

Beyond competition: A report from the bureaucratic frontline

A threadbare patchwork of support

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Perhaps more than any area of healthcare, treatment for alcohol-related issues can involve a myriad of funders and providers. If you were being treated for the narrowest definition of an alcohol-related problem – physiological dependency – you might receive medication for a detox in hospital as part of preparation for surgery, in your own home through an NHS trust or a charity (funded by your local council), in a specialist centre (again funded by your local council), or perhaps prescribed by your GP without any specialist involvement at all.

The work of the local council in this patchwork arrangement is funded from the public health grant from central government. My role, as a local authority ‘commissioner’ of substance misuse treatment services in Dorset, is to award this funding to organisations to deliver treatment services, and ensure they do what they’ve promised to do in return. In our case, we have a mixture of NHS organisations and charities delivering support locally, linking with GPs, hospitals and other community healthcare services. I don’t work directly with patients, clients or service users. The frontline of my work is in committees and board meetings.

Within this article I want to reflect on these experiences and think about how well this patchwork of services is functioning. First, I’ll outline what services are trying to do, and explain some of the history. Then I want to discuss the two huge interlinking challenges that local councils and the NHS are facing right now. One of these is, of course, the financial challenge of austerity. However, it’s also important that we talk about a second, perhaps more abstract, issue: how our response to these conditions of austerity has been weakened by the structures and cultures of the organisations that are responsible for providing support to people with alcohol-related problems.

The problem, I suggest, is an adversarial culture where people and organisations seem to pit themselves against each other. Alcohol treatment is an area of healthcare that has been at the forefront of market reforms, and where ideological battles over the nature of addiction continue to be fought, so while it might be an outlier it could also be seen as a bellwether. This isn’t a criticism of provider organisations, competing for scarce resources; it’s more about policymakers and commissioners who have created, accepted and perpetuated damaging structures and cultures that have shaped the whole sector.

Given that I don’t have much good news to report from my experiences on the frontline of public sector bureaucracy, this might seem like a portent of doom for the wider healthcare sector. However, I’m confident I can do more to challenge this tendency to competition in my own work, and I hope this article can serve as both a warning and encouragement for people working in different roles and different fields across health and social care.

How well do we treat alcohol issues?

In treatment discourses, we often talk about ‘recovery capital’, meaning the stock of factors that support people to improve their situation (Best & Laudet, 2010). This refers to having some kind of financial safety net, stable accommodation, good health, employment, and so on – not to mention the importance of being surrounded by supportive, like-minded people.

What seems like an ‘alcohol’ problem, then, is often best addressed through interventions that aren’t specifically about alcohol, boosting people’s wider ‘recovery capital’. It’s not so surprising then that a lot of organisations are potentially involved in

alcohol treatment, and it can look a bit messy. Maybe a patchwork arrangement is perfectly sensible – or least unavoidable – given the challenges we face in defining the problem.

So how well are our messy services dealing with this inevitably messy set of problems? The usual comparison is with ‘drug’ treatment services – i.e. services for people who have run into problems using illegal substances, typically opiates (like heroin) or crack. Services in England engage a far higher proportion of opiate users in treatment – about 55% – than we manage with alcohol, where specialist services saw about 22% of dependent drinkers in 2017-18 (Public Health England, 2017a, b, 2018). However, when services do engage dependent drinkers, they’re more likely to get a successful outcome than opiate users (Public Health England, 2018). This suggests that the issue isn’t one of quality or ability on the part of services and staff; it’s about engaging more people and having the resources to help them in the same way if they do come.

For some people, this difference between alcohol and other drugs might seem counterintuitive. Campaigners often note that making certain drugs illegal has increased the stigma around their use, so people are less likely to seek out help (McCulloch, 2017). Equally, though, it’s possible to argue that the legal status of alcohol, and the fact that even heavy drinking can be constructed as ‘normal’, means it’s harder for people to accept and reveal they have a problem (Morris, 2017).

Tough on the causes of crime

But this difference in numbers isn’t just a consequence of one substance being legal and more deeply embedded in our society. It’s also the result of conscious policy decisions by successive governments to prioritise addressing use of illegal drugs.

The funding allocated to substance misuse treatment in the 2000s was justified in terms of the New Labour pledge to be ‘tough on the causes of crime’. In that period, heroin was seen as a key driver of acquisitive crime, and therefore treatment was designed to reduce crime for the good of society as much as promoting recovery for the individuals concerned (Seddon, Ralphs & Williams, 2008).

The funding, therefore, was for drug treatment (specifically heroin and crack), not alcohol issues – illustrated by the fact that the local partnerships set up to oversee funding plans were called Drug Action Teams (DATs). It was only much later that DATs became DAATs, with the addition of ‘Alcohol’ to the acronym, but even then there was no accompanying increase in funding. Alcohol treatment was largely seen as the duty of the NHS, despite the fact that prescribing for detoxification was noticeably absent from the new 2003 contract drawn up for primary care GPs.

