

How was it for you? - A decade in view

This section of our response provides a snapshot of our stakeholders' views of the past ten years of drug strategy.

There was a universal welcome for the additional investment that had taken place over the past five years. Although there were concerns in some areas that the drug treatment sector had expanded too quickly - resulting in a dilution of skills and a reduction in specialism - by and large the rapid increases in workforce, budget, client load, are seen as an overwhelmingly positive development. However in spring 2007, every area we visited (with the exception of Cardiff) had recently experienced cutbacks across their treatment, DIP or young people budgets. Notwithstanding the difficulties inherent in any reduction of funding, stakeholders told us that the way the funding was cut was as problematic for them as the fact of the cutbacks. Commissioning plans need to be completed and finalised at the very latest by the beginning of the financial year – this means drafts need to be available for local and NTA approval in January and February. Yet most cuts to local budgets in 2007 were announced “in year” – after the cut off dates for treatment planning and local budgeting. This meant that commitments made by commissioners had to be changed and service configurations altered at little or no notice. This has a real impact on the ability of local partnerships to deliver best value – and to plan collaboratively.

DrugScope hopes that in future, funding commitments and funding expectations made by government will be honoured and that if reductions are made sufficient notice will be given to local areas to enable them to achieve efficiencies sensitively and with minimum impact on service users.

The major result of the increase in investment has been a substantial increase in treatment capacity - identified by many in the field as the single most important achievement of the current strategy. The focus of

the treatment effectiveness strategy on the individual and the move towards the recording of individual treatment outcomes through TOP (the Treatment Outcomes Profile) is positive. However, this very recent attempt to measure effectiveness is being undermined by concerns expressed by many engaged in face to face work with drug users that the treatment experience is becoming ever more mechanised and that there is a risk of “losing the individual” in the treatment system.¹ Others have expressed concern that the emphasis of TOP on measures of offending behaviour lends an inappropriate focus to what is essentially a healthcare intervention.

The increased ability of the drug treatment sector to account for its performance was seen as a welcome development, though some people representing smaller agencies felt that they were overburdened with data collection. There is a concern currently that performance management has become detached from real “value for money” indicators of success – and that systems overestimate the crime costs of drug use and underestimate the health and other social costs. In most groups we talked to there was concern about the “TESCOisation” of drug treatment services – where

“...as long as the right boxes get ticked and the right forms get faxed it doesn’t actually matter what happens to the client.”²

People working in the criminal justice system (particularly in the metropolitan centres) strongly expressed the view that the highly structured treatment systems that now existed presented a number of barriers to effective multi agency working. Examples of this identified in

¹ Ashton M.(2004) *Burgered: quality of life and addiction treatment*. Unpublished. This makes the challenging point that the goals of a national treatment strategy might not necessarily be the goals of the client.

⁴ See Kemmesies, U.E.(2002), *What do hamburgers and drug care have in common: some unorthodox remarks on the McDonaldization and rationality of drug care*, *Journal of Drug issues*, 689-708.

our consultation included multiple assessment and duplication of and confusion between case and care management.

The increase in funding in the current strategy and the emphasis on performance management has meant that the role of the commissioner has become ever more important. There was a highly variable level of confidence about commissioning across the country. Many providers particularly talked about inconsistency of commissioning practice across regions, “obsessive-compulsive” tendering of services, contractual instability and poor guidance for commissioners particularly around procurement. Concerns were expressed about a lack of transparency and a perception that ‘political’ factors influenced decision-making. The recent NTA commissioning training was welcomed as a step towards dealing with the skills shortage.

Commissioners themselves were critical of the systems within which they were commissioning. Key issues for them included the application of European procurement regulations to small contracts; lack of notice of reductions in funding; poor levers to engage partner agencies (e.g. housing, primary care), over- prescriptive guidance restricting local flexibility and ‘data blight’ - too much information to analyse locally and too few central reports being generated for local use.

Commissioning at tier four is highly problematic with a number of practitioners highlighting the difficulty of getting funding for tier four placements and tier four providers talking about the difficulty of financial survival when, for example, spot purchases were being reviewed on a fortnightly basis in some cases.

Across England there was a strong recognition of the NTA’s role in achieving these improvements. In particular they were credited with driving reductions in waiting times and standardising access to treatment across the country. There was also a welcome for Models of Care and its update with participants commenting that it established a

reasonable framework for service provision even if sometimes it was used inflexibly. However there was a sense in all workshops that in achieving these gains the NTA and the Home Office had adopted a “strong-arm” approach that had stifled debate and discussion in the field. Alongside what was described as “rigid performance management” a number of participants in workshops said they felt frightened to speak out and that locally criticising the drug strategy was “not allowed”. This was particularly described as an issue in three regions.

Other participants felt that the strong leadership shown by the Home Office and the NTA had effectively let the Department of Health and the-then Department of Education and Skills “off the hook”. Participants referred to the impact of this locally stating that if there wasn’t a lead for education and health from the Whitehall departments then there wasn’t a lot of leverage locally to “get people round the table”.

As might be expected, criticism of the criminal justice focus of the drug strategy particularly since the establishment of the Criminal Justice Intervention Programme (CJIP) and the Drug Intervention Programme (DIP) was widespread. The chief criticisms were that this had led to a lack of emphasis on healthcare and social issues meaning critical gains that could be made through the increased investment were either being under-reported or simply not achieved. The shelving of the roll out of the Integrated Drug Treatment System for prisons (IDTS) is a major concern for those working in DIP and regular treatment systems – as well as for drug users themselves.

Evidence provided to **DrugScope** indicated that in some areas the current system for DIP is complex and inflexible – the opposite of what the intentions were at its inception in 2003. According to our reports and as detailed later in this report this meant people’s needs “got lost” within the system, or they were “assessed to death” through repetitious overly bureaucratic processes. In three of our nine areas, participants

described individuals having four or five required assessments and follow-ups within short periods of time.

The need for better co-ordination of aftercare and better access to mainstream services and opportunities such as education, primary care, and employment for service users was probably the most common theme across the country. In particular the lack of adequate housing services was identified in seven out of our nine groups as the biggest blockage in the treatment system. One troubling phenomenon was the lack of incentive to those involved in housing management to provide support to drug users. In every area we received reports of people being evicted from their housing because of their history of drug use with no other housing or social support being offered. Universally this led to deterioration in their ability to manage their drug use and offending.

Young people's issues were high on the agenda in all our discussions over the summer. The reduction in the Young People's Substance Misuse Grant and the possible removal of the ring fence raised huge concerns about the future of young people's services. However, the integration of young people's drug interventions into the local Every Child Matters (ECM) agenda was viewed as a positive move – and there was a high level of confidence that this would yield positive results across the country. This commitment to holistic, child-centred services by the Government was applauded. However concerns about the fragmentation of the agenda came to the surface with the awareness that young people's drug treatment was becoming a political issue and was about to be overseen by the NTA. Young people's specialists, practitioners and managers greeted this with general dismay as they believed this meant that young people's treatment would be delivered from within a system developed to run adult treatment. This was felt to be inappropriate and unhelpful in terms of local fit with Children's Trust arrangements.

The potential successes of integration and mainstreaming in the young people's agenda were seen by many as further evidence of the need to embed drugs needs assessment, commissioning and intervention in the Local Area Agreements. Utilising the locally agreed outcomes of the Sustainable Communities Strategy was suggested as a way of safeguarding investment in and commitment to drug interventions in the long term. There are concerns about the possible removal of the "ring fence" on the pooled treatment budget. While DAT partnerships we spoke to believed this was still desirable, there would need to be specific outcomes within the LAA that could provide some transitional protection.