News

Addiction services in England: in need of an intervention

With change comes both opportunity and chaos: an assertion nowhere more true than with England's addiction services. Over the past 5 years, government initiatives to increase cost-effectiveness have opened up bidding for local services to third-party providers. With increased competition, the thinking went, bloated NHS trusts would sharpen their edges and the quality of care would be improved.

But for Gail Critchlow, a psychiatrist at the NHS' Warneford Hospital, Oxford, the restructuring has created a fractured system that risks failing the most vulnerable. After 15 years as a specialist addiction psychiatrist, Critchlow last year switched to general psychiatry because she says the new working conditions made her position untenable. "Both doctors and patients would have to jump through hoops, which really slowed down people's access to treatment."

Critchlow had been working in a service in Oxfordshire where a pilot scheme was introduced 3 years ago. Under the scheme, patients would be sent by their GPs to local assessment and referral centres. There, she says, an often non-qualified person would see them and assign a tariff on the basis of their complexity. If they needed methadone maintenance, they would go to the Harm Minimisation Service, a partnership between the NHS trust and a voluntary provider. Those deemed to be more motivated would go to a Recovery Service, provided by a voluntary organisation.

Critchlow explains that, in line with their contract with the local authority, the Harm Minimisation Service would receive payment based on the proportion of patients being passed to the recovery provider. "The pressure was on the Harm Minimisation Service to move patients on", she says, "but many people weren't ready—huge waves of people were coming in and out of the recovery provider and along the way many would drop out of the system altogether."

Critchlow's concerns are felt by many across the NHS. Such bureaucratic hurdles and lack of continuity between systems, explains Colin Drummond, Professor of Addiction Psychiatry at King's College London, hold up treatment for patients who move between providers. Chief among Drummond's concerns about the new system is what he refers to as an ideologically and cost-driven move away from methadone maintenance for patients with heroin addiction.

"There's good evidence that methadone maintenance keeps people alive", he says. "It prevents risky behaviour and blood-borne virus infection, like hepatitis and HIV, and is approved by NICE. " He adds that its pharmacological actions decrease illicit drug use, crime, and the risk of overdose. On this note, he expresses concern over the most recent Office of National Statistics report saying deaths from heroin or morphine overdose have increased by 32% in 2013 compared with 2012.

> **"Methadone treatment needs to be…based on clinical need… rather than being determined by bureaucrats, politicians, and ideologues"**

"It would be wrong to portray this simply as methadone versus recovery. Methadone treatment needs to be readily available based on clinical need as part of a balanced treatment system rather than being determined by bureaucrats, politicians, and ideologues", he adds. "If it was a NICE-approved treatment for cancer that was being denied, there would be a national outcry. But perhaps drug addicts are not afforded the same level of importance by society."

Oscar D'Agnone, Medical Director of Crime Reduction Initiative (CRI), a major third-sector provider, does not agree with Drummond. "I don't think there is a drive away from methadone but a drive towards a more balanced system offering people the opportunity to recover", he says, pointing out he cannot speak for the entire sector. "Over the years it became apparent that the harm minimisation approach [methadone maintenance] was good for getting service users in and retaining them in treatment but offered almost no option to get out. As some say, people were 'parked on methadone'."

"The so-called recovery model", he continues, "needed a more dynamic approach to achieve its aim. That was something that the NHS organisations, due to their large and complex structures, were not ready to offer. That is the main reason most of the new contracts formerly provided by NHS services have been re-tendered and awarded to third sector organisations."

Data are scarce for just how many contracts have been awarded to third-sector organisations. Peter Burkinshaw, commissioning and clinical lead at Public Health England, says

For the **Office of National Statistics' report on deaths related to drug poisoning in England and Wales, 2013** see http://www.ons.gov.uk/ons/dcp171778_375498.pdf

King's College London: Professor Colin Drummond

Colin Drummond, Professor of Addiction Psychiatry at King's College London, discusses his concern about the state of England's addiction services

that these data are not collected. On the basis of informal information, he estimates that the composition 2 years ago was about half NHS and half non-NHS. Drummond suspects that with the passing of the Health and Social Care Act in 2012, the balance has swung in the favour of non-NHS providers. He is doing a survey to get a firmer grip on numbers.

