 4 categories: specialised substance abuse treatment (therapeutic communities, crisis centres, day care centres, medical-social centres and other specialised out-patient centres); mental health care centres; psychiatric hospitals; and social welfare centres (shelters for the homeless and places for sheltered living).

Results

Co-ordination of care

Referral

In most services, clients themselves (n=14) or their surroundings (family, friends) (n=7) usually make the first contact. General practitioners, judicial agencies (e.g. youth court, probation) and 2 specialised services (a medical-social centre and crisis centre) also regularly initiate the contact with these services. Compared to other services, self-referral is most common in specialised substance abuse treatment.

The amount of referrals is limited and fluctuates over time. Most services only occasionally refer clients, while 5 services refer about 50% of their clients. Direct referral on first contact can be observed in about 25% of all cases in 7 services (particularly social welfare centres). Clients are referred to various specialised (e.g. therapeutic communities, medical-social centres) and non-specialised services (e.g. mental health care centres, shelters for the homeless, psychiatric wards) without one particular centre or clear referral patterns dominating.

The qualitative analysis showed that most services receive referrals from various other centres; services that are part of a network of services tend to refer clients within their own organisation. The reason for referral is not always clear: sometimes clients are referred to a specific service for a specific problem; mostly other reasons play a role such as the choice and place of residence of the client (n=13) or care-givers in different services who know each other or who have been working together before (n=7). It appears from a study of the clients’ records that the proper reason for referral could not be established in 1 in 5 files.

Communication

When a client is referred to one of these services, about half of all services (48%) ‘always’ or ‘nearly always’ have contacts with the referring agency within the first days after referral. Mostly, this contact is initiated by the referring agency (2/3 times), but a systematic and uniform pattern of communication is lacking. Most services (n=19) communicate this information by telephone, while 8 centres mainly receive written information which is complemented by telephone communication.

Qualitative analysis shows that few services have systematic contacts with the referring agency to provide feedback about the result of the referral. Key informants again confirm that communication between services is easier when they know a staff member at the referring agency. Only in 6 services the communication of client information is always based on the ‘informed consent’ of the client.

When a service itself refers a client, 18 services ‘nearly always’ exchange information with the centre the client is referred to. If information is communicated, almost all services (n=25), as
referring agencies, initiate this contact themselves. Most services (n=15) communicate this information through telephone contacts, although 12 services (mental health care centres, social welfare centres, in-patient specialised substance abuse treatment) have telephone contact in addition to the written information they send.

Qualitative analysis of the interviews shows that services usually receive no feedback about the results of their referrals. Alternatively, key informants suggest using standardised forms for communication and also communicating information about the course of treatment. Most key informants prefer to receive written rather than telephone information, since this kind of communication is less transient. Some key informants complain about the lack of basic information they receive about certain clients. Privacy regulations are often cited as a major reason for the lack of or insufficient communication.

The interviews (n=12) that preceded the study of the records revealed wide variations in communication procedures at different services. After the initial contact about the referral, only one service reports on the course of treatment and only a quarter of all services communicate important changes in the situation (e.g. suicide attempt) or treatment of the client (e.g. admittance to a general hospital) to the referring agency. If a service further refers a client, most services (n=7) ‘nearly always’ inform the referring agency or the general practitioner.

The study of the client files reveals that information from the referring agency is absent in 25% of the files of all referred clients. Twelve records contained feedback that was sent to the referring agency after the referral. One third of the files contained information that was communicated by another service, although nearly all clients had been treated in other services. An ‘informed consent’ for the communication of client information was found in only 28% of all files.

**Registration**

According to the type of service (e.g. psychiatric wards, mental health care centres, specialised substance abuse treatment), specific registration forms are sometimes used in addition to other registration forms developed within these services. From the study of the client records, it appears that the client’s treatment demand is registered in most records, but in more than three-quarters of the files there is a lack of information on why a client is coming to this service and why he is doing so at this particular time. Almost all records contain information about physical health, employment, drug and alcohol use, psychological state and judicial situation.

**Client files**

Key informants indicate that client records contain various forms and a large quantity of information. In 10 services, files consist of various parts located at different places. Qualitative analysis reveals that various services use different forms to compose and structure these records, and even within some services structural differences between the records could be observed. Most files do not have a fixed structure, clear or chronological order, table of contents or summary of the most important client information and consist almost exclusively of hand-written information. Several files also contain duplicated information.

