UKDPC

UK DRUG POLICY COMMISSION

Evidence to the Health Select Committee inquiry into Public Health

Briefing
June 2011

Kings Place
90 York Way
London
N1 9AG

020 7812 3790
info@ukdpc.org.uk
www.ukdpc.org.uk

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:

Summary

- The UK Drug Policy Commission broadly welcomes the renewed focus on Public Health and the proposals within the health reforms that place drug misuse and dependence in a Public Health context, recognising the role of inequality and disadvantage, and a range of social, environmental and economic factors in promoting and sustaining poor health outcomes.
- However, we also have a number of concerns about the arrangements outlined in the Healthy Lives Healthy People white paper that are being legislated for in the Health and Social Care Bill that specifically relate to the provision of services for people with drug problems.
- The white paper 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.
- 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 and rates of infection will increase.[1]
- 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.
- The National Treatment Agency for Substance Misuse (NTA) and the Health Protection Agency (HPA) have provided the drive and focus for the development of services and the associated health and social gains resulting from these. They have also developed information systems which are the foundation for monitoring levels and quality of provision and the outcomes of treatment and harm reduction services. It is essential that these monitoring capabilities are retained and adequately resourced within Public Health England as local areas would not have the capacity to undertake the work to the same standard.

---

[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.

Background considerations

1. There are a number of contextual factors that need to be borne in mind when looking at the likely impact of the proposed NHS reforms and the greater focus on public health for people with problems relating to illicit drug use and dependence.

2. Firstly, it should be noted that drug problems are often, although not exclusively, associated with disadvantage, and there are disproportionate numbers of people with drug problems in deprived areas. The prevalence of drug problems is comparatively small when considered alongside some other public health problems, such as hazardous alcohol use[2], but drug-related harms are extensive and wide-ranging. The most recent estimates of the costs of Class A drug use estimated them as £15 billion, with crime costs being the biggest contributor (90% of the total)[3].

3. The Drug Strategies over the past decade have therefore recognised that drug interventions are a cross-departmental responsibility and that partnership approaches are necessary at all levels for efficient and effective delivery. There has been a considerable investment in increased drug treatment provision over this period, which has been overseen and co-ordinated by the NTA.

4. As our recent research has highlighted, people with a history of drug problems and their families are a highly stigmatised group. At one level the general public recognise that being part of the community is important to recovery from drug problems. Yet people also express reluctance to live near or work with people with a history of drug problems and are fearful of having services in their neighbourhood.[4]

Maintaining adequate investment in drug treatment and related services

5. In the past, drug treatment funding has come from a range of sources in addition to the pooled treatment budget distributed by the NTA. As well as 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 by other departments will reduce or cease altogether, particularly if it is felt that that is the remit of the Public

---

[2] It is estimated that about 1% of people aged 15 to 64 in England are problematic opiate or crack users (see Hay et al (2010) "Opiate and crack cocaine use: A new understanding of prevalence". *Drugs-Education Prevention and Policy*. 17, 135-147) and that about 3% of adults aged 16 to 59 in the household population had used illicit drugs at least once a month in the past year (Hoare & Moon (eds) (2010) *Drug Misuse Declared: Findings from the 2009/10 British Crime Survey*). By comparison, in 2007, 33% of men and 16% of women (24% of adults) were classified as hazardous drinkers. This includes 6% of men and 2% of women estimated to be harmful drinkers, the most serious form of hazardous drinking, which means that damage to health is likely (The Health and Social Care Information Centre (2010) *Statistics on alcohol: England, 2010*, London, Health and Social Care Information Centre).

[3] Gordon L et al (2006) "The economic and social costs of Class A drug use in England and Wales, 2003/04" in Singleton et al (eds) *Measuring different aspects of problem drug use: methodological developments.* Home Office Online Report 16/06. London: Home Office

[4] Singleton, N. (2010). *Attitudes to Drug Dependence: Results from a Survey of People Living in Private Households in the UK*. London: UK Drug Policy Commission. (Available at: http://www.ukdpc.org.uk/publications.shtml#Stigma_reports)

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.

