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Rehab funding

The 1990 Community Care Act changed the funding arrangements for places at residential rehabilitation placing the onus now on social services to provide the cash. Led by David Turner, SCODA fought a campaign to retain a ring fence around services for drug users. The campaign culminated in a SCODA picket in 1993 of the first European Drug Prevention Week held in London. This was a severe embarrassment to the UK government, to the extent that all the evidence points to David's removal as Director of SCODA in 1994, as the price SCODA was forced to pay to retain government funding.

The financial pressures on residential rehabilitation have been unrelenting. The housing-related funding stream 'Supporting People' (2003) did provide a new revenue opportunity, but only to the extent that rehabs could demonstrate they were supporting' rather than 'caring' for people. The programme still exists, but in a re-run of the Community care Act, the ring-fence has been removed allowing its gradual incorporation into local authority wider grants.

THE FUNDING CRISIS FOR DRUG REHABS

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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 wholesale closure of projects. To avoid this, earmarking of drugs money must continue.

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. This is far from ideal and 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 and of not being cash limited. This financial backstop

means agencies can respond quickly to people in crisis.

The introduction of care plans as proposed by the white paper and the bill 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 or by the district health authority. Without this agreement, agencies risk admitting individuals with no guarantee of even the level of funding currently available.

In many cases, arguably the majority, 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 out of the individual's hands, 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 local authorities or health districts 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 resident in homes before April 1991, a breathing space that will be of interest to nursing homes for the elderly. However, agencies working with alcohol and drug dependence are likely to feel the impact of these changes within months or even weeks as their throughput of clients is much quicker.

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 needs and of each individual's 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
- the local authority social services department as 'care costs' 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 rather than 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.

Myself and other people in the non-statutory sector predict 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.

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DRUG REHABS FACE CLOSURE UNDER COMMUNITY CARE FUNDING REVOLUTION

Britain could start losing most of its residential services for drug users within months of new community care provisions coming into effect in April 1991.

The provisions are part of the NHS and Community Care Bill now going through Parliament. Amendments which could have safeguarded drug services failed at the bill's Commons committee stage in March, though some will be reintroduced during the Lords debates due to start in mid-April.

Turning Point, one of Britain's largest service-providers for drug users, sees funding as the crucial issue. From April 1991 the bulk of the social security payment now guaranteed to each resident will instead be at the local authority's discretion. With no tradition of looking after drug users, the fear is that authorities will refuse funding or underfund to save limited community care budgets for 'higher priority' groups.

SCODA, Alcohol Concern and Turning Point combined to call for drug and alcohol money to be earmarked within local authorities' community care budgets, in the same way as mental health. Their amendment was turned down after Health Minister Roger Freeman argued it would restrict local autonomy, but will be reintroduced in the Lords by Viscount Falkland.

SCODA's Residential Services Officer Kazim Khan explained that the intention was to safeguard the £14 million allocated to health authorities for drug misuse services, plus other money spent on drugs by health or local authorities – perhaps a yearly total of £25 million. Without a protective 'ring fence' round it, the concern is that much of this money will be diverted to other groups.

The intensity of the lobbying from organisations such as SCODA, Turning Point and Phoenix suggests they seriously believe houses could close after April 1991. Turning Point's PR department has mail shot peers and is seeking high profile publicity to get the funding amendment through at what may be their last realistic opportunity.

Also to be reintroduced in the Lords is an amendment to allow emergency admissions without having to wait for the relevant authority to assess the potential resident – crucial to agencies such as London's City Roads crisis intervention service.

The amendment failed, but Tory support in committee persuaded junior Health Minister Virginia Bottomley to reconsider the issue. What may emerge is a commitment for health authorities to fund the first few days of an emergency admission.

Just eight clauses of the NHS and Community Care Bill deal with community care, providing no more than a legislative skeleton. Department of Health project groups are developing guidance notes on how local authorities and other bodies should implement the new system.

Even if the bill is passed unamended, input into these groups could still help avoid the dire consequences predicted for drug services. The last backstop is organising locally to influence your own local and health authority.

A foretaste of what's to come in the UK may be seen in the current furore in the USA over treatment programme cutbacks forced by the drive to cut costs. There 'managed care' is already doing what many fear 'care managers' will do for the UK under the new community care system. The major casualty has been inpatient or residential care – the sector most at risk in Britain.

In the last few years, health insurance companies and employers have taken fright at the cost of treating alcohol and drug abuse – for General Motors in 1987, a bill totalling $78 million. Their response was to hire 'gate keeping' companies to determine what treatment was needed and for how long.

With an assessment role disturbingly similar to the proposed local authority care managers in the UK, these gatekeepers served their employers by minimising access to expensive inpatient care and cutting outpatient treatment to the bone. One major US company, GTE, cut its mental health care costs by a quarter after introducing managed care.

Managed care has spread rapidly to the point where treatment providers now claim centres are being forced to close or cut treatment capacity. That capacity is still needed, says the president of the US national treatment providers' association, but funders are refusing to pay for it to be used.