The professionals: the journey from DIY to DANOS

Voluntary sector services have come a long way from the days of enthusiatic amateurs dispensing tea and talk. **Peter Martin** maps out the long and winding road to the land of professionalism, performance and partnership

Thirty years ago, drug treatment could perhaps be characterised as a well-meaning effort to provide support, with projects run by pioneers who were fired by personal involvement and passion. Some of these had family or personal experience of drugs misuse.

These voluntary sector projects had few resources but generally gave clients a warm welcome, a cup of tea and a listening ear, with a non-judgmental approach, while learning what worked best for the client group. Practical help, with accommodation, finding healthcare and advice on benefits was given frequently. Talk therapies were the mainstay of any treatment on offer.

Addaction was founded in 1967, as the Association for Parents of Addicts by a mother, Mollie Craven, who made an impassioned appeal in the *Guardian*, because she could find no help for her son who was addicted to heroin. Some other early projects, originally set up to offer shelter to the homeless, metamorphosed into developing drug treatment schemes, because what was available within the limited statutory provision was not enough.

FUNDING DILEMMA

Fundraising and small statutory grants were the only source of income in the early days. However, with the dawning recognition that the sector could not hope to respond to the rising tide of problematic drug use in the 1980s and 90s without government funding, the flag of independence was lowered.

At the point when governments began to fund more treatment, and competitive tendering began to be driven through the procurement processes of government, market forces were applied in order to get value for money and raise standards.

As a result of competitive tendering the characteristic of passionate, united advocacy was temporarily diminished. Competition in this sense was divisive. We are now working hard to rebuild unity in the sector and reaching out to form wider partnerships.

TREATMENT

But, to go back, after GPs lost the licence to prescribe heroin, Drug Dependency Units (DDUs) handled all the user lists. Psychiatrists were in the driving seat of policy, while DDUs were in charge of prescribing controlled drugs. Detoxification and bed spaces for rehabilitation in hospitals were available on a limited scale, and habit-forming methadone was prescribed in varying amounts, depending on the particular volition of the psychiatrist. Pharmacological interventions, although useful, are cul-de-sac approaches when delivered in isolation. Treatment is about integrated 'whole treatment' that helps people regain lost opportunities and move on to lead productive lives.

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The voluntary sector also had a lot to learn. A collegiate atmosphere among the various agencies meant that they sometimes helped each other to renovate projects. Treatment methods however, were often unproven and ranged from the draconian to the innovative to the experimental and sometimes weird.

Back in the 1970s, when *Druglink* first appeared, 'treatment' was a euphemism for any response that might just work, borrowing therapeutic concepts and pharmacological interventions eclectically. All of this occurred without any solid evidence base for what worked. It was neither evaluated nor subject to accountability measures in any meaningful way.

The advent of both the Registration of Homes Act, and 'Care in the Community', saw the availability of in-patient detoxification and residential rehabilitation decline. Day care centres and open access now dominate the landscape of community treatment provision. Of course, getting off drugs was never simply about residential care or the availability of en-suite bathrooms, but about human relationships, engagement, motivation and role-modelling.

With the spread of HIV in the early 1980s, a much clearer direction came from government towards reducing harm from blood-borne disease and there was a major push to open needle exchanges. UK policy worked to reduce the spread of HIV with injecting drug users. We were way ahead of the US on this. Of course, we like to think that needle exchanges began around 1985, but clean equipment was freely available at voluntary sector services such as the Community Drug Project in Camberwell in the 70s, where one could find a 'shooting gallery' for safer intravenous injection. But in the debate on harm reduction, the balance shifted away from abstinence.

PROFESSIONALS

There is no doubt that from the late 80s, the voluntary sector as a whole was beginning to change and become increasingly professional. This affected the sectors' perceived ability to deliver. When the *National Treatment Outcomes Research Study* (NTORS) came out in 1996, the full potential of the voluntary sector to deliver cost effective treatment, was, at last, underpinned by some good evidence of what worked.

The last decade has seen the advent of two

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overarching drugs strategies – *Tackling Drugs Together* introduced under the Conservatives, and *Tackling Drugs Together to Build a Better Britain* under Labour. Another major change was the commissioning arrangements for services via a tier of Drug Action Teams. Since 2002, the National Treatment Agency has been established as the governing body for setting standards in the field. In that same year, the updated drugs strategy, under Home Secretary David Blunkett, allocated approximately £500 million per annum to drugs treatment.

Of course the 'paradigm shift' in drugs policy, as Philip Bean calls it in his book on drugs and crime, was to marry drugs policy with criminal justice interventions. This approach began in the US, and over time, it became the principal driver for streamlining strategy, backed with funding, in the UK.

Subsequently, a lot of voluntary sector treatment provision has been, and is being delivered, within the criminal justice setting.

Professionals with attitude: 'the fire in the belly has not been reduced'

CRIME CASH

We have been part of that calibrated process, where every pound spent on treatment is justified by the amount it saves society in the criminal justice system. This has its downside, because stigma tends to define all drug users as criminal, which, in turn, feeds negative perceptions in the public and the client. It also underscores the cultural contradictions in society's attitudes towards alcohol misuse.

The major treatment providers do work more closely now, helping to articulate the needs of smaller agencies, and continue to present the treatment case to politicians and public. Of course, strategy too often seems to seed burgeoning bureaucracy. A common cry from the sector has been to get funds down to the front line more quickly.

We also bang on about the need to support staff retention, about level playing fields between the statutory sector and us, and about gaps in care – particularly aftercare, which can wastefully undermine our work to deliver across the continuum of care. The Department of Health is now funding a pilot aftercare service in Newcastle, run by Addaction, which is to be evaluated.

HUMILITY

So, generally, treatment agencies are being listened to more, but I don't think we have an unrealistic view of just how much more we need to press home the case for properly funded support and streamlined processes for treatment.

In the real world of conflicting priorities and needs, in a world where voluntary sector treatment has grown up, I believe there is a level of humility in the sector. Treatment may be counted among the big boys now, but we still have many more smart moves to make.

One thing that has not changed over the past 30 years, although much improved and refined, is our focus on the clients we serve. The fire in the belly has not been reduced by improved professionalism, but professionalism has added to our successes, renewed our motivation and kept us open to new learning. ■