THE IMPACT OF THE NHS REFORMS IN SCOTLAND ON A NON-NHS IN-PATIENT FACILITY WHICH USES THE MINNESOTA MODEL' APPROACH TO TREATMENT (SECTION 13)

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The Facility

The Reforms

The Funding

Outcome Study

References

The facility which I am describing is registered with the Local Health Board and has a maximum capacity of 47 beds in the first stage of care, which is detoxification and intensive rehabilitation, and a further 20 beds in extended card. The first stage of care takes place at Castle Craig, a mansion house, and the second stage care takes place in cottages in the grounds. The treatment consists of medical assessment and detoxification followed by group therapy which is backed up by individual counselling and didactic lectures and video presentations. Each patient is assigned to their own therapist. This first stage of treatment takes on average six weeks and for those who require further extended care or do not have initially a stable home to return to, further treatment for as long as is necessary is provided in the extended care cottages.

All stages of treatment are under specialist medical direction. The philosophy of Alcoholics Anonymous (1) and Narcotics Anonymous (2) is used extensively throughout all stages of treatment.

Prior to the introduction of the NHS Reforms (3) in 1991 the sources of revenue for an independent or private treatment facility such as Castle Craig would be made up of privately funded patients. These were either paid for by medical insurance, such as BUPA and the PPP, or from their own resources or companies paid for many of their employees who needed treatment. Some private clinics also admitted patients who were in receipt of Social Security Income Support and since they were being admitted to a nursing home they were able to receive £280 per week paid by the Government, which was paid to the Clinic. This did not cover the costs of treatment only the costs of their accommodation in the nursing home.

Clinics run on charitable lines or non-profit making foundations use the profit from their fee paying patients and funds that they were able to raise through charitable means to subsidise and make up the shortfall for these Income Support patients. Whilst not a charity, Castle Craig adopted this policy as well. This did not make the company commercially viable, although we managed to break even financially. The Income support payments did however meet the costs and show a profit when the patients were in the extended care unit. One advantage of these Income Support patients was the lack of red tape in admitting them into treatment. Providing the Medical Director was satisfied that the patient was genuinely dependent of alcohol or drugs and was in need of in-patient care the payments from the Department of Social Security were automatic. No outside assessments were required.

Following the introduction of the NHS Reforms patients. were divided into two categories. The first category were patients who needed health care, in which case the funding of

treatment and the provision of treatment was the responsibility of the National Health Service, and the other category was patients who needed social care, and the responsibility for the funding and provision or purchase of social care was the responsibility of the local Authorities. The first difficulty immediately arose , especially in the early days of the Reforms, when the Health Boards in particular would decline responsibility on the grounds that social care only was required and we found it necessary to independently assess patients and our Medical Director would write a Report stating the severity of the dependence and the necessity for in-patient treatment. This report would then be sent to the patient's general practitioner and a copy also to the Health Board accompanying the application for funding.

The Reforms were a year behind in Scotland compared with the rest of the UK and in particular it was more difficult to get funding from Health Boards by way of extra contractual referrals (ECRs). This was the mechanism by which the funding was arranged. Each case was treated as a one-off contract, outside the main contracts. In fact the ridiculous situation arose whereby it was easier for an English General Practitioner to get his patient into Castle Craig than it was for a Scottish General Practitioner. Strenuous representations were made to the Scottish Office and the Health Minister, Lord Fraser of Carmyllie, to change the obvious unacceptability of the existing arrangements and accordingly the Guidance to Health Boards (4) was altered which made them much fairer to the independent medical sector.

The new guidance stated that a General Practitioner's request for an extra contractual referral could only be refused on exceptional grounds and these grounds were very limited. it also stated that systematic bias against the independent sector was unacceptable. This Guidance to Health Boards was introduced in August 1993 and changed the situation. UP to then ECRs had only been occasionally granted by just a few Health Boards and because other aspects of the Reforms had stopped the Income Support patients coming into treatment, patient numbers dropped and from April until August we were in a very difficult state financially. At some stages the numbers of patients were down to 13 whereas we had been running at over 30 prior to April 1993.

The new ECR Guidance transformed the situation and we are receiving a steady f low of these Health Board funded cases. There is however the need to negotiate over each case with the Health Board, sometimes quite vigorously, and for this it has been necessary to employ an admissions nurse full-time and an assistant doctor who devotes one third of his time assessing cases and, it needed, discussing the patients with the medical staff at the Health Boards.

The first six weeks of detoxification and intensive treatment therefore comes under the heading of health care and is funded by Health Boards. Many patients can return home at this stage and carry on with their aftercare plan. As I stated previously however, some cases need rehabilitation but as the treatment is less intensive it would fall under the heading of social care. Therefore further funding had to be obtained,' and in these cases it is necessary to apply to the Social Work Departments of the local authorities. We make this application shortly after the patient has been admitted into first stage care if it becomes obvious following their assessments that this extra care will be needed. The Social Work Department have to allocate a Social Worker, if there is not already one, and the Social Worker will have to carry out a "needs assessment (5). our own assessments of the case will assist them in their decision to approve funding. The main difficulty is the time taken for the Social Worker to come to Castle Craig to assess the case. This sometimes does not happen before the patient is ready to move into the extended care unit. It would be most unacceptable to either keep this patient in first stage care or to discharge them and readmit them when funding was

approved. So we have to take the risk and transfer them to extended care before the funding decision is given. This has led to several lively discussions with Social Work Departments, as we have always made the application in good time we inevitably receive the funding backdated. There have been other minor problems but the system appears to be settling down and working quite well.

The funding that we receive from the Health Boards for first stage patients is a proper economic payment, as is the payment received from the Social Work Departments. We are well pleased with the arrangements and in some respects we are at an advantage over our English colleagues as the Guidance in Scotland is more conducive to a "level playing field" with equivalent National Health Service Treatment Units where they exists. Our costs to Health Boards are certainly comparable with National Health Service units now that the cost of their treatment has been calculated for the first time. Our numbers in first stage care have settled down to about 25 to 28 patients in treatment at any one time, which is less than previously.

The extended care unit is now virtually full the whole time. In the past we seem to cater either for the very wealthy who had insurance or could fund treatment themselves and the very poor who were on Income Support. Now we are able to admit into treatment all those who fell in between these two categories.

Outcome Study

It has become important to produce reports on how patients progress after they leave treatment. This is useful for ourselves but also the funding authorities expect to see how their money is spent. We have excluded the private patients from our survey only including those approved for treatment by Health Boards thus avoiding any argument over diagnosis. The follow-up study was undertaken by a member of staff, one of the therapists, who contacted the patients at regular intervals and also asked them to complete a questionnaire. Whenever possible and with the patients' permission we spoke to a family member. We also endeavoured to contact the patient's GP.

Bearing in mind the criticisms that are levied at in-house outcome studies, not least the accusation that we may be tempted to over-estimate the success, we have asked Professor Martin Plant of the Alcohol Research Group at Edinburgh University to independently confirm our findings by investigating one in four of these cases.

I will now turn to the overhead projector to show you the results of our studies.

References

1. Alcoholics Anonymous, AA General Service Office, York 1976, Chapter 5.

2. Narcotics Anonymous, World Service Office Inc., Van Nuys, CA, USA, 1988, Chapter 4.

3. Department of Health. Working for patients. HMSO, London. 1989.

4. NHS in Scotland Management Executive. Guidance on Extra Contractual Referrals. The Scottish Office, 1993.

5. Social Work Service Group. The Needs of People With Alcohol and Drug Problems Within Community Care. The Scottish Office 1993.