Sink or swim

Britain now has arguably one of the best drug treatment systems in the world. But there are choppy waters ahead, says **Susanne MacGregor**.

The government's 2008 drugs strategy aimed to "deliver new approaches to drug treatment and social reintegration". It gave long overdue attention to children and families. It also mentioned injectable heroin and the more questionable, incentive-led 'contingency management'. It said drug users have a responsibility to engage in treatment and then move on and reintegrate into the community when they can. 'Personalisation' carrots and welfare to work sticks might help, with drug co-ordinators in job centres, rather ambitiously, aiming to link treatment with employment support and on to jobs.

The previous ten-year strategy achieved a great deal, mainly because of an unparalleled increase in expenditure. At the last count, £800 million a year was being spent on providing a 'balanced range' of services with numbers in treatment increasing from 85,000 (1998) to 195,000 (2008/9). Three-quarters are now retained for 12 weeks or more. Waiting times have been dramatically reduced. There is a new qualifications framework and suite of occupational standards for treatment workers.

While there was a welcome stress on reintegration, the 2008 strategy did miss an opportunity to build in more attention to recovery and to alcohol, partly perhaps because these issues were only just then surfacing. In the main, it continued on the path of trying to improve the effectiveness of existing services.

Recovery is explicit in Scotland's drug strategy – The Road to Recovery, supported by researchers like David Best, who became sceptical when he saw how little time was devoted to therapy in treatment encounters. Professor Neil McKeganey – very vocal in public debate – makes much of the fact that the people he speaks to in his research say that what they want is to come off drugs.

The recovery movement believes that what matters is finding new sources of self-esteem and hope, a different identity and involvement in new groups. The idea that professionals patronise and disempower is central to self-help and mutual aid. But I worry that too strict a 'pull yourself up by your bootstraps' mantra will not work. And a particular version of the recovery approach might play well with those now arguing for cuts in expenditure.

The policy community tries to contain such tensions, shaping policies in response to pressure and adapting to elected representatives' values. In the last years of the New Labour government, the recovery agenda was taken on board, and blended with what was known about the treatment journey, the difficulties of treatment and the likelihood of relapse. The National Treatment Agency (NTA) now says: "The goal of all treatment is for drug users to achieve abstinence from their drugs of dependency. . . partnerships [should] have recovery as the bed rock of all commissioning decisions."

ALL THE TIME, THE ISSUE OF THE EFFECTIVENESS OF TREATMENT BUBBLED AWAY BENEATH THE SURFACE. THE WORRY WAS THAT THIS WAS PROVING HARD TO DEMONSTRATE

Critics of the current system argue treatment today consists mainly of methadone maintenance and some doctors feel that all they do is write scripts. Others feel the model is based too much on acute services and that continuing care is neglected.

Practitioners know that methadone on its own is ineffective and interventions like counselling, establishing a good relationship between therapist and patient, and continuing care are also needed. But lack of after-care and 'wrap around services' mean social reintegration is difficult to deliver. Achieving these aims requires partnership working, and this did become a central feature of policy. Others argue a more fundamental shift is needed, giving primary care a central place: when done well, this looks at the whole person, all their health needs and those of their family. It is also accessible, flexible and good value for money.

Treatment was a fundamental plank of the 1998 strategy because it was thought it would break the link between drugs and crime. Politicians and civil servants somewhat misread NTORS data and thought the Problem Drug User could be made to disappear within five years. The policy aim was "to enable people with drug problems to overcome them and live healthy and crime free lives".

The Treasury was persuaded that 'treatment works' but it was not much interested in what actually happens in treatment. Initially the main issue was access – how to get people into treatment. Around the country, parents, newspapers and local politicians were clamouring for more places in treatment and for waiting lists to be shortened. It was reported that in some places there was a six-month (even 18-month) waiting list.

There was indeed much evidence that treatment worked. But the public and the experts have hugely different views on what this means. Methadone maintenance therapy saves some social costs, especially with reductions in crime, but it has only a modest impact on reducing drug use among users. Cost effectiveness studies show reduced costs mainly by diverting individuals from involvement in the expensive criminal justice system into less costly health and social care and stabilising prolific offenders.

Public expectations however are that treatment will result in a safe, complete detox, reduced use of medical services,

the elimination of crime, a return to employment and an end to family disruption. For health professionals, the issue is meeting need and the outcomes looked for are reduction of health risks and fewer episodes of relapse and use of emergency care. Practitioners' experience is that withdrawal on its own is insufficient and can be dangerous. They see problem drug use as a chronic relapsing condition best treated like other chronic ailments, such as diabetes, asthma or hypertension.

The key event in drug treatment policy was the establishment of the NTA. In the 2000 spending review, Keith Hellawell, the drug czar, and Mike Trace, his deputy, argued for a big increase in expenditure on drug treatment: they were backed up by lobbying from the police and the health sector. Ring-fencing and tight control of the new monies was essential. Wise heads feared that any increase in funding could leak away if put direct into the NHS. The final package was a big surprise to many civil servants. The plan came direct from No 10 and reflected New Labour's approach to public sector management. The NTA's remit was to expand the availability and quality of drug treatment and monitor expenditure of the pooled treatment budget (introduced with £129 million initially).

