THE FUNDING CRISIS FOR DRUG REHABS

New community care funding arrangements could mean the end of many drug rehabs in Britain

Community care funding arrangements coming into force next April will decrease the guaranteed per-resident payment to residential drug projects and leave the bulk of the funding at the discretion of local authorities which may need to assess each applicant. Local authorities have not prioritised care for drug users so the result could be delayed admissions and closures. Thus, earmarking of drugs money must continue.

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RESIDENTIAL SERVICES for drug users – most of which are non-statutory – stand to be hard hit by the reorganisation set in train by the *Caring for People* white paper and the NHS and Community Care Bill. The greatest concern is over funding. Despite attempts by SCODA and other organisations, government has rejected the proposal that local authorities should be given a specific financial allocation for the care of drug users, a 'ring fencing' scheme that would prevent money now allocated to drug services being diverted elsewhere.

Local authorities' need to exercise financial control also threatens to impede assessment and admissions procedures, which often need to be completed quickly if the referral is to be successful.

Most drug rehabilitation houses are funded with the help of income support paid to their residents by the Department of Social Security. Unfortunately, many agencies end up with large arrears because of the inefficiency of the system. However, it does have the advantage of being a guaranteed payment not limited by cash. This financial backstop means agencies can respond quickly to people in crisis.

The proposed introduction of care plans will prevent agencies responding to immediate needs. Before admission, a care plan will have to be drawn up, submitted, and agreed by the local authority. Without this agreement, agencies risk admitting individuals with no guarantee of even the level of funding currently available.

In the majority of cases, agencies such as Phoenix operate at the whim of the court, parole board or other institution. Where the date of admission is out of our hands and that of the individual's, it will be extremely difficult if not impossible to draw up a care plan. Unlike many other care sectors, drug rehabilitation houses often take clients from across Britain. This, plus the mobility of drug users, will mean making care plans with authorities throughout the country – virtually impossible unless they are prepared to regard approving care plans as simply a matter of exchanging paper.

Proposed changes in funding arrangements will have extremely serious implications for the treatment of people with alcohol and drug problems. From April 1991 financial support of people in private and voluntary homes over and above the general social service entitlement will be transferred to local authorities. This will not apply to people in homes before April 1991. However, alcohol and drug agencies could feel the impact of these changes within weeks as their throughput of clients is much quicker than other types of home.

Funds for community care will be transferred to local authorities as part of the government's revenue support grant. They will be expected to manage their budget and make the best use of the funds available in the light of an assessment of local and individual needs. There will, however, be no specific allocations for any particular type of client, with the possible exception of the mentally ill.

In particular, money redirected to local authorities from the drug misuse allocation to health authorities will no longer be earmarked for drug services, but merely form part of the overall community care kitty. As we understand it, there will be no ring fencing of the support grant.

Guaranteed funding cut

Services for drug and alcohol dependence are generally registered homes and therefore come under the auspices of the local authority. The Department of Social Security's income support grant is a guaranteed payment that amounts to £140 a week to each resident, or £190 to residents of registered nursing homes. The difference between this and the cost of each resident is made up through top-up funding sought from the resident's local authority or through grants.

In future, the income support grant will be replaced by three different sources of funding, with the guaranteed element drastically reduced. Under the new arrangements money would come from:

– income support for personal living costs, a guaranteed social security payment of about £25 a week;
– housing benefit from the local authority, again a guaranteed payment; and
– 'care costs' paid by the local authority social services department to cover the care element of the programme, a discretionary payment made only if the authority assesses the individual as in need of the residential care on offer.

Housing benefit is difficult to assess because each local authority will have to determine the eligible rent on which benefit can be paid. Our assumption is that they will take the average cost of a single person's rented accommodation in their district.

The bulk of each resident's funding will in future come from the care costs which must be negotiated with the local authority prior to a client's admission. No longer paid 'as of right', payment would depend on the decision of the local authority from whose area the client comes. This will slow down the admissions process, but also has other serious implications.

Many of our clients come from local authorities that have never accepted responsibility for drugs or alcohol, although they will have the final responsibility for agreeing a care plan under the new system. In view of the undoubted stigma still attached to drug clients, we suspect they will be last in the queue for care funding. Local authorities are already stretched to provide for people in residential care; groups such as the elderly and the mentally handicapped are likely to be considered priority cases over drug users.

There is the possibility, although remote, that community care as specified in the NHS and Community Care Bill would be funded by the district health authority under provision for mental health services. However, the same problems would remain. Will, for example, the district health authorities be purchasing a block of service from a non-statutory agency, or will they, as we suspect, want to agree a care plan for each individual? Where Phoenix House receives funds from health authorities this is now paid through a district but top-sliced by the region on the understanding that we offer a region-wide service. It appears that in future most spending will be devolved down to districts. Having to negotiate with each district separately would entail an enormous administrative workload.

The prediction has to be that, if the white paper is implemented in full, by the middle of 1991 most residential and nursing care for drug and alcohol problems will disappear. The only exception will be fee-charging services financed largely by their clients' own personal assets or by private insurance.

TO AVOID THE demise of Britain's residential drug services we have either to seek exemption from the provisions of *Caring for People* and the NHS Bill, or seek to ring fence money now specifically given to district health authorities for the treatment of people with drug and alcohol problems or suffering from AIDS-related illnesses. At the time of writing, neither of these crucial changes look like being accepted. ■

▲ Rapid throughput agencies such as Broadway Lodge will start to feel the pinch within weeks of the new funding arrangements, but the impact will be cushioned by their fee-paying residents.

▶ Longer-stay houses such as Phoenix will have a breathing space of several months but will not have fees to fall back on.

Assessment complications and delays

Difficulties in assessing people for residential care will depend on whether the local authority has contracted for a service (or a number of beds in that service) to be available to its residents, or prefers to pay separately for each individual they refer.

Contracted services

Where a contract is arranged, the funding of the project would be secure for the contract period, but difficulties would remain with referrals and with clients' access to projects.

Clients from the contracting local authority would still need to be assessed to establish that residential care is appropriate and that resources are available. This may not be too contentious, as the authority will have purchased beds in advance so has an incentive to use them. However, it could result in the movement of clients to the project which the staff may feel are not totally appropriate. Where demand is high, a person who frequently leaves prematurely may be assessed as not being in need of residential care, despite the fact that multiple relapses and admissions are characteristic of the drugs field.

All these and more problems apply to clients from outside the contracting authority. In these cases, the contracting authority will wish to recoup funding from the clients 'home' authority – *assuming this can be established.*

The 'home' authority may:
– not agree that the client is eligible for assessment; there is no right to assessment under the NHS Bill;
– not agree the need for *residential* care; remember that assessment of need is to be in the light of available resources;
– only be prepared to offer fund places at agencies with whom they have arranged contracts;
– agree the need for residential care, but a cheaper form;
– say their maximum limits for payment are less than amount of funding required.

In practice, where the entire service is under a contractual arrangement, the contracting authority would probably have to resolve these cross-funding difficulties.

Uncontracted services

The points above apply in the same way to projects operating as an uncontracted services except that the *project* would now have to arrange 'per capita' payments for residents from their 'home' authority rather than these being handled by the contracting authority.

The lack of a requirement on local authorities to fund alcohol and drug services, and experience of the difficulty of obtaining such funding, suggest that the viability of projects without full contractual arrangements will be very shaky indeed.

One way of resolving these problems would be to establish that assessments could be carried out by the drug service on behalf of the local authority. However, it is difficult to see how this could be considered acceptable as (except perhaps in the case of fully contracted services) it would be tantamount to the authority giving budgetary control over to outside agencies. ■

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