**Co-operation**

Overall, the co-operation between services is positively evaluated. Five services report problems in co-operating with some specific services. Qualitative analysis of the interviews shows that – compared to a few years ago – co-operation and deliberation between services is growing and improving and that services are gradually showing more openness towards other
centres. None of the key informants reported systematic co-operation concerning some aspects of the treatment process, e.g. time-out, detoxification. According to these informants ‘good’ co-operation depends on persons rather than on services and co-operation seems to improve if care-givers from different services know each other better. Co-operation is hindered by the competition between services due to the co-existence of similar services and programmes, the system of allocating subsidies and by the conflicting objectives of different services.

Key informants criticise the lack of flexibility, long waits and reluctance to work with substance abusers in some mental health care centres. Most general practitioners also seem to be reluctant to work with this target group. Social welfare centres complain that some specialised centres do not communicate essential information, e.g. doses of methadone. According to the key informants, the lack of co-ordination and co-operation is best illustrated by the so-called ‘drug treatment tourists’, who take advantage of the lack of communication between services.

**Continuity of care**

**Intake procedure**

In most services (n=19), a treatment demand is followed by an appointment for an intake interview. Re-start of treatment with clients who have been previously treated in this particular service is unconditional in 5 centres, while 22 services evaluate on a case-by-case basis whether a client can be treated again or not. Only 6 (residential) services regularly use a waiting list, but key informants explain that these waiting lists are mostly temporary and resolve automatically as clients contact other services.

**Treatment process**

Most client records contain a large amount of information about the treatment history (e.g. origin of the problem, coping mechanisms, number of previous treatment periods), but only half of these files contain information about the content, course and result of previous treatment. An extended problem analysis is part of most records, but little information can be found about the client’s competencies and about goals and expectations of treatment. Only in 6 records (10.5%) could a treatment plan be found. Most files contain a logbook with information about the treatment process, but the lack of structure and order in these logbooks might restrict their utility. In two-thirds of the files an evaluation of the treatment process was found, but the product offered to the client (strategies and methods) is rarely evaluated.

**Follow-up**

At the end of treatment, most services (n=17) ‘nearly always’ contact the referring agency about the result of treatment. The more contacts during the course of treatment, the greater the chance that the referring agency will be informed about the end of treatment. In cases where a client stops treatment with negative advice from the staff, referring agencies from the judicial sector will ‘always’ be contacted.

Only 7 centres follow up clients after the end of treatment, but this mainly relates to informal contacts after long-term residential programmes. In cases where treatment ends with negative advice, the only thing some services (n=6) do is to send a reminder to clients. The lack of follow-up after treatment is – according to the key informants – due to lack of time and resources to do so. Some of them are reluctant to follow up clients as this might imply acting at the same time as other care-givers are involved. Follow-up of clients after referral is restricted to those cases in which the referring agency remains involved in the treatment of the client.
Case management
According to the key informants, experiences with case management are limited to some isolated cases, and only in 2 psychiatric hospitals is a model of case management used to follow up a small number of clients. About half of all key informants (n= 12) state that some of the basic functions of case management are already used in their centres.

Key informants suggest that the implementation of case management might help to avoid duplicated work, to reduce costs, to guarantee the continuity of care and to centralise information about the client. Moreover, case management can stimulate co-ordination and cooperation and can help to reduce shopping. On the other hand, it can limit the free choice of the client and lead to stigmatisation. They feel that the implementation of case management will be hindered by the lack of a structural place for this method in the Belgian health care system. The key informants suggest starting with a small pilot project and using this method to help clients that are addressed by various care-givers at the same time.

Discussion
Structured interviews with key informants in all services involved in substance abuse treatment in the province of East Flanders (n=27) and a study of client files (n=57) in 12 of these services have been conducted to evaluate co-ordination and continuity of care. Consequently, two sources of information have been used for this evaluation, the former representing the more subjective interpretations of key informants, the latter giving a more objective analysis of the situation.

According to the theoretical frameworks of Graham et al. [18], van Achterberg et al. [34] and de Weert-van Oene & Schrijvers [24] several aspects of co-ordination of care have been evaluated, focusing on the referral, communication, registration, client-files and co-operation. Graham et al. [18] stress the importance of exchanging information at referral and during the course of treatment and of ‘ad hoc’-co-operation concerning some specific cases. The importance of monitoring and evaluation is emphasised by van Achterberg et al. [34], while de Weert-van Oene & Schrijvers [24] add co-operation, registration and the making of client-files as important indicators of co-ordination.

The analysis of the referral procedure shows that most referrals are self-referrals or referrals by family or friends, which corresponds to the results of the analysis of drug treatment demands in 23 European cities [4]. It can be questioned whether clients are able to address the most appropriate service for their problem themselves. If clients are referred by another service, the reason for referral is not always clear and is based rather on informal mechanisms such as the personal choice of the client and referral to affiliated centres. As long as this referral meets the client’s needs, these ‘subjective’ motivations for referral can be a good addition to more objective reasons such as a DSM diagnosis, specific problems, etc. [38].

