UKDPC

UK DRUG POLICY COMMISSION

A response to the Department of Health

Healthy Lives, Healthy People consultation

Briefing

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The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

UKDPC is a company limited by guarantee registered in England and Wales No. 5823583 and is a charity registered in England No. 1118203. The UKDPC is grateful to the Esmée Fairbairn Foundation for its support.

The UKDPC brings together senior figures from policing, public policy and the media along with leading experts from the drug treatment and medical research fields:

The UK Drug Policy Commission broadly welcomes the approach in the strategy document Healthy Lives Healthy People, which places drug misuse and dependence in a Public Health context that recognises the role of inequality and disadvantage, and a range of social, environmental and economic factors in promoting and sustaining poor health outcomes. We also support the strong focus on using and developing the evidence base in support of interventions, and that the budget devolved to local authorities will be ring-fenced.

However, across the strategy and associated consultation documents, we have a number of concerns that specifically relate to the provision of services. Our key concerns are that:

1. The strategy and associated documents contain very few references to drug dependence and related services despite the fact that the current drug treatment budget will make up a significant part of the total budget for Public Health (about a quarter of it). Although we recognise the need for flexibility to enable local areas to meet local needs we are concerned that, for a range of reasons that include the widespread stigma attached to drug users even when they are trying to address their problems, there may be significant reduction in investment in drugs interventions.
2. The strategy is largely silent with respect to the important 'harm-reduction' services, such as needle exchanges and vaccination programmes, which have been largely responsible for the comparatively low rates of HIV infection among injecting drug users (IDUs) in the UK. If these services are not protected there is a danger that they will be neglected.[1]
3. As mental health services are to be commissioned through GP consortia while drug treatment services will be within the Public Health remit, there is a danger that the difficulties already encountered by people with mental health and substance misuse dual diagnosis will be exacerbated, and they will increasingly suffer from the gap between services.

These, and other, concerns and suggestions for addressing them, are elaborated on below under specific consultation questions but there is considerable overlap and interaction between the issues.

[1] The UN Commission on Narcotic Drugs has just adopted a resolution calling for scaled up HIV prevention acitivites for injecting drug users worldwide http://www.unaids.org/en/resources/presscentre/featurestories/2011/march/20110328cnd/ . The UK has been in the forefront of such provision in the past and as a result has a comparatively low level of HIV among injecting drug users. It is important that this is maintained under the new arrangements.

***Healthy Lives, Healthy People*: Our strategy for public health in England**

a. Role of GPs and GP practices in public health: *Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?*

Some GPs have a special interest in substance misuse and provide prescribing services within some drug treatment systems. All GPs also have an important role in providing support to family members of people with drug problems (an often overlooked group who are subject to much stigma and hence may be reluctant to seek help[2]), both directly and through signposting them to other services.[3] The strategy makes no mention of these issues and it is not clear how the GP's role as provider will be separated from their role as commissioner of services to deal with potential conflicts of interest. It is also a concern that there are currently no outcome measures to incentivise activity in these areas. The Directors of Public Health and the health and well-being boards will need to ensure that GPs are aware of the importance of providing support to these groups. The content of current GP training also needs to be reviewed to ensure it includes a focus on these issues if they are not to be sidelined.

b. Public health evidence: *What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?*

c. Public health evidence: *How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?*

d. Public health evidence: *What can wider partners nationally and locally contribute to improving the use of evidence in public health?*

We welcome the emphasis on the use of evidence. The new National Institute for Health Research (NIHR) School for Public Health Research provides an excellent opportunity for the development of the evidence base and could play a pivotal role in drawing up, in consultation with all stakeholders, a broad research programme which all funders could support in addition to the work it funds itself.

In addition to developing the evidence base it is important that it plays a role in ensuring the continuing provision of those interventions for which there is already a strong evidence base, for example substitute prescribing and some harm reduction initiatives such as needle exchange.

It is also important there is national leadership in developing multi-site evaluations, since local areas will not have the capacity or through-put to mount such studies.

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[2] *Getting Serious About Stigma: the problem with stigmatising drug users*, UK Drug Policy Commission, 2010 http://www.ukdpc.org.uk/publications.shtml#Stigma_reports

[3] *Supporting the Supporters: families of drug misusers*, UK Drug Policy Commission, 2009 http://www.ukdpc.org.uk/publications.shtml#Families_report

Healthy Lives, Healthy People: **consultation on the funding and commissioning routes for public health**

Q1: Is the health and wellbeing board the right place to bring together ring-fenced public health and other budgets?

While having the drug treatment budget in the ring-fenced public health budget alongside alcohol treatment is not an issue per se, we do have some concerns.

1. We are concerned that, since mental health service funding is to be undertaken by GP consortia while drug treatment services will be within the Public Health remit, there is a danger that provision for people with dual diagnoses of mental health and substance misuse problems may become even more fractured. The danger that such people are simply passed back and forth between services or fall into the gap between is well recognised[4] and it is important that safeguards are put in place to prevent this occurring.

