

Druglink interview with Paul Hayes



After a lifetime spent in the London Probation Service, Paul Hayes is the Chief Executive Designate of the National Treatment Agency (NTA). What can the drug field expect? Paul Hayes talks exclusively to Harry Shapiro

DL: *How do you respond to the concerns in the field that the public health agenda has been sidelined in favour of criminal justice considerations and that coming from probation, your appointment may exacerbate those concerns?*

PH: I can understand how people might feel. But I genuinely believe the whole thing hangs together. The basis of the strategy is to reduce the whole variety of harms that flow from problematic drug use. Looking back, one of the proudest things in my career was finding a way in the late 1980s for the probation service to adjust itself to the harm reduction agenda, which was dominating policy at that time. Together with colleagues in the Inner London Probation Service we developed a model of practice that enabled the probation service to join forces with other people in what I think was one of the triumphs for social policy in this country, which was to prevent the spread of HIV. There is an awful lot of common cause between criminal

agencies, drug services, and public health, but people sometimes paint themselves into a corner by identifying it as either/or. Nowadays, it's just that the stuff which frees up the money, which gets the politicians' juices flowing, is the perceived link between drug use and crime.

DL: *Given the government emphasis on performance and targets, what is the key task expected of you and what are your priorities?*

PH: They want somebody who can deliver on making treatment more effective to meet all the various strands of the drug strategy, not just the criminal justice strand. The way I envisage doing the job is to focus on quality. What we've got to do is to make sure that treatment is accessible, but that it's also good. If treatment isn't any good, then all the rest of the strategy falls away.

The first priority is human resource planning. There is a major workforce shortage and there is also a skills deficit. We need to improve skills in treatment and in management. The field needs to be much more at ease in being held accountable and attract a more diverse workforce, which reflects the whole community. There also needs to be a major investment

in research. There are good reasons to believe that treatment works but there is much less clarity about which treatment works for who and how. We particularly need to develop effective treatment for stimulant use and we are probably significantly behind other parts of the world in tackling that one. We also need to think how those services are best delivered. The NTA should develop demonstration projects so we can see how the best ideas that flow from research can be implemented. Another priority is going to have to be performance management – we need to improve the flow of information. Some people don't like to hear that because they think of bureaucracy. But at the moment, some of our major providers can't even tell us how many people slept in their detox beds last night. With the investment in treatment, that's untenable. For too long, treatment has been all about belief. Users have been referred to services that have been left to get on with it. Drug services are now being asked to come up to speed with the rest of the public sector.

DL: *As with other areas of health care, waiting lists are an issue. How will you tackle that?*

PH: The first thing I'm going to be looking at is why do we have waiting lists at all? Are we using the resources we've got to best advantage? If we have to have waiting lists, what can we do with people while they're on them? What can we do to improve throughput?

DL: *Presumably this ties into the belief that part of the problem is the fast-tracking of offenders into treatment at the expense of others?*

PH: If we can get rid of waiting lists the idea of offenders fast-tracking into treatment disappears. But to be honest I am

entirely at ease with the idea that people who are doing a lot of harm to the community actually get access to services quicker, because there is more benefit to the community. But generally, I'm dubious that there are very many examples of people who are really desperate to access treatment being held back while the services are being provided to offenders. Don't forget the other side of the story. There are people being discharged from prison who cannot access services because the services are not particularly keen to work with the sort of people who have been through the criminal justice system.

DL: *Ultimately what will you have to put in place to really make a difference?*

PH: Within three years I hope we will begin to see different sorts of services emerge – services with a different shape, using different techniques and quicker to access than those we have the moment. Commissioners will be expected to purchase the most effective services for their community – drawing on the information we will make available to them about how much it should cost to purchase a particular service and what the quality standards and outcomes should be.

We need to improve the skill base of the workforce and a qualification process to go alongside that for individuals. But we also need some sort of accreditation process for services. The expectation would be that purchasers would only buy-in those services which have the appropriate 'kitemark'. I want service staff to feel they have better resources and are better trained, better supported, and better managed. But if neither the ordinary drug user nor the local communities notice the improvements to their lives, then the NTA will not have been successful ■