The results of both structured interviews and study of the client files show that information is not systematically communicated and that a standardised pattern of communication at referral is lacking. Feedback about the result of the referral (e.g. client was further referred, client admitted in the hospital) in particular is not often communicated, although a referral can be regarded as an important step in the treatment process. Most of this information is exchanged by telephone, which is more transient and superficial than information in writing. Good informal contacts between care-givers from different services improve the exchange of
information between services, which is characterised by Siegal as “social services bartering” [45]. According to the Belgian privacy regulations, information about clients can only be communicated if they give their ‘informed consent’. Only a quarter of the client files contain an informed consent, which is opposed to the principle that communication of information should be consistent with confidentiality regulations and professional standards of care [45].

Good co-operation between services is based on positive informal contacts between individual staff members rather than on structural agreements between services. Although co-operation and deliberation have been growing recently, fragmentation and lack of co-ordination continue and maintain institution-related thought and action [28] due, among other things, to the competition between services for scarce funds. This observation is illustrated by the criticism of some key informants that large organisations consisting of different services refer clients within their own organisation.

As in Italy and other European countries [29], no standardised registration forms are used by all services involved in substance abuse treatment, but specific forms are used by various types of services. The development and introduction of standardised forms to use at intake and referral was suggested by several key informants to improve the exchange of information between services.

The records of the clients are well documented, but when compared with some minimal criteria for a qualitative record [44], some shortcomings can be observed e.g. concerning the presence of a treatment plan, the objectives of treatment and evaluation of the treatment process. Moreover, the structure of these records differed between and even within services. Little evidence of written communication between services could be found since only a few files contained information from services previously involved in the treatment of these clients. Surprisingly, it appeared that most records consist of hand-written information and only a few services use computers for the registration and creation of client files, although researchers have proved that computers can reduce the costs of health care and may lead to more effective and efficient care [17].

Continuity of care has been evaluated based on Bachrach's dimensions [40], which stress aspects such as the need for longitudinal and individualised care, accessibility of treatment and good communication between services.

As has also been observed in the Netherlands [30] and Italy [29], each service developed a specific intake procedure to start the treatment process, but all services are easily accessible and only some of these centres sometimes use a waiting list. Re-commencement of treatment with recidivist clients who have been treated at this service before is decided on an individual basis. This might lead to a risk of some hard-core clients who have been treated several times at one or more services or who have caused trouble at a particular place being excluded from treatment in some services.

Most services contact the referring agency at the end of treatment, but few services follow up clients after treatment, and if they do so it cannot be characterised as a pro-active follow-up. Due to the high relapse rates among drug users, follow-up of former clients after treatment is one of the basic characteristics of case management [43, 44] and can also be useful for early intervention and relapse prevention. Lack of time and resources and reluctance to interfere
when other care-givers are involved are recorded as the main reasons for not following up clients.

Experiences with case management in substance abuse treatment are limited to two services, and some services report taking up at least some case management functions. According to the key informants, case management is considered to have many advantages – besides some disadvantages – and should be directed to the group of clients with multiple and complex problems who are known at different services.

If compared to the indicators of co-ordination proposed by Graham et al. [18], we can conclude that a lot of information is exchanged at the time of referral although not systematically. However, few information is communicated about the result of the referral. Co-operation is evaluated positively and is mainly based on informal mechanisms, but ‘ad hoc’-co-operation concerning some specific cases is lacking. A lot of work is already done concerning registration and making of client files, but standardisation of registration forms and client files is necessary to improve the quality of the registration and client-files. Monitoring and evaluation of the treatment-process is unusual.

According to Bachrach's indicators for continuity of care, especially the longitudinal approach and the individualisation are not well elaborated as follow-up of drug abusers after treatment is unusual and as few initiatives can be observed that are directed at the individual. Moreover, some of the core functions of case management related to individualisation (e.g. planning, monitoring and evaluation) are not realised and the so-called ‘drug treatment tourists’ illustrate the lack of individualised and comprehensive treatment. The indicators flexibility, accessibility and proximity of treatment are evaluated positively as only few services have a waiting list and as re-commencement of treatment is usually possible. As could be derived from the indicators of co-ordination of care, information about the client is exchanged at the time of referral, but few information is communicated concerning the course of treatment.

As key informants asked for more systematisation and standardisation of communication, the introduction of a formalised stepwise plan was regarded as a prerequisite for systematising and optimising communication between services. Following such a stepwise plan, the implementation of a model of case management was considered an appropriate answer to improve co-ordination and continuity of care in this region. According to the key informants, case management can contribute to the avoidance of duplicated work, reduction of costs, centralisation of information and limitation of ‘drug treatment tourism’, although the risk of stigmatisation and restriction of the free choice of the client should be closely monitored.