6. As mentioned above, recently published UKDPC research shows that there is widespread stigma directed at drug users in recovery and their families.[5] 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. This would have severe consequences for the individuals concerned (including families of people with drug problems) and society as a whole.

7. 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[6] 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 an excluded and vulnerable group.

8. The development of more integrated services for drug and alcohol problems and a greater focus on prevention (in those programmes where there is evidence of effectiveness) that might result from a prioritisation of Public Health may be beneficial but may take some time to realise. If what does occur is simply a shift of funding away from drug interventions then the hidden nature of drug problems and the lack of outcome indicators in these areas may mean that problems arising from such disinvestment may not be picked up quickly but the impacts on communities and individuals may be severe and wide-ranging.

9. 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.

Arrangements for commissioning drug services.

10. 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

---

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

between is well recognised[7] and it is important that safeguards are put in place to prevent this occurring.

11. It is proposed that 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.

12. 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.

13. There are a wide range of interventions aimed at tackling drug problems at a local level so 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 or 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 runs the risk of overlap or issues falling through the net between Health and Well-being Boards and Community Safety Partnerships.

14. The consultation documents suggest that there is 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, which 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.

15. The recent report by the Communities and Local Government Committee, *Localism,* pointed out some of the potential pitfalls of decentralising all aspects of services. There are other important functions that would be more appropriately managed at the national level for reason of efficiency, coherence and consistency. These include workforce development and research, as well as information systems (discussed further below).

16. 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[8]), both directly and through signposting them to other services.[9] The

---

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

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

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

strategy makes no mention of this work 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.

Monitoring outcomes

17. The proposed Public Health Outcomes Framework contains only one item relating to drugs, concerning numbers in effective treatment. We are concerned that this limited representation within the outcome indicators will lead to drug services being given a low priority.

18. Because of the strict criteria applied to items for inclusion in the framework 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, (such as other interventions, social and environmental influences) that play a part. Thus, not all changes in these indicators may be due to the interventions put in place under the public health programme.

19. The current 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-related deaths and drug-use prevalence) 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.

20. It is also 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 there will be a tendency to shift focus away from interventions which may have substantial longer term pay-offs towards those that have an immediate but limited effect on outcomes.

21. 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.

22. There should be some recognition within the outcomes framework 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.

23. 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 a number of programmes to address drug-related deaths, such as take-home naloxone, for which there is a growing evidence base.

24. The National Treatment Agency for Substance Misuse (NTA) and the Health Protection Agency (HPA) have in recent years provided the drive and focus for the development of services and the associated health and social gains resulting from these. They have also developed information systems which are the foundation for monitoring levels and quality of provision, and the outcomes of treatment and harm-reduction services. It is essential that these capabilities are retained and adequately resourced within Public Health England as local areas would not have the capacity to undertake the work to the same standard.

25. 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 in addition to the work it funds itself, it could play a pivotal role in drawing up, in consultation with all stakeholders, a broad research programme which all funders could support.

26. In addition to developing the evidence base it is important that NIHR 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.

27. 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.

Incentivising improved outcomes

28. Payment by results (PbR) is seen as mechanism for incentivising improved outcomes and on the face of it seems very sensible. However, at a recent expert seminar organised by UKDPC, a number of concerns were raised about the model being proposed for the PbR for recovery pilot schemes. These concerns included: the complexity of the model with outcomes across multiple domains; the risks to service providers, particularly small voluntary sector providers, from the full outcomes payment model proposed; the potential for 'gaming' given the complexity of the proposed system; and the unrealistic timescales.[10]

29. These concerns remain, and it is notable that the model proposed for the PbR for recovery pilot schemes is far more radical than any being operated or developed elsewhere in the public sector. This could be perceived as experimentation on a vulnerable group and raises ethical concerns.

30. Many of the concerns identified with respect to PbR would also apply to the idea of incentivising local areas' performance through a health premium. The potential for perverse incentives and other unintended consequences are considerable. An

---

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

approach that takes account of health inequalities is very welcome but it is not clear how this would work. If it does not recognise the additional difficulties that might be encountered in disadvantaged areas that might make progress there slower, it is possible that the incentives would end up entrenching rather than improving inequalities.