With the end of the current drug strategy only 24 months away, how will Britain be caring f

Brave new world

THIS year will be critical for the drug treatment field. We'll have the final Spending Review and with it the final set of Public Service Agreements (PSAs) of Tony's Blair's tenure at Downing Street. In many ways more important than any published strategy, PSAs form the bargain between the Treasury and the departments which receive public money. "If we give you this," say the Treasury, "what will you give in return?". And in two years' time the existing drug strategy will almost certainly be replaced with a newly-packaged strategy for drugs in England. To enable this, preparation must begin in 2006.

I say 'almost certainly' because there is no obligation for the government to have a drugs strategy. However, the substantial public interest in the issue of drugs and drug use and the moral panic excited by claims for the extensiveness of drug-related crime makes walking away from this area of policy very difficult for any political party facing an election. And I say 'newly packaged', because there can be little doubt that the next strategy will be similar in tone and message to the last. The four aims of *Tackling Drugs To Build A Better Britain* are as valid now as they were at its launch eight years ago.

HOW MUCH PROGRESS?

Whatever progress we believe we have made towards the targets of the last strategy, few would claim that illicit drug use in this country is substantially contained or managed. We still have a significant market for illicit drugs and it is far easier in some areas to purchase a broader range of substances than it was ten years ago. However many people attend treatment services, we still have rising levels of blood-borne viruses among young drug injectors. The majority of people we imprison use drugs.

So will anything change? Well, it's likely that there will be substantial changes in the policy environment for drugs which will have a huge impact on what can be achieved over the next decade. Most of these changes will come about as a response to changes in other areas of public policy. Many of them will happen simply because it is not possible to keep drugs outside the mainstream public service reforms. The fast-moving agendas around 'Localism' in public services, 'Personalisation' and 'Choice' in health and social care will begin to impact on drugs policy simply because of their momentum. New commissioning structures will have a significant affect on services, as will the inevitable levelling out – or effective reduction – in investment.

In order to influence the development of drug treatment we need to look over the parapet into the rest of health and social care. The reforms and changes which are happening in mainstream policy can have a far greater impact on the wellbeing and opportunities available for drug users than any number of philosophical shifts in attitudes towards drugs. To exploit these changes we need to understand what they might mean to drug treatment.

TAILORING

The government commitment to 'Choice' and 'Personalisation' – whereby a patient has the choice of five different healthcare providers for each intervention or a user of social care controls their own budgets for that care – is possibly the single biggest change to happen to healthcare since the foundation of the NHS. The operation of a health and social care economy which enables individuals to design their own care pathways and choose their own treatment options will hugely challenge the drugs treatment field – at all levels, from commissioner to provider.

Sara McGrail is the author of The National Drug Strategy: a guide for local partnerships

drug users in 2008 and beyond? **Sara McGrail** poses the challenges for the treatment industry

But there is no point in offering choice if there is only one option. The local market must provide individual users with a genuine choice between service providers. The interaction between user and provider may happen face-to-face or may be brokered – in the form of person-centred care management or within an advocacy framework. Our current commissioning system prohibits the development of plural markets simply because in most cases we are commissioning on too-small a scale. The average DAT spend on community drug services ('tier three' services) is not going to be able to sustain much more than one or two treatment providers. The only way, within the current system, of growing a multi-choice market is to develop cluster commissioning – where two or more DATs pool their resources and commission jointly. There are some places where cluster commissioning is working. But more often than not it is being used to jointly purchase one big service, like a mental health trust specialist treatment unit – surely the opposite of the choice-filled market we should be seeking.

NO 'RIGHT WAY'

There is another challenge that 'Choice' and 'Personalisation' bring to the table, and that's to focus on the people who use services. The drugs field is one of the most riven and philosophically divided fields in health and social care. The harm reductionists sneer at the criminal justice workers, the abstentionists recoil from those advocating maintenance, the 'addiction is a disease' lot peer suspiciously at the 'society's to blame' clique. Champions of the different treatment philosophies – motivational interviewers and cognitive behavioural therapists, the Minnesotans and the Dutch Modellers – all bicker over the single 'right way' to work with drug users. We build treatment systems that respond to our own philosophical imperative. So keen are we to define what we do as the 'one thing' that works, we forget the most important fact about working with people – they are not all the same. As much as people *ought* to have a choice, they also *need* to have a choice, because not every treatment intervention will be the right thing for every drug user. And as any drug worker will tell you, people who participate actively in their own treatment have a better chance of achieving their goals.