It seemed that local alcohol policy discussions were less about treatment and more about prevention and harm reduction, with an emphasis on the night-time economy, licensing and brief interventions all seen as legitimate concerns of local public health teams – but without any significant funding attached. Alcohol, as a more commonly used substance that was known to cause widespread harm across the population, always felt like more of a public (or population) health issue, while ‘drug’ use was seen as a largely criminal matter.

This mattered because, even after DATs became DAATs, there was a sense that alcohol treatment remained the ‘poor relation’ of drug treatment (Drink and Drug News, 2013), and certainly less was spent on this specific area of substance misuse treatment. In the first year after substance misuse responsibilities (and budgets) moved to local authorities under new public health teams, local authority data suggested that almost £600m was spent on drug treatment for adults, compared to about £200m on alcohol treatment (HM Government, 2015). Some commentators, and even parts of government, hoped that the budget might now be rebalanced to address alcohol problems more adequately. The Government strategy ‘Putting Full Recovery First’, lamented that ‘For too long alcohol has

been a neglected and isolated partner in the treatment system’ and promised that the public health reforms would ‘mean that alcohol misuse is finally given the treatment attention its serious impact merits’(HM Government, 2012: 12, 4).

Competing for resources?

However, rebalancing the budgets in this way would have meant reducing the funding for some other function unless the overall funding pot was being increased. Instead, despite occasional specific funding opportunities, overall public health budgets are being reduced year on year, and substance misuse has been one of the areas that has been hit hardest (The Kings Fund, 2017).

Funders therefore face difficult decisions. When treatment budgets moved to public health departments, my initial fear was that ‘tough on the causes of crime’ wouldn’t be as powerful an argument for public health professionals, and so services like methadone prescribing would be squeezed. This has happened to some extent, but generally not because resources are being redirected to prevent alcohol-related issues. It’s simply the result of the overall budget cuts. Interestingly, a different set of arguments have been found to justify public health expenditure on drug treatment: reducing mortality; reducing communicable diseases (like HIV and Hepatitis C); and reducing health inequalities.

So my fear today isn’t the same as it was five years ago. There’s a certain logic to housing substance misuse treatment and prevention in local authorities, given the complementary responsibilities for licensing, planning, community safety, housing, families, education, prosperity and wider social issues such as social care. But that wide range of interests – to reverse the management cliché – doesn’t just offer opportunities, it also presents challenges.

If we’re in a competition for resources, which will surely only get more fierce with the likely removal of the ringfence on the public health budget in 2020 (Department of Health and Social Care, 2018), then those other responsibilities represent competing claims as much as complementary activities. And of course, the potential competition for resources isn’t just within local authorities, but with other organisations, like hospitals, GPs, the police and so on.

Therefore, just as I was afraid in 2013 that the rationale for drug treatment wouldn’t persuade public health practitioners, I now worry that neither local authorities nor other organisations will be persuaded of the value of treating substance use disorders regardless of the substance involved.

An aggressive retreat

But this discussion of competition is slightly misleading. In my experience, it doesn’t feel like different organisations are fighting over their share of the cake. Instead, it can feel more like they’ve each taken their share and are hiding in the corner, hoping someone else gets caught in the spotlight. This is particularly true if we broaden our concern to all of the organisations involved in that ‘messy’ picture of delivering support for someone who might have run into issues linked to alcohol.

Once it’s accepted that there isn’t enough money to go around, the game seems to change. It’s no longer about getting hold of enough funding to do the best job you can. It’s about redefining your job as narrowly as possible so that you can focus your limited resources and not get blamed for any adverse incidents: you can say that a particular problem isn’t your responsibility. This applies just as much to organisations as individuals: pressured local authorities focus on their statutory duties, and hospitals worry about emergency department waiting times. Too often, although calculations can demonstrate the value of an

intervention – the social return on investment – the question is whether these savings are ‘cashable’ and who they accrue to. Will a local authority invest to save an NHS acute trust money?

Perhaps it’s not so much organisations competing against each other as aggressively retreating, leaving behind problems for other organisations and the system of public services more generally.

The characteristically messy issue of ‘dual diagnosis’ is a case in point. This refers to people who have been diagnosed with a substance use disorder and a mental health issue. Substance misuse services should interlink and work hand in hand with mental health services. But of course budget cuts and the retreat in responsibilities mean that cracks appear. Those with the most severe mental health issues still meet the thresholds of Community Mental Health Teams (CMHTs), and those at the lowest levels can have their mental health issues reasonably well dealt with by substance misuse services. It’s those who don’t meet the thresholds but whose issues are beyond the confidence or competence of substance misuse professionals who I’m worried are falling through the cracks.