"It's surprising that this grand experiment is not being more closely monitored", says Drummond, adding that problems caused by this changing composition are pushing addiction specialists like Critchlow out of the system. First, retendering of services roughly every 3 years is resulting in a lack of consistency, and thus motivation, for staff and patients.

Second, countering D'Agnone's claim that third-party organisations are more agile and thus winning contracts, he says that funding cuts for addiction services mean the NHS is being outcompeted on price. "For many of these non-statutory providers to come in under the tendered price threshold they have to take out a lot of specialists—it's not rocket science", Drummond says. "They very often replace addiction psychiatrists with GPs for the medical input and specialist addiction nurses are replaced by drug workers with no nursing or specialist qualifications."

Birmingham City Council's contract, previously run in partnership between NHS and non-NHS providers, was put out to tender and was last month won by CRI. In response to a freedom of information act filed by *The Lancet Psychiatry*, the city disclosed that the price of its annual contract had decreased from just over £26 million in 2013–14 to just under £19 million for 2015–16—a loss of roughly £7 million every year from addiction services in Birmingham.

D'Agnone refutes claims that his organisation is winning contracts by stripping out expertise. Most of the medical staff on the ground, he says, are experienced consultant psychiatrists or doctors with intermediate grades in addiction. He adds that they also have lead clinicians specialised in addiction who provide monthly supervision to all medical staff.

"If the number of addiction psychiatrists has fallen over the last years", says D'Agnone, "I can assure you it was not because the third sector expanded but because those responsible for ensuring the continuity of education and training didn't support the changes in the system".

Here, Rosanna O'Connor, Director of Alcohol and Drugs at Public Health England, agrees. Third-sector organisations have traditionally relied on the NHS to train addiction psychiatrists, she says, but now as the market is changing that model will no longer be sustainable and changes are needed.

D'Agnone bemoans a lack of support from university deaneries and the royal colleges for third-sector organisations. He gives an example of one NHS contract the company took over. The resident addiction psychiatrist transferred over but his three related training positions did not, despite, he says, CRI "doing everything we could to provide continuity and ensure that nothing would change. The Deanery removed the positions and the result was the loss of three training positions."

In this respect, Drummond says researchers in the NHS are also feeling the squeeze. 2 years ago he started a drug trial funded by the Medical Research Council. Drummond's team were awarded funding to do the trial in three NHS units in London. Since they started, two of the three have been retendered and closed. They recruited four additional units—two of which have since closed.

"The whole pace of retendering has hampered our ability to carry out clinical research", he says, explaining that many non-NHS services do not have indemnity insurance to do medication trials. "The UK had world-class addiction services that are being dismantled with this rush towards privatisation. It's an absolute disaster."

O'Connor worked at the National Treatment Agency for substance misuse, a special health authority set up within the NHS in 2001, to drive improvements in treatment for people with addiction problems. Its role has since been subsumed into Public Health England. "There was room for more cost-efficiency", she says. "Mental health trusts taking money in an unaccountable way to prop up other bits of services was common in the 1990s. That has largely been driven out of the sector by being managed by proper commissioning processes."

Some of the NHS, she says, has been slow to adapt to the system and the constricted financial climate. "Look at local authority finance," she says. "They need to make the money go further. People who tender for service need to recognise that and look at how they can get the best out of what local authorities have available in tender processes. We're not about protecting any particular sector in the market; we are about providing better outcomes for service users."

Mark Napier, the director of The Centre for Public Innovations, a non-profit organisation aimed at helping public and voluntary social organisations, completes the circle of finger pointing. "People are often asked to evaluate a service but nobody ever asks you to evaluate the commissioning", he says. "It's the elephant in the room—a lot of the quality of service is dependent on the quality of commissioning. You do get commissioners who think the best idea is to endlessly take things out to market, which isn't terribly helpful to anyone."

While the debate rumbles on, the addiction psychiatrist position that Critchlow vacated will soon be lost from the NHS as the contract is being put out for tender.

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