As a consequence of this study, a formalised and stepwise communication system is being introduced to systematise and optimise the communication between services at referral. It starts from the experience that services consider it important to receive basic information from the referring agency and that a large amount of information is communicated, but that this often occurs non-systematically and without the informed consent of the client. The introduction of this system assumes the following prerequisites: respect for the autonomy of each service, referral to the most appropriate service according to the client’s needs, exchange of written information and communication of client information based on their informed consent. The proposed procedure primarily consists of systematic communication of a short letter of referral by the referring agency (including the reason for referral, information about the treatment
process) and the systematic feedback on the result of this referral by the agency the client is referred to [47]. Additionally, the sending of a temporary report and reporting on important changes in the situation or treatment of the client is recommended. The implementation of this communication system is accompanied by the introduction of standardised forms.

Secondly, the implementation of a comprehensive model of case management can follow the systematisation of communication and is identified by key informants as a possible alternative to improve co-ordination and continuity of care. A small pilot-project is being established to address those clients that are contacting various services in a relatively short period of time. The project is conceptualised according to the operational features of case management, identified by Robinson & Bergman (1989) [17]: consumer directedness, range of assessment or focus, programme structure, degree of direct service provision, target population, case manager training, service site, staff-to-client ratio, staff credentials, staff availability, intensity/frequency of contact, duration of service provision, administrative authority. The objectives of this intervention aim at reducing relapse and re-admission in treatment, providing individualised and continuous care and preventing social exclusion [48]. At a more structural level, this project is intended to improve the co-ordination of care for substance abusers and the communication between the services involved in this treatment.

The model of case management mentioned above can be characterised as a rehabilitation model [45] [49], and the primary functions of the case manager in this project are assessment, treatment planning, direct (e.g. information, support, advice) and indirect (outreaching, coordination, linking, advocacy) interventions, monitoring and evaluation [43]. The target group for this project consists of a small group of drug users with multiple and complex problems, which is operationalised as persons who are dependent on drugs and/or alcohol for at least 2 years, who have several problems besides dependence (health, the courts, relationship and psychological problems) and who have been treated for drug problems in at least 3 different services. The following prerequisites are formulated to facilitate the implementation of case management: the development of a manual for case managers [50]; predominance of the interest of the client, involvement of general practitioners [51]; use of standardised forms for the evaluation; involvement of the client’s family [44]; development of clear programme descriptions [43].

The implementation of this method of case management is accompanied by an evaluation study and started at the beginning of 2000. During this implementation, an experimental group of 30 drug abusers will be compared with a control group not receiving case management in addition to standard treatment. Both groups will be interviewed at the start of the project and 12 months later, using the European Version of the Addiction Severity Index [52], the Circumstances-Motivation- and Readiness-scale [53] and an open interview to study the satisfaction of the persons involved. Besides these interviews with drug users, all other partners involved will be interviewed: case managers, programme-directors, and stake-holders. In addition, logbooks and files kept by the case managers will be studied. Finally, as case managers operate in a certain service, it will be very important to study the characteristics of the units where case managers are working.
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Table 1: Overview of specialised and non-specialised services for drug abusers in Belgium, including some of their main functions

<table>
<thead>
<tr>
<th>General care</th>
<th>Specialised substance abuse treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
<td><strong>Outpatient</strong></td>
</tr>
<tr>
<td>• Social welfare centres (social and financial assistance)</td>
<td>• Day-care centres (medical and psycho-social assistance + day programme)</td>
</tr>
<tr>
<td>• Street-corner work (outreaching)</td>
<td>• Medical-social centres (low threshold medical care (e.g. methadone prescription) + psycho-social assistance + harm reduction)</td>
</tr>
<tr>
<td>• Social workplaces (training + employment)</td>
<td></td>
</tr>
<tr>
<td>• General practitioners (medical care)</td>
<td></td>
</tr>
<tr>
<td>• Pharmacists (methadone supply)</td>
<td></td>
</tr>
<tr>
<td>• Mental health care centres (psycho-social + psychiatric assistance)</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td>• Shelters for the homeless (accommodation)</td>
<td>• Crisis centres (detoxification, motivation and orientation)</td>
</tr>
<tr>
<td>• General hospitals (medical care, e.g. detoxification)</td>
<td>• Short-term therapeutic programmes (short-term residential treatment (&lt; 6 months))</td>
</tr>
<tr>
<td>• Psychiatric hospitals (psychiatric care)</td>
<td>• Therapeutic communities (long-term treatment (&gt; 6 months))</td>
</tr>
</tbody>
</table>