This isn’t really, therefore, about competing providers; it’s the funders and commissioners who are more likely to talk about ‘core business’ and be keen to define responsibilities tightly so that ‘their’ money gets spent delivering ‘their’ outcomes.

Is competition just the result of market forces?

Sadly, this competitive dynamic isn’t simply about substance misuse challenging other local organisations, or even alcohol competing with other drugs. There’s a competitive element within our sector. Even that word ‘sector’ is revealing. In my experience, substance misuse staff and service users are more likely to refer to ‘the sector’ than those working in mental health, for example. Other areas of health or social care might refer to a ‘specialism’ or a ‘profession’, but not a sector. They would see themselves as part of the healthcare system, or the local authority. This idea of a ‘sector’ is partly the result of a competitive market for contracts. Rather than being the collective term for local authorities, or even different NHS trusts, it refers to a set of competing organisations, both charities and NHS trusts, as well as potentially private companies.

Again, this is largely the result of structures and regulations actively created by policymakers and public sector employees like me. Drug treatment was something of an outlier in the ‘new public management’ of the New Labour years, with substance misuse treatment not simply being delivered by the NHS or social workers ‘in house’ at the local authority, but through multi-million-pound contracts awarded to the highest (or rather lowest) bidder. In some cases, what had been small charities prior to the 1980s resembled major corporations by 2010 (Mold, 2012).

But this idea of competition within the sector isn’t just about organisations; it’s about philosophy and ideology too. Different people understand treatment as having different aims, a debate often characterised as a battle between ‘harm reduction’ and ‘recovery’. Indeed A Thomas McLellan and William White have referred to the way this argument has played out in relation to treatment for opioid use disorders as the ‘methadone wars’ (McLellan & White, 2012).

Personally, I see these two ideas as complementary – unless you reduce the harm from substance misuse a person will die, and you can’t recover if you’re dead – but this approach is seen by some as a trite way of ducking the question. Which side am I really on?

You talk, we die

But how can we get beyond these ideas of competition? It's not just about rethinking the flawed idea of commissioning, though that's crucial. And equally it's not just about finding a magical consensus definition of 'recovery'. Even if there wasn't competition for contracts, and even if we could agree on the terminology in our 'sector', the confusing, overlapping, messy nature of substance misuse as a problem would remain. We'd still need to work across and within different organisations and departments and reach out beyond that sector. This is not something that can be remedied by a great reform or change in structures or ideology.

I've recently heard young people's substance misuse services criticised because they don't feel part of 'the health family'. That's perhaps because they're not commissioned or delivered by a healthcare organisation, they don't employ healthcare professionals and they don't really deliver healthcare. Equally, they probably don't feel part of the local authority family, for many of the same reasons. But that's not to say they shouldn't work closely with both. Life is about more than individuals or families. There is, or should be in this context, such a thing as society.

What we need to move beyond this impasse – even if the times of plenty return – is a genuine change in culture and approach to something more cooperative, even collaborative. Reflecting on my own experiences working in various roles on the commissioning of substance misuse treatment services, we – I – need to become less defensive. More open to criticism and the change it might produce. More open to working with different people, with different aims and life philosophies.

This may sound trite, and the response from some service user groups to this kind of exercise is often, quite rightly, 'you talk, we die'. But this shouldn't be just 'talk' about the abstract idea of changing culture. It should be about action – practical decisions.

Let's get service users, providers, commissioners, budget holders, elected representatives and members of the wider public in the same rooms, sitting round the same table, discussing the issues they all care about. I'm not just thinking of substance misuse; I'm thinking of that whole set of 'messy' interests including employment, housing, education, and other health and social care organisations.

Let's be clear about what we're trying to do and why. And let's be clear about what we can't (or won't) do, and why. If we decline to take appropriate action because we won't reap the benefits (personally, or as an organisation), that's fine – but let's make that clear to the people who use our services and their families, and the wider community. I'm not sure they'd be sympathetic to the GP who won't conduct alcohol screening because they're not specifically paid for it; or the hospital trust that won't invest in alcohol liaison services because they save the local authority money on social care; or the local authority that won't fund preventive work because the savings accrue to the NHS.

These conversations are already happening in some places – like Plymouth, for example – but this level of genuine partnership and public debate and scrutiny is rare. I want to make a general call for us to stop hiding in the corner with our piece of cake, and come out into the spotlight to openly say what we're doing and why. Only then can we work together much more efficiently and effectively. After all, as Louis Brandeis said, "Sunlight is said to be the best of disinfectants; electric light the most efficient policeman."

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