Discordant defence

Poor coordination is leaving rehabs at the mercy of the market

WITHDRAWAL IN OCTOBER 1992 of the plan to ringfence funds for residential care left local authorities and providers the near impossible task of having systems in place for April. Even more difficult was the need to make major financial and policy decisions at short notice, with limited information, and in an atmosphere of near panic. Most local authorities were unprepared, some with no assessment procedures, many with obstructive or inept ones, others having made ill-advised block-purchasing deals which proved untenable in the face of clients' diverse needs and preferences. The first three months were marked by chaos in assessment, impeding clients' access to services. Soon it was clear that the most needy were not making it through the obstacle course.

The response of SCODA and Alcohol Concern received much criticism; it did seem lacking in urgency. ADSA (the Alcohol and Drug Services Alliance) was important in monitoring developments, providing information and a link for smaller providers. However, its lobbying was flawed by the unrepresentative and unaccountable nature of the group and by its failure to coordinate with SCODA at key moments when cohesive public representation was required.

"Providers have accepted spending limits: the words 'turkeys' and 'Christmas' spring to mind"

This came to a head in July when the DoH released the report from Goldsmiths' College on the first three months of community care. It recorded significant drops in the resources available to residential services and in staff and bed numbers, but the fact that wholesale closures had been averted allowed the Department of Health to claim all was well.

Days before ADSA had fired off a press release based on its finding that "Over 90% of the agencies ... say their clients are not getting the help they need". It might have had greater impact if saved for a coordinated drugs/alcohol field response to the cosy picture painted by the Department of Health. SCODA and Alcohol Concern did respond to the DoH's statement, mildly warning against assuming Goldsmiths' report "paints the final picture," but they did not contest the official line that, for now at least, the system was holding up. These contradictory messages discredited well-founded concerns about client access and the viability of services.

Goldsmiths' key findings that admissions had dropped by 'just' 27 per cent and that local authorities had set aside £33 million for drug and alcohol clients also went uncontested. Both were soon shown to be perhaps 50 per cent on the wrong side of reality. SCODA and Alcohol Concern failed to spot this, depriving services of crucial ammunition in their attempts to show they were not crying wolf.

Providers too can hardly be said to have stood firm or together. A providers' coalition to match the power of the purchasers is noticeable by its absence. To widespread dismay, some houses plumped early for deregistration as care homes, maximising their residents' rights to housing benefit. This aids short-term survival but also undermines claims about the specialist nature of drug and alcohol services and their value in improving public health and reducing criminality. By August, 17 per cent of beds had been deregistered. While a few low-care projects can deregister without affecting their services, it is increasingly difficult to agree housing benefit rates which can support the level of supervision drug users need. Services which provide nursing care, care for children, or cater for other specialist needs, do not have the option of deregistering.

The allocation formula resulted in generous community care grants to shire counties, while inner-city boroughs, where drug use is higher, were left hopelessly short. Many local authority purchasers had no choice but to ration care. Early on limits were put on lengths of stay and costs. The 12 inner London boroughs agreed to limit charges to £220 and £315 a week for care and nursing homes respectively. This was done without consultation with providers and in the absence of a proper assessment of costs, outcomes, or quality. It fails to recognise the importance of maintaining a range of provision, where more specialist services, and those catering for complex needs, cost more.

Many providers have capitulated and allowed these limits to be imposed. Some can survive in the short term using subsidies from their parent organisations or reserves, but long term this can only result in reduced levels and standards of care. If providers accept the myth of the buyers' market, we escalate the trend which will force high-care services out of business and result in a reduction in the range of services. The words 'turkeys' and 'Christmas' spring to mind.

Purchasers are looking for cheaper alternatives to residential care and some providers are happy to propose day programmes. Fine, if you can ignore the needs of drug users who are homeless or too chaotic to turn up Monday to Friday. Pity the drug user who gets thrown out of the low-care hostel after five minutes for using drugs and is dropped from the day programme because he missed his 10am assertiveness class!

The Government's agenda seems clear. Loss of drug and alcohol services will cause few electoral ripples; HIV services are likely to be next. The market will do the rationing for them, ably assisted by poorly informed purchasers.

Providers now need to put maintaining an adequate network of drug services above short-term survival. The priority is to press for reallocation of the community care grant to put drug and alcohol monies where demand is greatest. Better informed purchasing is in the interests of budget-holders, providers and, most of all, service users. We should give purchasers the hard information they need to prioritise budgets, so that drug users in crisis, and those with complex, entrenched problems have the services they need. ■

by

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