Trouble at Tier 3

Too many tier 3 services are stuck in a rut – low in quality, high in cost, and failing service users. Why are we turning a blind eye to this dismal date of affairs, asks Sebastian Saville

Tier 3 services represent the key element in the present government's reconfigured and reinvigorated strategy for the provision of treatment to the estimated 300,000 regular users of heroin and cocaine/crack in England and Wales who want it. The services' vital ingredient is substitute prescribing – including methadone, which a powerful and growing evidence base supports as indispensable. While counselling, social support facilities and preventative discourses all have undoubted value, no treatment strategy can be expected to work without substitute subscribing services.

It is with considerable alarm, therefore, that I note the precarious state of current tier 3 provision. Much of it remains low in quality and high in cost; its financial and contractual arrangements are opaque and obscure. Telephone help and advice lines run by drug user organisations report the continued existence of geographically patchy and often substandard services, which, by failing to meet the clinical benchmarks laid down in the Department of Health guidelines, leave clients unsatisfied and their real health needs unmet.

This dismal picture arises against a background of substantial and ongoing increases in the financial resources directed toward drug treatment. Some £417 million of taxpayers' money was spent in 2004/5, with the figure set to climb to £700 million by 2008. In view of these levels of expenditure, it must surely be a matter of urgent concern that so much of the tier 3 service delivery remains unsatisfactory. How then have these circumstances come about, and – the most important question – why are they allowed to persist?

The late 1990s saw expanded resources brought to bear upon the entire drug treatment sector. A sharpened policy focus and new forms of expertise accompanied them. Beneath the resultant policy spotlight, it quickly became apparent that, despite absorbing significant sums of public finance, many existing treatment services were of dubious quality, had unacceptably long waiting lists, and were lacking a fundamental transparency in their contractual and financial practices. These problems were at their most acute in the tier 3 prescribing sector.

Composed largely of specialist substitute prescribing clinics, these services were in the near-exclusive grip of NHS Mental Health Trusts. It is estimated that, in the year 2000, 60 per cent of total drug treatment expenditure was allocated to this group of providers, to whom service delivery was contracted out by local commissioners. The newly formed National Treatment Agency regarded the modernisation and improvement of these services as a core component in its brief, which was to raise treatment standards in accordance with the objectives of the government's national drug strategy.

Initially, the NTA proposed that service commissioners would work in partnership with their existing NHS providers. The primary objectives were to reduce waiting lists, to improve clinical practice by bringing it in line with a specified evidence base, to eradicate postcode prescribing, and to develop more transparent commissioning. While this process of 'modernisation' has clearly had some positive and enduring impact on the commissioning process, it soon became apparent that large numbers of Mental Health Trusts were either unable or unwilling to implement the required improvements. In spite of the best of intentions, the upshot was a continuation of the same old bleak pattern of inadequate and exorbitant service provision.

Recent years have witnessed a gradual but undoubted transformation in the attitudes of some commissioners, and an attendant desire to open up the field to genuinely competitive tender. However, while various commissioners are expressing an aspiration to radically improve their local tier 3 services, there remains in place a set of forces that keep the doors to new players seeking to enter the field firmly shut; forces that seem determined to obstruct any movement away from the effective monopolisation of the sector by Mental Health Trusts.

The stock responses to calls for a freeing up of the sector to allow the entry of new providers are customarily twofold. Firstly, it is argued that putting tier 3 services out to tender will jeopardise and disrupt broader relations between the commissioners and the Mental Health Trusts. The additional contention is that there are no alternative providers out there anyway, so the question is merely an academic one.

The former point was perhaps understandable in the early years of the strategy, when there existed an implicit faith in long-established models – a faith underpinned by NHS domination. In 2005, following six years of massively increased investment in services and commissioning systems – and limited signs of improvement – such a stance becomes indefensible. If, despite these enhanced resources, service providers continue to demonstrate a failure to meet NTA waiting-time targets; to comply with the standards of clinical governance set forth in the Department of Health guidelines, Models of Care and the NTA's best-practice protocols; or to present clear activity and expenditure data that displays an accurate 'unit-cost', then an alternative provider should be found.

Under these circumstances, it is difficult

to avoid the conclusion that there are other factors at work underpinning the continued faith of commissioners in the failed relationships of the past. It would appear that local NHS politics, and social networks in which individuals from both sides of the contractual relation mix together, are taking precedence over quality of care and value for money.

It has already been demonstrated beyond doubt that specialist prescribing based in a user-friendly environment can provide services that are both cheaper and more effective than the traditional Drug Dependency Unit model that typifies the Mental Health Trust approach. Kaleidoscope has been providing accessible, user-friendly prescribing in South London for many years, and the Junction Project, a service I managed with Dr Chris Ford in the London Borough of Brent from 1997 to 2000, are both examples of services that completely replaced and dramatically improved on existing NHS provision. Such opportunities, however, remain strictly limited, with the majority of commissioners apparently committed to struggling along with their existing providers through repeated cycles of 'improvement plans' and 'last chances'. Still the impasse persists.

Fed up with trying to get things moving through traditional pathways, I started DTL (Drug Treatment Limited). Yes, a private sector company. It seemed the only way to operate in the flexible and responsive manner needed so desperately in the field. I find laughable the almost hysterical knee jerk reaction to the thought of good drug services being delivered by the private sector – free at the point of delivery to users of course. I have worked in both the voluntary and public sectors and have witnessed the waste of vast amounts of resources.

So yes, I could be accused of being an interested party, with a stake in this debate. This might appear less so when looking at the group of respected names in the UK drugs field, all with proven track records in the public sector, who have become involved with DTL over the last year. Mike Trace, Professor Gerry Stimson, Monique Tomlinson, Dr Gordon Morse, Gill Bradbury and Martin Blakebrough are among those who have come together with a stated objective of stimulating this much talked about 'modernisation' of treatment – particularly in the area of tier 3 prescribing. All of us can testify to the existence of an urgent and unmet need in this arena, and believe we are well positioned to meet it.

But the point is that this is not rocket science. In principle, any NHS or independent sector provider can, with the necessary will, knowledge and creativity, provide tier 3 services to a much higher standard and at a lower cost, than those with which commissioners and users alike have been forced to make do in recent years. An estimate, derived from discussions with a variety of key stakeholders across England and Wales' drug treatment sector, would look as follows: of the Mental Health Trusts contracted to deliver tier 3 services, 25 per cent are good, 25 per cent are acceptable, and 50 per cent are of unambiguously poor quality. Many people appear to be fully aware of this state of affairs.

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And yet there remains a stubborn resistance among some commissioners to properly open out tier 3 services to competition. We hear on the one hand an alleged desire for innovation and modernisation, yet unless you can show that you have been delivering services (however effective) for many years, it is almost impossible to be considered. Furthermore, some of the commissioning structures have become bedevilled with procurement processes so enwrapped with red tape that they appear to have been specifically designed to stifle innovation; a catch 22 situation which impacts on the public, the service user, their family and the NTA themselves.

It represents a truly extraordinary state of affairs when a large, publicly funded organisation is unable even to supply an accurate number of clients treated and, consequently, to put a figure on its unit costs. Superimposed on this is the further problem of disaggregating the actual cost of drug treatment from the overall package of services supplied by the Mental Health Trust. These circumstances render large numbers of Trusts effectively unaccountable for the immense fiscal sums they spend, year on year.

It will be apparent to the reader that there are no winners in such a scenario – certainly not the service users, who are forced to accept inadequate services or return to the illicit market. It is high time that some senior figures within the government began to ask why the return on their investment in drug treatment has been so small.