Not for turning?

Tory MP Iain Duncan Smith's description of methadone as "a fatalistic, short-term, and damaging approach to drug and alcohol addiction" signalled a growing mistrust of the pragmatic harm reduction measures introduced by Margaret Thatcher in the 1980s. **Paul Hayes** and **Annette Dale-Perera** look back at the politics of treatment.

What could turn out to be one of the closest run general elections in decades is virtually upon us. Speculation in the drugs field about a future government's direction on drug treatment is rife. With the economy and the public finances naturally centre stage, the major parties have signalled intent on drug policy, without having to tie themselves into a plan made on the election campaign trail. So what can we learn from how current policy has been developed that may point us to where it could go in 2010 and beyond?

If we took our source as Kathy Gyngell, researcher at the Centre for Policy Studies, she would have us believe that 'harm reduction' was invented, out of the ether, in 1997 by New Labour. The truth is much more complex than that, as anyone in the drugs field knows.

Harm reduction policies in Britain arose from a unique set of circumstances facing the Thatcher government. Mass youth unemployment and very significant hopelessness amongst a generation collided with the start of the HIV/AIDS epidemic and geopolitical changes that brought cheap, smokeable heroin into Britain by the bucket load. Heroin use went through the roof, particularly in Liverpool, Manchester and London, with thousands of users graduating from smoking to injecting. In some cases, we are still living with the consequences of a heroin epidemic that took a grip more than 20 years ago.

A pivotal moment for determining the treatment response was the publication of the ACMD's report in 1988, which declared that the spread of HIV/AIDS was a bigger threat to public health than drug misuse. The crisis was genuine, and the response from the then Conservative government was swift, decisive and politically brave. Alongside the bold public health campaign to contain the AIDS/HIV epidemic, Norman Fowler, then Secretary of State for Health, led the introduction of needle exchanges into communities in 1986 to allow heroin injectors to get clean needles and syringes and to encourage safer injecting practices.

THE CRISIS WAS GENUINE, AND THE RESPONSE FROM THE THEN CONSERVATIVE GOVERNMENT WAS SWIFT, DECISIVE AND POLITICALLY BRAVE

At the time, the main treatment available took the form of drug dependency units, based at some city hospitals, which focused almost exclusively on short-term detoxification, plus a limited number of residential rehabilitation places. The Conservatives decided to greatly expand and improve community provision to tackle the growing numbers of heroin addicts, most significantly in 1989 when a Central Funding Initiative released Department of Health money to health authorities to set up community drug teams and needle exchange services. Prescribing practice also began to shift in response to the emerging evidence about the effectiveness of maintenance prescribing.

By the mid-1990s, the sense of crisis was beginning to abate as the harm reduction approach had kept HIV/AIDs rates low amongst injecting drug users. However, drugs now represented a formidable problem as heroin use spread and crack use began to emerge.

The need for treatment was spiralling, with around 25,000 users in drug treatment in the six months to September 1996, 48 per cent higher than the equivalent period three years before. In 1995 the first cross-government strategy, 'Tackling Drugs Together', established the partnership approach through the creation of Drug Action Teams.

The findings of the government's 'Task Force to Review Services for Drug Misusers' in 1996, commissioned by then Health Minister Brian Mawhinney – who was dubious about the appropriateness of substitute prescribing and favoured abstinence-based approaches – was instrumental in shaping future policy. With access to the growing body of evidence available to clinical and academic experts treating drug addiction, the review concluded that "drug treatment works".

Hard evidence included the findings of a National Treatment Outcome Research Study, commissioned by the Task Force, which also found treatment to be cost effective: saving £3 for every £1 invested. John Major's government adopted the Task Force's findings, including an expansion of evidence-based treatment, and in March 1997 issued guidance to health authorities advising them to ensure prescribing treatment, including methadone maintenance, was available to drug misusers.