2. In the past, drug treatment funding has come from a range of sources in addition to the pooled treatment budget distributed by the NTA. In addition to funding for the Drug Intervention Programme, in many areas there has been funding from Primary Care Trusts, and local authority Social Care budgets have been used to fund residential rehabilitation. There is a danger that, in this period of reorganisation when local budgets are being squeezed, such spending will reduce or cease altogether, particularly if it is felt that that is the remit of the Public Health function. It is important therefore that there is clarity about what has been included within the Public Health ring-fenced budget, and what is not covered.

3. It appears that some drug treatment services (in prisons) will be commissioned through the NHS Commissioning Board, some may still be commissioned through local authority social care budgets, and GPs will also be undertaking some provision. It is important that the health and well-being boards are able to take responsibility for co-ordination and ensuring that the whole range of provision is adequately provided and cost shifting does not occur.

4. At the local level, commissioning of drug treatment services has in the past been undertaken by Drug (and Alcohol) Action Teams, many of which have been situated in PCTs. Within the organisational changes underway we are concerned that there is a danger that this specific expertise will either be lost or transferred into GP consortia rather than into local authorities.

5. There are a wide range of interventions aimed at tackling drug problems at a local level and co-ordination of activities is essential. The criminal justice system is also a large consumer of drug and alcohol treatment through programmes such as the Drugs Intervention Programme and Drug Rehabilitation Requirements. However, as currently constituted there is no mention of having any representatives from policing of other parts of the criminal justice system on health and well-being boards. This may have a negative impact on such programmes, reduce partnership working, and

[4] *Dual Diagnosis Good Practice Guide* Department of Health, 2002

runs the risk of overlap or issues falling through the net between health and well-being boards and Community Safety Partnerships.

Paragraph 2.13 of the document talks about the potential for supra-local commissioning arrangements for services that are specialised in nature. We would suggest that such arrangements might be appropriate in some cases for residential rehabilitation services, who often currently draw patients from a range of local areas, and further consideration should be given to how this might work to provide greater security to these providers.

Q2: What mechanisms would best enable local authorities to utilise voluntary and independent sector capacity to support health improvement plans? What can be done to ensure the widest possible range of providers are supported to play a full part in providing health and wellbeing services and minimise barriers to such involvement?

The drug sector already has very strong representation of the voluntary sector within current provision as a result of well-established competitive tendering processes. The new recovery movement, which includes a strong element of grass-roots peer support, has the potential to increase this and needs to be protected. Family support is another area which has a very big component of voluntary sector involvement. We are concerned that the aim may realistically be more a case of preventing a fall in involvement rather than increasing it for the following reasons:

- Recently published UKDPC research shows that there is widespread stigma directed at drug users in recovery and their families,[5] and there is a concern that if budgets are tight these groups will be seen as relatively undeserving and the money currently spent on well-evidenced interventions will be diverted to other areas. As well as having severe consequences for the individuals concerned and society as a whole, this will hit the voluntary services that are currently providing these interventions.
- At a recent expert seminar organised by UKDPC to discuss payment by results (PbR), a mechanism that it is suggested will help to increase the involvement of the voluntary and independent sector in providing services, it was suggested that, perversely, PbR might actually reduce the involvement of smaller grass-roots organisations who would be less able to bear the risk associated with delayed outcome payment or to prove their specific contribution to the outcomes in question.[6]

Q5: Are there any additional positive or negative impacts of our proposals that are not described in the equality impact assessment and that we should take account of when developing the policy?

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[5] *Getting Serious About Stigma: the problem with stigmatising drug users*, UK Drug Policy Commission 2010 http://www.ukdpc.org.uk/publications.shtml#Stigma_reports

[6] *By their fruits: Applying payment by results to drug recovery,* UK Drug Policy Commission, 2011 http://www.ukdpc.org.uk/publications.shtml#Localism

A number of the risks identified within the impact assessment are particularly pertinent to drug treatment services. For example, as discussed above they are likely to be commissioned by several bodies with the potential for cost shifting. At the same time, since their funding is currently ring-fenced, they will not be subject to the benefits of the proposal to ring-fence the public health budget. The impact assessment does not include any consideration of the impact of what amounts to, at least, a partial removal of ring-fencing from drug treatment provision. The current pooled treatment budget will make up a substantial portion of the new Public Health budget (probably around a quarter) but there is currently only one outcome measure associated with drugs proposed. The experience from the Total Place pilots[7] suggests that local authorities may well transfer spending from drugs to other areas within the Public Health remit. This is likely to be exacerbated by the stigma directed at drug users and their families, who are already excluded and vulnerable groups.

