

Model for a sustainable future for alcohol and drugs in the UK

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Introduction

In the economic light of austerity and its prolonged use in reducing public spending, substance misuse services have been completely re-structured in some areas of the country with the NHS and its professionals of doctors and nurses being streamlined into more economical structures. This can be seen as a weakening of the clinical structure of services which compromises service provision, and its service users and patients. There must be a better way of thinking around this issue.

Also the movement of the budget for drug and alcohol service provision has been moved from the NHS budget to the Public health budgets that sit with the local councils. This has led to the large scale reductions in the budget for this service and drug and alcohol services have been depleted mainly in primary care. This does need to be challenged as this has had a negative impact on services and forced them into constant re-structuring exercises that are timely impacts on services negatively.

However, currently primary care should not be the area that suffers the cuts in drug and alcohol findings but can be seen as the solution to it. Hence this piece which is based on an 'opinion piece' arguing for a re-thinking of service provision where clinical structures and staff are retained. It suggests that along with the sustainable transformation plans that primary care should be an integral part of health care and for substance misuse. This is for alcohol and drug treatment. Nursing has been a role that has diminished in nearly all drug services across the country. The main reason being that it is seen as an expensive resource and in difficult economic climates having nurse led teams could not be sustained. I am arguing that it can with primary care being where the majority of nursing staff should be concentrated in substance misuse. This is argued from the initial perspective of political economy but suggests that a wider role for nurses in substance misuse is economically viable.

Political economy

Political economy is the study of how political or strong social outlooks can affect and shape the economy in terms of output and design. Political economy explains for example how the Japanese economy had a strategy of learning and updating the innovative thinking of the West to push through their own dominant economy in cars and electrical goods that dominated the world in the 1970's and 1980's. What is needed this paper argues it an outline of thinking of how the political and economic outlook can shape the delivery of drug provision in England. This has been recently in England, dominated with the politics of austerity. Hence through this economic outlook England has tried to balance its trade deficit with cuts in public expenditure and a rise in taxation.

This has led to the restriction of health care spending which has affected drug and alcohol provision. However with the politics of austerity still being prominent, there was also been a move to further cut public expenditure from a national budget to a local one. Drug

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and alcohol provision was moved from an NHS budget to a public health one and it now sits with the local authority. Whilst much of NHS funding has remained stagnant the Public health budget has been cut and this has damaged the drug and alcohol provision in England as services go through a constant exercise in re-structuring which is having a damaging effect. This will affect provision and shape services in very different ways that could weaken them and in the long run, potentially make them unfit for purpose.

What is proposed here is a sustainable model that has a 'core' that is resilient enough to survive in the era of austerity and in more generous economic times can expand. However due to the cyclical nature of capital, the core will be an effective mechanism that can deliver good value services and with a level of quality too. This hopefully will be cost effective and protected in the future with funding returned to the NHS budget.

Substance use service provision

Drug services are delivered in two ways:

a. One service delivers

Complex needs

An assessment gateway

Shared care

Pathways to detox and rehab both community and in-patient

This can give service provision uniformity and clarity in the delivery of drug and alcohol treatment. However, the service can also become ineffective to change by being too big and therefore unresponsive to a changing environment. This can be both politically and economically called inertia. In the past this has happened in certain boroughs across the country with a dominant mental health Trust controlling drug and alcohol provision and being unresponsive to new ideas. Hence there was a new way of commissioning sort with a more fragmented service model in some boroughs as a response to this.

b. Different services deliver

Complex needs

An assessment gateway

Shared care

Pathways to detox and rehab both community and in-patient

This can be strong and diverse with different services producing a level of internal competition that makes service provision responsive and adaptive to change. However the weakness is that there can be very

different perspectives in treatment delivery and therefore this system can have poor uniform structures that limit effective service delivery. This model can also produce 'gaps' in service delivery. Therefore what model is best? In terms of creating a model of drug & alcohol service delivery in an economic and political climate of austerity one provider offering all services is seen as the best option. There is a rationale for this as mentioned; it delivers uniform treatment and a contract to only one service. This can be more easily managed than a multiple one that needs to accommodate more than one service. However, one can argue against this in stating the rational though logical, has its faults. However, in reality this seems to be the preferred model. Therefore if this is the case, what is best for how service delivery is designed? Can professional standards be maintained without losing professionalism of the nursing and doctors in substance misuse? As this has been important in maintaining good standards of clinical work with strong governance structures how can they be protected? This paper proposes a way that these questions can be answered.