By the election of the Blair government, the scene was set for the scoping of the future treatment system under the new drugs czar. However it wasn't until Labour's second term in

Give her a big hand: DJ Kenny Everett, who died of AIDS, was a supporter of Margaret Thatcher's public health policies to combat the spread of HIV/AIDS

government, when additional money was freed up, that the agenda developed by the Major government and built on by the new drug strategy 'Tackling Drugs to Build a Better Britain 1998' could be fully realised. The need for decisive action was starkly apparent in homes, communities, prisons and GP's surgeries across the country. However, left to their own devices, health and local authorities had never – and were not about to – prioritise this marginalised client group.

In 2001, the demand for action was met with the crucial elements for delivery: political leadership, funding, and structure. To overcome the difficulties of delivering a cross-cutting agenda where the cost benefits of a policy is a reduction in crime delivered through health services, the Blair government drew together funds into the Pooled Treatment Budget and charged a new agency with delivering mass availability of drug treatment in England.

The National Treatment Agency for Substance Misuse (NTA) agenda was set by the Audit Commission's damning 2002 report, Changing Habits. It reported that users struggled to be treated, two-thirds of GPs did not have easy access to specialist services, drop out rates were high and provision patchy, with long waiting lists, then averaging nine weeks. The aim to rapidly double the numbers in drug treatment from a base of an estimated 85,000 was ambitious.

Drug Misuse 2004, the Audit Commission's follow-up report, declared that "impressive progress" had been made. Today there are 210,000 drug users getting help for their addiction every year, the average wait to start treatment is less than a week and most users stay in treatment long enough to benefit.

By 2005 the National Treatment Effectiveness Strategy acknowledged that access to drug treatment had greatly improved: but having put the building blocks in place, getting more users into treatment was a job half done. Whilst many benefited from initial stabilisation in treatment, there had not been the same focus on getting users through treatment to overcome their addiction as there had been on making sure they could get into treatment in the first place.

The drug treatment system, having been born out of political and expert consensus, and having made significant progress, then came under sustained attack in 2007 for not 'curing' enough people from heroin addiction. This sparked an 'abstinence versus maintenance' civil war in the sector, reflected in the wider political and media debate. Thankfully this has abated somewhat. Partly in recognition that in difficult financial times ahead, lack of cohesion in the sector risks unraveling the achievements of the past few years, but also because the majority of people in the drugs field are supportive of a fusing of the two: a recovery-orientated agenda which promotes a balanced, evidence-based treatment system able to respond to service users' aspirations.

What does this mean for informing future policy? Firstly, we need to remind ourselves how far we've come. Not just the improvements to treatment in more recent years which provide a readily accessible gateway to initiate recovery from drug addiction, but from the dark days of the late 1980s when the lives of thousands of young adults and their families were devastated.

Heroin addiction remains a significant problem, and the growth of polydrug, stimulant and alcohol misuse present new problems, however the decline in young people presenting to treatment for heroin addiction is grounds for cautious optimism. Second, it demonstrates that at the critical junctures, the role of 'experts' and evidence-based policy is absolutely central. The time is ripe now for political leadership to consolidate the achievements of the last 20 years, support the increasing consensus towards recovery-orientated treatment, and lead the reintegration of drug users into their communities.

We can and should expect people to get better from addiction, but this will not be delivered on a mass scale by any 'silver bullet' treatment – it will come from systematically linking treatment, which can initiate recovery, to the wider services and communities necessary to consolidate and sustain recovery, including jobs, housing, training, mutual aid and family support.

Finally, a skip through the recent history shows that politicians have acted pragmatically in response to events. Looking for an ideological split between the parties may do less to inform us than recognising that over the years, policy has been shaped by events, evidence, and professionals' experience rather more than politics, and for this we should be grateful.

■ **Paul Hayes** is Chief Executive, National Treatment Agency for Substance Misuse (NTA). **Annette Dale-Perera** is Strategic Director of Addiction and Offender Care at Central and North West London Mental Health Trust and former NTA Director of Quality