While there may well be some advantages to developing more integrated services for drug and alcohol problems and placing a greater focus on prevention (in those programmes where there is evidence of effectiveness) these may take some time to realise. The hidden nature of drug problems and the lack of outcome indicators in these areas mean that problems arising from any disinvestment may not be picked up quickly but the impacts on communities and individuals may be severe and wide-ranging.

Q6: Do you agree that the public health budget should be responsible for funding the remaining functions and services in the areas listed in the second column of Table A?

Although not clear within the table, it is essential that the drug services covered include interventions such as needles exchanges and vaccinations for hepatitis B and C for injecting drug users.

It is also not clear where national health promotion services, such as FRANK, sit within this framework.

Q7: Do you consider the proposed primary routes for commissioning of public health funded activity (the third column) to be the best way to:
a) ensure the best possible outcomes for the population as a whole, including the most vulnerable; and
b) reduce avoidable inequalities in health between population groups and communities?
If not, what would work better?

See concerns about the disconnection between mental health and addiction services, and between community and prison provision mentioned elsewhere.

[7]Eg *Leicester and Leicestershire Total Place Final Report* Leicester and Leicestershire Public Services Board, 2010.

Q8: Which services should be mandatory for local authorities to provide or commission?

It is important that the full range of drug treatment and support services are available in all areas, including harm-reduction services such as needle exchange and hepatitis B vaccinations for injecting drug users, through to the support services necessary for sustaining recovery. It is also essential that support for family members/carers of people with drug problems is available. At present, since there are no outcome measures associated with such services in the proposed framework there is a danger that these will be neglected unless mandated in some way. At the very least they should be an explicit component of the Joint Strategic Needs Assessments.

Q12: Who should be represented in the group developing the formula?

The work being done on developing outcome indicators for Payment by Results pilots, including the PbR for drugs recovery, needs to be linked in.

Q15: Would linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework provide an effective incentive mechanism?

The requirement that indicators in the Public Health Outcomes Framework are measurable at the local authority level means that some things that are important but quite rare or difficult to measure (such as drug use prevalence and drug-related deaths) are excluded and action in these areas is not incentivised. There is a need for methodological work looking at ways to deal with this issue, such as combining data across years or proxy measures, to overcome this problem.

Also it is important to note that while some indicators have a short time lag between data collection and data provision there may be a much longer time lag between an intervention occurring and any impact on the indicator. There is a danger that the intended shift of focus to interventions which may have longer term pay-offs is lost if too much weight is given to those that have an immediate effect on outcomes.

Q2: Do you think these are the right criteria to use in determining indicators for public health?

See previous response at Q 15 above. By applying all these criteria strictly there may be a danger of focusing on what is measurable rather than what is important. It is also the case that, although there is a requirement for outcomes to have an evidenced link to interventions it is still possible that there may be multiple factors, other interventions, social and environmental influences, that play a part so not all changes in these indicators may be due to the interventions put in place under the public health programme.

Some outcomes may be difficult to measure at a local level but may be still be useful at a regional and national level. An additional range of outcome indicators could be identified at these higher levels. In the area of drugs, it is important that major surveys, such as the British Crime Survey and Smoking, Drinking and Drug Use among Schoolchildren continue to be funded to allow monitoring of drug prevalence nationally.

Q6: Have we missed out any indicators that you think we should include?

We feel there should be some recognition of the importance for Public Health of some of the harm-reduction programmes for drug users, particularly injecting drug users. These could be in line with some of those already included, eg rates of new HIV infection acquired through injecting drug use, uptake of hepatitis B and C immunisation.

Drug-related death rates should also be considered, although the instability of single-year data and delays in registration of deaths are an issue, they are probably not insurmountable and there are number of programmes to address drug-related deaths, such as take-home naloxone, for which there is a growing evidence base.

Q7: We have stated in this document that we need to arrive at a smaller set of indicators than we have had previously. Which would you rank as the most important?

It is essential that the single indicator relating to drugs is not lost.

Q9: How can we improve indicators we have proposed here?

(a) Accommodation problems and unemployment are widespread among people with drug problems and these are also important elements for the achieving and sustaining of recovery. As such they are outcomes that are being considered for inclusion in the pilots of PbR for recovery. Drug dependence is both a mental disorder diagnosis and a cause of much disability It is therefore important that the following indicators in Domain 2 specifically include people with drug problems:

- D2.7 Proportion of people with mental illness and/or disability in settled accommodation.
- D2.8 Proportion of people with mental illness and/or disability in employment.

There are indicators within the National Drug Treatment Monitoring system that may be suitable for inclusion within this indicator.

(b) The indicator D3.7 (the number of people leaving drug treatment free of drug(s) dependence) is the only outcome currently relating to drug problems. It requires that the individuals do not represent to treatment again within the next 12 months. Thus there will be a substantial time-lag before changes to the performance of the treatment system will be detected. This is a concern as the results of disinvestment in drug treatment may take some time to filter through by which time treatment capacity will have been lost.