VICIOUS CIRCLE

Put simply 'Localism' is deciding how money is spent and how public services are delivered on a local basis. For many areas, the development of Integrated Children's Plans and Local Area Agreements (LAAs) has been the first taste of localism. In some ways one could claim that the drugs field is ahead of this game. For the past ten years all activity for the drugs strategy that takes place at operational level has been either directed or commissioned by local DATs. A local planning and commissioning partnership of all the agencies involved in tackling drugs locally, DATs are an excellent concept. But do they pass the Ronseal Test – do they do what they say they will do on the tin?

The whole point of working locally is to ensure a better fit of national strategy and resources to local need. But this is something most DATs have clearly not achieved. Lack of local capacity and expertise coupled with highly prescriptive central guidance has led to a vicious circle where DATs lack the opportunity and support to really explore and meet the local agenda – while depending on central agencies which are held accountable for meeting the PSA to process-manage everything.

DATs never develop the skills they need to work effectively and central agencies never develop the confidence they need to let go. Consequently, most DATs commission to meet national targets, local involvement and engagement is tokenistic, providers and service users lose any real influence they ever had on the development of services and the system becomes self-serving, rigid and inflexible.

> **'The drugs field is one of the most riven and philosophically divided fields in health and social care'**

Decisions that should be made in partnership are actually made in individual agencies with little co-ordination. For example, most commissioning decisions rarely, if ever, go anywhere near the main DAT table. Most of them are essentially made by Primary Care Trusts (PCTs) as the holder of the Pooled Treatment Budget. As more places in England

develop LAAs that require agency level co-operation and local involvement in planning and development of services in exchange for a loosening of the central planning straightjacket, the DAT approach and its notional devolution of power is beginning to look outdated.

The challenge will be to develop structures for commissioning drug services that respond to the agenda for localism and provide choice. This is likely to require a different response from service providers too, as one commented recently on the development of the localism agenda in their area: "This first phase seems to have involved a 'positioning' scuffle by providers and commissioners engaged in activity to firm up Service Level Agreements and establish firmer outcome measures. But what is becoming clear is that the people making decisions do not have the same vision and map of the local area as a DAT. How could they?"

> We need to look over the parapet into the rest of health and social care

WHO COMMISSIONS?

The reorganisation of local health services – announced in the summer in the Department of Health circular *Commissioning a Patient-led NHS* will have a significant impact on treatment services. This policy alters the local healthcare commissioning and service-providing structure: PCTs will cease to provide any services and their commissioning role will move to GP practices.

What this means for drug treatment is uncertain – it is currently assumed, along with mental health, to be excluded from the services which will be commissioned at practice level. The development of expertise around drug use in primary care has moved on massively in the past ten years, but the learning curve for Practice Based Commissioning (PBC) is so steep that drug use is unlikely to be a priority except in the minority of practices. Drug users are also significantly less likely than the mainstream population to be registered with a GP and so less likely to be able to access services commissioned at practice level.

The option of shifting the Pooled Treatment Budget into the LAA is more complex than it seems at first glance. Firstly, most local authorities don't directly commission drug treatment and secondly, the overall status of health funds in the LAA is confused. Additionally, retaining drug treatment spend at a local level may prevent us from developing a multi-choice market. But if neither PCTs nor GPs are going to commission drug treatment, then who is?

Maybe the newly reconfigured Strategic Health Authorities (SHAs)? There are some advantages to this. The new SHAs are going to map closely onto government office regions – for whom drugs are a high priority. This would indicate a political will to at least safeguard the current investment. Another benefit of aggregating existing budgets up to SHA level is that this would give sufficient purchasing power and scope to develop a genuinely multi-choice market. It was announced at the Home Office Drugs Conference in November last year that the NTA regional teams would be subsumed into the new SHAs as soon as they were up and running (rumoured to be sometime between July 2006 and April 2007). In addition to this, the NTA is currently establishing regional commissioning advisory panels within existing SHAs whose role is to advise and support local commissioning – these could form the basis of future commissioning teams.