The Department of Health's Public Service Agreement (PSA) tasked the NTA to increase the participation of problem drug users in drug treatment programmes by 50 per cent by 2004 and by 100 per cent by 2008. It was also required to increase, year on year, the percentage of users successfully remaining in or completing treatment programmes.

PSAs, introduced in 2001, called for robust indicators – which increased the focus on the Problem Drug User – a stance backed by a Home Affairs Select Committee report in 2002. Retaining people in treatment for 12 weeks became a specific policy. So, priorities were improving access, reducing waiting lists and paying more attention to co-morbidity (symptoms of both substance misuse and mental health problems). While most were successfully dealt with, by 2008 co-morbidity had dropped off the agenda. Other priorities were reducing drug-related deaths, crack, heroin prescribing and links between cannabis and mental health.

Drug treatment policy had to link to other New Labour social policies, like modernising government and services, tackling social exclusion, regenerating deprived areas, enhancing equity and efficiency, involving service users, encouraging the voluntary (third) sector, working in partnership and in a joined-up way and giving priority to young people – all set within the dominant evidence-based policy approach.

Devolution had very important implications. The different countries of

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the UK developed their own policies, but all were co-ordinated within the overall UK strategy. Scotland emphasised public health and community issues, but also the effectiveness of treatment. It set up an Effective Interventions Unit to show what works and to monitor cost-effectiveness. Wales included alcohol in its substance misuse strategy.

Over these years, the drug treatment field was transformed. New staff were recruited and trained. A group of GPs with special interest in drug dependence emerged. From being a relatively anarchic and quasi-religious movement, a more professional workforce – a 'business' or 'industry' – appeared, regulated by an increasingly influential stratum of commissioners. In 2002, *Models of Care* was published, followed by guidance on commissioning and partnership, better coordination and support for primary care and attention to case management. Later NICE guidance became very influential.

At first, surprisingly little was known about what was actually happening in treatment services. An efficiently functioning and reliable data monitoring system had to be established. The National Drug Treatment Monitoring System (NDTMS) was set up and a Treatment Outcomes Profile tool developed later to try to give a rounded picture of the impact of treatment and other care.

All the time, the issue of the effectiveness of treatment bubbled away beneath the surface. The worry was that this was proving hard to demonstrate. The factors associated with better outcomes of treatment were engagement with and retention in treatment. Once the first policy aim to expand the availability of services had been achieved, these then became priorities. Soon it became apparent that results varied greatly by agency.

It was not long before patience began to wear thin at the Treasury. Effectiveness became an important issue in spending reviews, which have only a two to three-year time horizon – there was pressure to show results to justify the additional money. Is treatment cost effective? The Prime Minister's Delivery Unit demanded constant monitoring of the drugs strategy. Where before, the Home Office interest was just in how to deliver people to the door of treatment, as early as 2003, it became 'what is happening in treatment?'.

In 2005, the NTA launched its treatment effectiveness agenda, focusing on the client's journey through treatment – to improve engagement, retention, completion and reintegration. This led to Drug Treatment Outcomes Research Study

(DTORS), research to evaluate the long-term effectiveness and cost-effectiveness of drug treatment. It concluded that drug treatment improves the physical and mental health of individuals in treatment and estimated the cost-benefit ratio at a saving of £2.50 for every £1 spent. The National Audit Office (Tackling problem drug use 2009/10) concluded that there had been significant improvements in the provision, delivery and outcomes of treatment, reduction in the cost of each treatment episode, increase in the number of users completing treatment free of dependency, reduction in waiting times, and a reduction in the sharing of needles and syringes.

These conclusions were received with relief in policy communities. Any complacency had been exploded in November 2007, when the BBC's Mark Easton pointed out that, in 2006, only three per cent of patients recovered from addiction in the sense of emerging from treatment entirely drug-free. This led to a clamour of criticism that policy was focusing too much on numbers in treatment with not enough attention to the outcomes of treatment.

Britain now has arguably one of the best drug treatment systems in the world. But much of the expansion of services was paid for from unstable revenues. Now the bubble has burst and reductions in government spending are the priority, where next for drug treatment? Did any developments bed down well enough to withstand the coming winds of austerity?

A redirection of priorities was achieved, new services and different practices were introduced and a neglected area was given appropriate attention. These were significant achievements. But they will need to be defended vigorously as opponents gather and other needs compete.

Once again the effectiveness of treatment and the value of methadone have to be demonstrated. But policy has also to take on new issues. The drug treatment population is ageing and the older body needs special attention. While there may be evidence on what works with opiate users, we are still unsure what to do about stimulants and polydrug use (including alcohol and tobacco).

With government policy now promoting a shift from public provision to social enterprises, the role of specialist NHS addiction units may be further undermined. Local determination of policy could provide an opportunity to support innovative, integrated approaches, responsive to local needs, but funding will be the key problem.

Reduced budgets will present hard choices. Overall, however, rebalancing policy to give more support to mutual aid and GPs, in partnership with necessarily slimmer but still high quality specialist services, could retain the best of what has been achieved while keeping costs down and responding to a wider set of health and social needs.

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