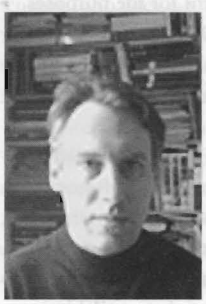
Paul Johnson, Noel Towe, Mike Ward

Local care
Central control

Considering the impact of a national treatment agency on community care for drug users



Paul Johnson works for Bradford Social Services, **Noel Towe** works for the Local Government Drugs Forum, **Mike Ward** works for Surrey Social Services

Many people were left with the distinct impression of having heard a yelp and a splash, as yet another baby was thrown out with the bath water. This baby was called community care and the cause of its distress was the idea of a national drug treatment agency.

In the summer and autumn of 2000 there were persistent rumours that residential care for drug users would be purchased nationally. This would have removed from social services their key local role in providing community care for substance users. In the initiation of the pooled budgets this rumour came to nothing. Instead there was specific encouragement from the UK Anti-Drugs Coordination Unit (UKADCU) for local authorities to use new monies to support community care budgets for drug users.

Nonetheless the plans for the National Treatment Agency have left open the possibility of central purchasing. This is a reminder, to those of us working in local authorities, that many people still hanker for some pre-1993 idyll, when rehabilitation services did not have to deal with social services departments for their funding.

Whether the treatment agency proposal flourishes or fades it is worth re-asserting that community care has led to positive changes. It offers a structure for providing far better care than existed prior to 1993.

Some social services departments have failed in this area. It is still possible to find departments who have set ludicrously small budgets and delegate the oversight of both money and clients to poorly trained and over-worked staff. Yet where community care works it provides an excellent, client-focused system.

Three arguments

Three strong arguments stand out for the care management system. Firstly, the oversight provided by social services care managers is better able to identify bad and dangerous practice than any other system.

Within a year of the introduction of community care two social services departments had jointly identified and tackled a rehabilitation service where frankly dangerous practice had prevailed in the pre-community care era. It is unlikely that this situation would have been identified under a national system of oversight.

The close relationship between care manager, client and rehab can be a vital safeguard for vulnerable people.

Secondly, care management has led to much better matching of client and rehabilitation service. This requires care and attention, with consideration being given to both the range of community services available and how these services link into any subsequent residential option.

This careful approach helps people to recognise that, for the majority, residential services are not a first

point of entry in to services but part of planned package of care. Any residential component should be planned for, with the individual helped to look at the options available to them.

There are many departments with good systems throughout the country, which report uniformly improving rates of retention of clients in rehabs. This is almost certainly due to the ability of care managers to apply a wide and dispassionate knowledge of rehabilitation to the individual needs of the client. And to the way in which care managers maintain contact both with the person in the residential placement and, where it is appropriate, with members of the client's family.

Thirdly, and most importantly, care managers can provide a safety net for clients who do not engage successfully with a service. Prior to 1993 the mechanisms for picking up non-engaging clients were non-existent. Without care management it is hard to see how this would be possible in the future.

In a system where people may enter and leave rehabilitation services many hundreds of miles from their home area, the link offered by a care manager is a vital safeguard. It is this latter advantage that offers the greatest potential for further developing community care structures.

For example, Surrey Social Services Department is attempting to develop services that support and contain people who are not ready for treatment. Their aim is to initiate and maintain contact with high need clients (for example those in the criminal justice system) through a range of services. The aim is:

- to facilitate the greatest degree of stability possible in their clients' lifestyles, thereby reducing risk to the clients and others
- to monitor the extent to which the clients' risk behaviour poses a risk to themselves or others
- to introduce or re-introduce clients to services which will facilitate change as soon as is possible.

Surrey is not unique. Many other authorities also recognise that a key feature of good care management is to ensure clients are followed up once their care plans founder.

Surprisingly, this is often not the case in many substance misuse services. Many clients who drop out of treatment services will have only the most limited follow-up – maybe a couple of letters for example.

National funding for residential services will guarantee the stability of these services, but our priority must be the client

Surrey and some other authorities make it clear that there will specifically not be a bar on offering further care to people whose initial attempts at change do not work out. Instead positive efforts will be made to re-engage these clients because they may present the most significant risk.

Follow-up plans may involve:

- swift re-entry into a residential facility
- assertive outreach and befriending to maximise stability, reduce risk and encourage the client to re-engage with treatment
- access to emergency respite beds (where these are available) for clients who relapse into chaos or are vulnerable but uncertain about their next move.

Instant change

It is implicit in good care management for substance users that treatment *alone* will not work. It is only with a holistic support structure, co-ordinated by a care manager closely engaged with the client, that drug services will be able to deliver on the UK Anti-Drug Co-ordination Unit's (UKADCU) criminal justice and wider treatment agendas.

The high-risk offenders, who are high on the UKADCU agenda will not change permanently the instant they enter rehabilitation. The majority will relapse, perhaps several times. Good care management offers the chance to pick these clients up and feed them back into treatment as swiftly as possible, thereby reducing offending.

The pro's and con's of a national treatment agency will, it is hoped, be extensively debated in the coming months. However, in reconsidering funding streams let us not miss the point of who we are trying to help.

National funding for residential services will guarantee the stability of these services, but our priority must be the client.

A good localised system of care management will provide the greatest degree of support for clients. It may not work everywhere at present, but this is an argument for supporting and extending the role, not stripping social services of a responsibility they are uniquely well placed to undertake ■