TROUBLE AHEAD? LET'S FACE THE MUSIC AND DANCE!

Marcus Roberts on the twin threats posed to drug treatment by the creation of Public Health England and the mantra of localism

It is a bright cold day in April, and the clocks are striking thirteen – not 1984 this time, but April 2013. Following the abolition of the NTA, Skipton House – the tower block in South London that served as the NTA's national headquarters – is being reduced to rubble, Berlin Wall style, by members of the Recovery Concordat and supporters of the Centre for Social Justice and Centre for Policy Studies.

Across the country, local authorities ignite bonfires of red tape and ring fences. The faces of Directors of Public Health (DoPH) are illuminated by the glow, as they dream of innovative ways of implementing local public health priorities. Other local authority figures have left the celebrations early to reinforce or dismantle their silos, pausing only to cast a jealous glance at the DoPHs' purses, bulging with public health money. If you listen attentively you can hear the gentle sobbing of local authority Chief Executives sitting in darkened offices poring over their 2013-14 financial settlements.

At least, that is one way of picturing the scene. However it plays out, the coming months and years are likely to prove a watershed for our sector, representing an important opportunity, but also potentially the biggest challenge for a generation. The NTA will be abolished in April 2013, with its responsibilities transferred to Public Health England (PHE) and new public health directors employed by Local Authorities. It is estimated that around £1 billion of current spend on drug and alcohol services will transfer to the public health budget – that is around a quarter of the total amount, and as much as a half of the budget allocated to DoPHs. While the public health budget will be 'ring fenced', the 'pooled

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treatment budget' will be discontinued, and this money absorbed into the overall public health pot.

What will a 'public health' approach to drug and alcohol services mean in practice? The Global Commission on Drug Policy declared in its 2011 Report that 'drug policies should be based on human rights and public health principles'. The Commission adopts a familiar definition of 'public health' as synonymous with harm minimisation and management. While avoiding the language of 'harm reduction', the Government has recognised its importance. However, it has been at pains to distinguish the 'recovery-orientated approach' of the 2010 Drug Strategy from 'public health' understood as harm management.

So what does it mean by 'public health'? The Department of Health website explains that 'public health is about *helping people to stay healthy and avoid getting ill*, so this includes work on a whole range of policy areas such as immunisation, nutrition, tobacco and alcohol, drugs recovery, sexual health, pregnancy and children's health. It is tempting to append 'spot the odd one out' to this list, because drug and alcohol treatment services are delivering clinical and psycho-social interventions and support for recovery in a way that other areas of public health are not – at least, not in the same way or to the same extent – and they are not primarily about 'helping people to stay healthy and avoid getting ill' as understood in a public health context.

When public health assumes responsibility for commissioning drug and alcohol services there will be a tendency for investment to flow most easily into projects and initiatives that fit with a public health paradigm and mindset – for both better and worse. It was striking that when two leading public health specialists considered the implications of these reforms at DrugScope's 2011 annual conference, one focussed on the history of needle exchanges and the other on the potential to shift more investment 'upstream' for early intervention and wider population initiatives, particularly to address harmful alcohol consumption. But this transition is not simply about developing 'public health' approaches to drug and alcohol problems, it is about the public health service assuming responsibility for planning and commissioning entire treatment systems to deliver on the ambition for recovery-orientated services set out in the Drug Strategy 2010.

A Chief Executive of a local authority or Director of Public Health reading the Department of Health's *Healthy lives, healthy people* documents, would hardly get the impression that drug and alcohol money will comprise about half of their local budget, or that they are about to assume responsibility for a treatment system that is currently working with over 200,000 adults and around 21,000 young people annually. There are only a handful of passing references to drugs or alcohol in the White Paper, a more recent 'update and way forward' document identifies drug and alcohol treatment as one of 17 responsibilities, and the Public Health Outcomes Framework published in January includes only three drug and alcohol specific indicators out of sixty six.

The public health reforms will also mark a fundamental shift of decision-making and accountability from central to local government. Many will welcome the principle of a more localist approach, including the opportunities to cut down on 'bureaucracy', engage with communities, improve links to other services and work collaboratively. The nominal ring-fence on the pooled treatment budget has supported the expansion of services by harnessing investment to national targets. But it has not always been the sort of fence that you chat to the neighbours over, but sometimes more like the sort of fence covered by 'keep out' signs and constructed to protect a fortification. Centralisation has not always

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incentivised local collaboration or the activity most relevant to local need. We have all heard the stories of DATs preparing Action Plans to address crack cocaine problems, despite having little or no crack use in their local areas.