However, commissioning drug treatment from the SHA moves service design and development further away from service users, makes it less responsive to local need, less well-aligned with other local services and runs counter to the localism agenda being developed through LAAs. SHA commissioning would make the development of local brokerage essential – with the potential that this could simply become another layer of bureaucracy, impeding rather than facilitating choice. In addition, it is simply too early for anyone to be clear about the role or commissioning capacity of the new SHAs.

Given the emphasis on routes into treatment from the criminal justice system, the National Offender Management Service (NOMS) is another potential commissioner for drug treatment. However, while considerable resources are invested in drug treatment by the Home Office, the bulk of funding still comes from the Department of Health. It is unlikely that health monies would be willingly transferred to a Home Office body – whatever the guarantees of operational independence. In addition, the lack of a ring-fence round the Pooled Treatment Budget would make the monies vulnerable to poaching to support the chronically under-funded prison and probation services within NOMS.

PUBLIC PURSE

There are considerable pressures on the public purse in terms of healthcare, education and housing – and it's unlikely that drugs will retain its priority call on new money available at the Spending Review. On top of this, the cost of attaining the treatment targets over the final two years of the strategy is likely to see pressure on unit costs for treatment as increased numbers of people going into treatment exceeds the increased investment. The reliance on criminal justice routes into treatment also comes with a cost. In one part of the country, it's estimated that it costs £950 for a person to go through the treatment system via the Community Drug Team (CDT). Via the Home Office's

All this will begin to squeeze providers and commissioners alike, with the result that some form of treatment rationing may become necessary. We are already seeing a degree of pragmatism in this area with the reaffirmation of abstinence within the treatment effectiveness strategy. There will be a need to begin to regard our treatment resources as a scarcer commodity. This may not run against the interests of individual service users, as it is arguable that currently too many people are maintained in high-dependency, high-cost treatment services – such as specialist addiction units in mental health trusts – when they may actually want to get out of treatment or into lower-intensity treatment.

It is also clear that bad commissioning costs more money than good commissioning. People experience more treatment episodes, receive more inappropriate treatment and are simply not effectively engaged with by services which are poorly-commissioned, poorly co-ordinated or just poor. A leaner, more competitive drug treatment field with a lower dependence on large NHS trusts with their spiralling costs and specialist intensive services may not just make for more economically viable treatment, it could actually improve treatment outcomes.

So while the next strategy may look like more of the same, and while the Spending Review may identify similar targets, there are significant changes on the way. The challenge for the treatment field is to work with those changes to achieve the very best results it can – not just for individual clients, but through their achievements in treatment, for the broader community.

MAIN SHOW

In influencing and lobbying around these changes, we need to lose a bit of the preciousness and a bit of the posturing, and admit that we can learn good practice from other fields. While we've spent our coffee breaks at conferences arguing about whether the crime agenda or the health agenda should dominate, we've been missing the main show.

Ever since 1985, investment in drug services has been predicated on the demonstration of social outcomes – outcomes to meet either the crime agenda or the health agenda. This presents a challenge to all involved in setting policy. We may be measuring the success of our strategy in terms of reduction in crime and public health threats, but we need to acknowledge that those social outcomes can only be reached if people have an adequate choice of good quality person-centred services which genuinely meet their needs and maximise their own control of their substance use and related problems.

The real challenge over the next year is to utilise the developments in other fields of health and social care in order to ensure that the people who are at the centre of any policy shifts around drug treatment are the people who directly benefit from it. Not recognising this may result in serious conflict for providers, for commissioners and for drug users. As one provider commented to me recently: "It is only a matter of time before the police are able to access records all across drug services. The contrast between these ideas and the debate about personalisation and choice HAS to be interesting. It comes down to the argument about who the customer is." ■