Drug advisory committees in practice

Disjointed coordination

Coordination was their main mission, but were the obstacles too great?

Drug advisory committees were established in 1985 to coordinate local drug services, but without some of the elements originally recommended by the Advisory Council on the Misuse of Drugs. In practice the committees work well as information-sharing forums but frequently fail to provide clear guidance on the development of services. Performance could be improved by measures including clarifying objectives, widening membership, and providing support and training for the members.

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HEALTH REGIONS and districts were asked to set up multi-agency drug advisory committees (DACs) by the Department of Health (DoH) in 1985. Detailed guidance was issued in the following year, but since then government has shown little interest in the workings of what are supposed to be key agencies in the local and regional coordination of drug services. What's clear is that the committees have not lived up to their expectations or potential.

According to DoH guidance, district DACs should include representatives of the health service, social services, police, probation, local education authority and the non-statutory sector (including parents' and self-help groups). Their roles were to include: monitoring the local prevalence of drug misuse; assessing preventive measures, services, and training; proposing improvements; and promoting liaison and coordination at working level between the various agencies, professions and groups concerned.

DACs' proposals were, in the words of a 1986 departmental circular, to be "regarded as an important input to the work of joint consultative committees, joint planning teams and appropriate planning groups within the local authority".

Effective inter-agency working is known to be difficult to achieve in any area. The government's White Paper on community care, for example, acknowledged that joint planning has been a "modest success [that] falls far short of the aspirations of the mid-1970s".

Drug advisory committees have experienced many similar problems. Most are prone to serious weaknesses including inadequate status in the joint planning machinery, over-domination by the health service (and uneven representation from other sectors), irregular attendance by members, vague or ill-defined terms of reference, and a lack of commitment by members to genuine joint working.

While they may function well as forums for sharing information, drug advisory committees frequently fail to provide clear guidance for the development of local services. At best they could be described as no more than a modest success.

Some suffer from an even more damaging flaw: they simply don't exist, often having collapsed after the departure of an energetic chairperson or having been undermined by the bureaucratic nightmare of non-coterminous boundaries. Actual hostility to inter-agency cooperation – sometimes from consultant psychiatrists nurturing an outdated 'medical-led' approach to treatment and sometimes from local authority chief officers – has also led to the demise of DACs or to their stillbirth.

Ways forward

Health service and community care reforms are putting new strains on drug advisory committees and it is not clear how their role will now develop.

Anyone who shares the prevailing 'reformist' problem drugtaker analysis of the nature of drug misuse – and most practitioners now do – must be aware of the importance and necessity of inter-agency liaison. The record of some DACs shows they can achieve positive outcomes; front-line workers have found them a useful means of inputting into policy development in a forum including senior local and health authority officers. In any event, the DoH is not about to recommend the abolition of DACs; they will continue to exist in some form.

So what is the best way forward for drug advisory committees? How should they respond to the purchaser/provider split in the health service? Should the DoH be more prescriptive and ensure that properly constituted committees are set up in each district? Or should local agencies be left to determine what suits them best? Should the committees be given more powers, or should their limitations be recognised with an accept-

ance that they function most effectively 'merely' as talking shops?

Preliminary research commissioned by the DoH and conducted by the London Research Centre and the Local Government Drugs Forum – and the conference at which the research report was launched (March 1991) – signposted the moves committees may have to make to become more effective. In many, implementation of several basic organisational changes would result in a marked improvement in performance.

Membership of DACs should be more widely drawn, both vertically and horizontally. More agencies should be encouraged to participate. There is a particular need for greater involvement by the non-statutory sector, especially as it provides the bulk of front-line services in many areas. Self-help and parents' groups are not known to be represented on any DAC and their participation could also be helpful. DACs would benefit from a greater input by local authorities, especially social services and education departments and possibly environmental health and housing too.

There should also be a greater mix of members from different levels in their organisations' hierarchies. To deal with the difficulties of decision-making in larger committees, wherever possible work should be delegated to subcommittees – a course of action consistently recommended by the Drug Advisory Service.

Clarify objectives. It is essential that more committees draw up clear aims and objectives and a strategy statement. In particular, DACs should press for a clear position in the local joint planning machinery and also decide what role they should play in the allocation of resources to local agencies.