At the same time, it is hard to dispute the fact that expansion of provision in England has been driven by national targets, (nominally) ring-fenced budgets and the leadership of a special health authority within the NHS – by PSAs, the PtB and the NTA. With Local Authorities managing cuts to their budgets of an eye-watering 28 per cent over the current Spending Review period up to 2014-15, and in the absence of further safeguards, the risks of substantial disinvestment in drug and alcohol treatment are serious. Indeed, it is salutory to note that in 1998 localism was actually perceived as the problem and national leadership as the solution. 'The scope, accessibility and effectiveness of available treatments are inconsistent between localities and generally insufficient', declared New Labour's first drug strategy, 'there is considerable insecurity about funding and disparity in provision. Consequently, there is rarely immediate access for a drug misuser to a treatment programme – given the urgency of the needs of most drug users, this is unacceptable'.

Where local authorities have control over budgets, the warning signs on disinvestment are already there. DrugScope members report cuts of up to 50% in investment in some areas of young people's treatment, and fear that worse is to come. In 2011, when asked by a DrugScope survey about the impact of the removal of the Supporting People ring fence on housing support for their clients, over half (53 per cent) of respondents said there has been a decrease in SP funding, with many reporting cuts of 25 to 50 per cent.

In addition, the high profile and comparatively large investment in drug treatment under New Labour was primarily driven by its pre-occupation (from the time Tony Blair was Shadow Home Secretary) with community safety and crime reduction combined with emerging evidence that some problem drug users commit a lot of crime. We have no experience in England of delivering drug treatment on anything like the current scale other than through a national approach with targets and nominal ring-fencing, and no experience of persuading politicians (local or national) to invest on anything like this scale except on the basis of fear (in the 1980s of HIV/Aids and from the 1990s of crime).

Perhaps for the first time – beginning under New Labour and continuing under the current government – we are organising our practice and thinking about drug and alcohol treatment increasingly around 'public health' and a concept of 'recovery' which is about hope, not fear. But when the chips are down, will playing to anxieties about crime and community safety be the most reliable way of securing investment locally?

There is nothing wrong with highlighting the contribution to reducing crime and anti-social behaviour, which impacts disproportionately on marginalised families and neighbourhoods (including service users in treatment and recovery). But it would be regrettable to miss the opportunity for a new kind of political discourse. A DrugScope/ICM public opinion poll (February 2009) found that nine out of ten respondents (88 per cent) agreed with the statement that drug treatment should be available to anyone with an addiction to drugs who is prepared to address it. A UK Drug Policy Commission survey conducted in 2010 found that over two thirds of the public (68 per cent) think that people with drug dependence 'deserve the best possible care' (while observing that this still contrasts with 93 per cent who think the same about those with a mental health problem).

So what lies ahead? There are many uncertainties, particularly when the public health reforms are placed in a wider context. For example, how is the public health outcomes framework related to the eight 'best practice outcomes' for recovery in the Drug Strategy 2010? How exactly will Health and Wellbeing Boards work and what powers will they have? How does 'payment by results' fit in? There is a particular question mark about the relationship between public health and criminal justice. With the elections due in November (except in London where the new arrangement is in force) it is still unclear how Police and Crime Commissioners will contribute to local decision-making on drug and alcohol services. The budget for prison health care has moved from the Ministry of Justice to the Department of Health to encourage an integrated approach to offender management, but the responsibility for prison services will lie locally with offender health under the aegis of the NHS Commissioning Board, and not with public health.

Intellectually, it is important to resist the temptation to think in terms of simplistic polarities; we do not need to choose between 'centralism' and 'localism' or 'health' and 'community safety' – any more than we had to choose between 'harm reduction' and 'abstinence'. On the contrary, the challenge is to avoid 'going to extremes' and to achieve balance – including between truculent oppositionism and stoical mustn't grumblism. Strategically, we need to engage constructively without fluffing or compromising the messages on the dangers of disinvestment, which are real and present. This is a crunch time for the future of drug and alcohol services in England. If the Government keeps to its current course in April 2013 we really will be waking up to a new and transformed environment. Whether hospitable or not (and to what and whom) remains to be seen, and will crucially depend on what we say and do now.

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