NTA supplementary note for HASC 2012 drug policy review

1. Drug treatment funding (see attached diagrams)

1.1 Funding for drug treatment and recovery services in the community, in prisons and for offenders was streamlined in 2011-12 to channel the majority through the Department of Health (DH).

1.2 The core of this central contribution is the Pooled Treatment Budget (PTB), £466.7m in 2012-13. This includes £25.4m earmarked for young people's specialist services, and £60m to route drug-using offenders into treatment.

1.3 The Home Office provides a further £32m direct to local partnerships (also to route offenders into treatment), and the Department of Communities and Local Government supplies additional funds to local authorities which can be used for treatment purposes.

1.4 In addition, local authorities, Primary Care Trusts and criminal justice services can spend their own resources on drug treatment. About £216m¹ was allocated through local areas in 2011-12.

1.5 Funding arrangements for 2013-14 will change, since Police and Crime Commissioners will have a community safety budget, and (subject to the Health and Social Care Bill becoming law) local authorities will receive a ring-fenced grant from Public Health England that includes a component for drug services.

2 Formula for allocating the PTB

2.1 The amount each local partnership receives from the adult PTB is calculated as follows:

   a) 24% based on the York University index of deprivation and other socio-economic and health characteristics of each area.

   b) 56% based on activity, defined as the number of adults in effective treatment in the previous year (i.e. who either successfully completed a treatment programme or stayed in one for 12 weeks or more). This component is refined according to the number of heroin and crack users in treatment (who typically cost twice as much to treat); and also subject to the DH Market Forces Factor to recognise any differential local costs in terms of wages, buildings and land.

   c) 20% based on the number of clients who successfully completed treatment and did not come back into the system anywhere in England within six months. This component is adjusted according to the drug of dependency, since the type of substance affects the chances of sustained recovery.

¹NTA analysis of local expenditure profiles shows that in addition to the PTB, PCT’s earmarked £156m in 2011-12 alongside £54m from local social services and £6m from police and probation.
3 The four tiers

3.1 Drug treatment expanded over the last decade in line with a national service framework called ‘Models of Care’ which identified four tiers of treatment:

a) Tier 1: information and advice, screening and referral to specialist drug treatment services, provided by non-drug specialists (e.g. primary care)

b) Tier 2: information and advice by specialist drug services, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction services (such as needle exchange) and aftercare

c) Tier 3: community-based drug assessment and structured treatment (including community prescribing, psychosocial interventions, and day programmes)

d) Tier 4: residential treatment, such as NHS inpatient units and voluntary sector rehabs

3.2 In the Drug Strategy 2010, the government committed to consult on replacing Models of Care with an updated evidence-base and a recovery-focused framework. Subsequently the Inter-Ministerial Group on Drugs decided against issuing guidance from the centre. Some in the field still use the concept of the tiers, but its relevance is withering on the vine.

3.3 The current focus within the treatment system is on supporting recovery and enabling reintegration in order to meet the ambitions of service users and their families. This requires joint working between treatment providers, support networks and other services (particularly housing and employment).

4. Membership of health and wellbeing boards

4.1 Subject to the Health and Social Care Bill becoming law, health and wellbeing boards in every upper-tier local authority will be responsible for developing an integrated strategy across health and social care.

4.2 The proposed membership includes
- at least one councillor from the local authority
- the director of adult social services
- the director of children’s services
- the director of public health
- a representative of the local HealthWatch
- a representative of each relevant clinical commissioning group
- other persons the local authority or board thinks appropriate.

4.3 No formal representation is required from local criminal justice agencies. In theory, therefore, a local Police and Crime Commissioner or borough police commander would not automatically be involved in a strategic discussion about substance misuse treatment, even though it has a crime dimension.

4.4 This is a significant change from the current system in which drug treatment and recovery services are jointly commissioned by local partnerships which include police and probation members alongside local authorities and PCTs.

5. Dual Diagnosis

5.1 Mental health problems are common amongst drug misusers. One research study found that three quarters of people in drug treatment experience mental health problems, most commonly depression and anxiety
5.2 The National Drug Treatment Monitoring System recorded that 13% (27,309) of all people in treatment last year received care from mental health services for reasons other than their substance misuse, but this figure probably underestimates the extent of the problem and is not currently included in the published national statistics.

6. **How drug treatment and recovery services are organised locally**

6.1 On their recent visit to a drug and alcohol service in Brixton, members of the committee expressed an interest in what colleagues in Lambeth call the ‘consortium’ approach. This is where the commissioner has one contract with a single main provider (in this case the South London and Maudsley NHS Foundation Trust) which co-ordinates an integrated approach where multiple organisations work together to deliver a range of interventions.

6.2 In London, Hounslow, Croydon and Wandsworth have adopted a similar model to Lambeth.

6.3 However the ‘consortium’ approach is not the only way to deliver a range of interventions (from psychological services to housing support) under one roof. Other models work equally well: what matters is the quality of the joint working.

6.5 Elsewhere, it is common for commissioners to manage different contracts with different providers and still operate within an integrated local system. For example, in Redbridge a variety of providers are providing very good recovery results.