The Drug Advisory Service has recommended that DACs should play a major role in advising health and local authorities about resource allocation. District drug advisory committees may now have to decide whether to act, for example, as advisors to the purchasers of services, as agents of the services themselves, or as a forum for both providers and purchasers. These changes will help committee members clarify their roles and responsibilities.

Support and training. Like any other properly run committee, DACs require more than just a place to meet. Administrative support – to arrange meetings as well as to produce and circulate minutes, discussion papers and an annual report – is essential. Effective administration can also make collective work more fruitful by helping to implement decisions.

The role of the chairperson also appears to be crucial. Some committees might find the appointment of a 'neutral' chairperson to be helpful; the much-lauded East Sussex Drug Advisory Council is, for example, chaired by a dentist. It has also been suggested that chairs should be democratically and annually elected by the whole DAC.

It is often said that a 'charismatic' leader can transcend the difficulties inherent in joint working and create an effective committee. Charismatic people are few and far between, but there is surely a role for the training of DAC chairs in the skills necessary to run a committee efficiently. Similarly, training for other members is also likely to be useful, particularly to encourage joint working – not a natural skill.

Our survey showed that two-thirds of DAC members were men. It is well known that men find it harder to work cooperatively, a problem that might be rectified by appropriate development work. The Yorkshire Regional Health Authority has so far run two study days for drug advisory committee members. These revealed widespread problems as well as possible solutions. Such meetings might prove useful for all regions. For similar reasons, Colin Smart, Director of South Tyneside Social Services, has mooted an annual conference for DAC chairs.

Client focus. However DACs seek to improve their performance in the climate of the new reforms, they must do more than function well in administrative terms. It is not difficult to imagine a highly efficient committee that meets regularly, has an appropriately wide range of members and dynamic subcommittees, yet achieves little as far as drug users themselves are concerned.

DACs may need to develop performance indicators that revolve around meeting the client needs, both in terms of front-line service delivery and effective preventive strategies. This will also require *all* DACs to regularly review their own performances – currently done only by a small minority.

GIVEN THE CURRENT direction of government policy, it is highly unlikely that the DoH will attempt to regulate the work of drug advisory committees – that would neither be practical nor desirable. Instead, the department is likely to continue to expect DACs to do what they were asked to do when they were set up, and occasionally to take on additional functions, such as working more with prisons (as happened in 1988) and being involved in the establishment of regional drug databases (1989). It will remain up to local agencies to make DACs work. Despite the difficulties (and some of the cynicism about DACs these have caused) the examples of best practice suggest there is a potential for improvement – that drug advisory committees can move beyond being talking shops to play an important and necessary role in the development of drugs services. ■

The development of district drug advisory committees

1982

Advisory Council on the Misuse of Drugs

- ❑ Argued for a multi-agency approach based on 'problem drugtaker' model
- ❑ District drug advisory committees proposed as main local mechanism for coordinating the development of services
- ❑ Wide range of members recommended
- ❑ No executive or funding allocation responsibilities
- ❑ Administrative costs to be funded

1985

Department of Health letter to RHAs

- ❑ Asked health authorities to establish multi-agency drug advisory committees by the end of the year
- ❑ Committees to be based on regions as well as districts
- ❑ Health authorities to be lead agencies

1986

Department of Health circular

- ❑ Committee's remit to include health education and prevention
- ❑ Recommended drug advisory committee composition more restricted than originally proposed – excludes housing and youth services, CHCs, training agency, industry
- ❑ No requirement for DAC administrative costs to be funded
- ❑ Committee proposals should be an important input into joint consultative committees, joint care planning teams, local authority planning groups

FOR MORE INFORMATION

■ **COORDINATING DRUGS SERVICES: THE ROLE OF REGIONAL AND DISTRICT DRUG ADVISORY COMMITTEES. Peter Baker and Dorothy Runnicles. London Research Centre and Local Government Drugs Forum, 1991.**
Available from the LRC, 81 Black Prince Road, London SE1 7SZ or the LGDF, 35 Great Smith Street, London SW1P 3BJ.