Nursing

Under current thinking nursing resources have been seen as expensive and inefficient and this has enabled a decline in the number of nursing staff in substance misuse. This can lead to a loss of expertise and valuable clinical knowledge that could in turn affect service provision. Nurses do excellent work but maybe the parameters of their skills have not been fully utilized and this model proposes that we do:

This is the proposed model

Shared care: Nurse-led and working with GPs.

This shared care system will incorporate the following:

Treatment of complex needs patients with nursing and GP providing expert care.

Prescribing by nurses in GP surgeries that can enable a Nurse-led model to develop and provide effective and responsive care to GP's and their patients. Community detoxification in the area of alcohol and drugs with the extension of a home detox team can treat hard to reach groups such as an ageing population. Assessment for patients presenting to GP surgeries and treatment for most of these patients, but where necessary onwards referral for patients that would need temporary time limited treatment of co-morbidity issues such as mental health and unstable drug use. This is developed through an assessment hub also staffed by nurses from primary care being based in GP surgeries or day programmes.

Complex needs service

The short-term (Time limited) treatment of patients with unstable poly drug use. The short-term treatment of co-morbid patients who are unstable with either mental health or drug use or both. Onward referral systems back into primary care for patients. This is a streamlined service with one major owner sub-contracting either the shared care or the complex needs service. With having a large base in shared care there are benefits to cost savings in terms of:

- a. Minimal buildings cost: The majority of service provision will be delivered from primary care in existing NHS buildings. No rental costs. This is an effective way of reducing the cost of the providing substance misuse services
- b. Using existing resources already provided by the CCG such as GP's and GP with a specialist interest in substance misuse alcohol and drugs.

Nursing staff will be highly productive and mainly based in primary care delivering key-working, prescribing, and effective liaison and care for primary care based patients. Also, through maintaining nursing as a professional body still employed by the NHS can provide also, strong clinical governance that will protect patient care. Also, through the nursing staff providing much of the prescribing for patients can make the role more autonomous and responsive to patients. For, the management and prescribing for methadone or buprenorphine can be negotiated with the nurse and patients with no other prescribing third party such as the GP. Therefore, this could save the GP time and divert primary care resources to where they are needed. Therefore indirectly making the system more effective.

This is asking nurses to key-work and prescribe for their patients in shared care with no drug workers or GP's needed. This is asking nurses to work more holistically which is one of the main aims of treating patients in this area. Therefore, this will be a simpler and more effective structure for primary care to embrace. Indeed also this paper argues for a more central role for primary care drug and alcohol services. It makes sense economically and there needs to be attention paid to thinking primary care adds value to patients who do suffer with alcohol and drug dependency. Therefore primary care should not be sacrificed in the age of austerity.

Conclusion

The placing of nursing staff into the frontline of service provision for drugs and alcohol will enable a clinical base where there is expertise to cope and deal with complex patients to stabilized patients to patients in recovery. This model makes nursing in substance misuse relevant for today healthcare and protects them as a profession of remaining in substance misuse. Nursing can be effective and valuable and under this model need not be seen as expensive if placed in an area where they could be better utilized. They can also bring indirect cost savings of excellent clinical governance structures and accountability. It is one element of substance misuse services that one needs to not cut and dilute as this can weaken clinical direction in this clinical area. This paper is opening the debate that nursing can adapt and change to a challenging healthcare system, if commissioners can think of how best to utilize resources first rather than balancing the books. If thinking is clear, resources can be utilized and money saved with effective resource allocation. Nursing can play a very valuable role for this in the future.

However, it must be argued that the NHS does have a very valuable place in drug and alcohol provision and should not only be limited to a prescribing role. It should have a clinical lead and supervision role for services. Also a lead role in the lead of the development of services. It also should be noted that further cuts in the budget are now not sustainable and risks working against NHS development. The budget needs to be moved from Public Health towards the NHS budget and this can allow services to develop and improve and not constantly re-structure.

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Conflicts of interests

Author declares that there are no conflicts of interest.