'Drug treatment - a potted history: Roughly 1966 to the present day'

The following is the text, with accompanying power point slides, of a recent presentation by DrugScope Chief Executive Martin Barnes.

"Looking around I am conscious of how much expertise, experience and knowledge there is in the room. So I am aware that my brief potted history of the drug treatment system - taking us from the 1960s to the current day - will not perhaps do full justice to people's lived experience.

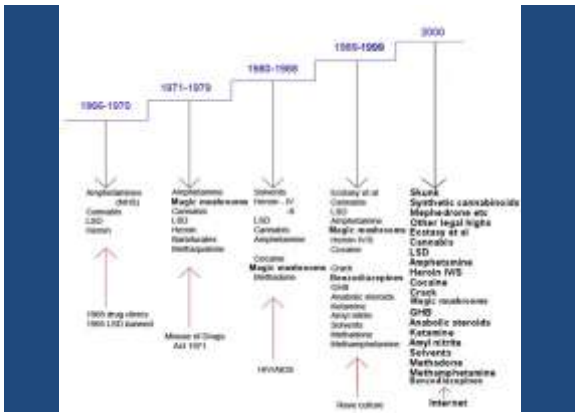
An understanding of the past is important in helping to inform an understanding of current policy and practice; how we got where we are today; but also whether lessons from the past have been fully learnt, particularly in terms of new structures and responsibilities, and also whether the sector can today avoid repeating simplistic and polarising positions: e.g., 'harm reduction' v 'abstinence'.

In terms of the development of the drug treatment sector, if we trace forwards from the early 1980s, there have been two broad drivers of national policy or, as it has been described: two broad paradigms. From the mid-1980s to the mid-1990s, a key driver and focus for drug treatment was 'public health' – primarily responses to concern about HIV and AIDS; from the mid-1990s onwards, a crime and criminal justice paradigm became more explicit and dominant.

Themes/paradigms:

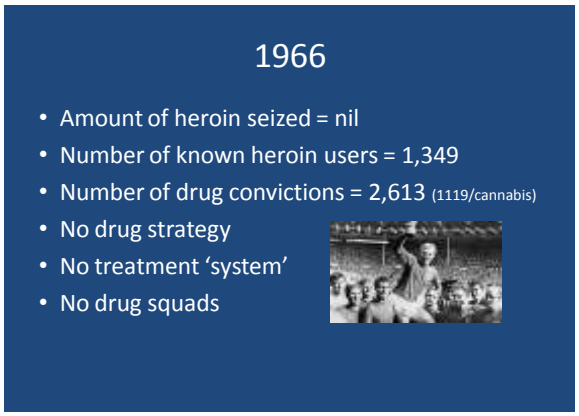
- Public health (mid-1980s)
- Crime (1990's →)
  - reducing risk & harms to the wider population
- Recovery (late 2000's →)
  – benefits to the individual & benefits to society.

But – despite apparent differences of emphasis – both were at heart responses to major perceived threats and harms associated with drug use; essentially both were about risk reduction to the wider non-drug using population. However, we may now be at a third paradigm: 'recovery' that focuses on the wellbeing and benefits to the individual and their families, which in turn provides benefits for the wider community.



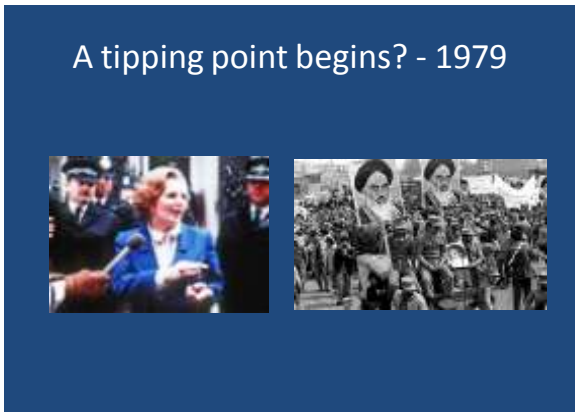
Heroin has dominated much of the discourse and development in drug treatment. But as you can see from the slide above, since the 1960s there have been new patterns of drug use, with an increasing number of substances. The internet has, for example, enabled more information and availability of 'new' psychoactive substances.

Go back to the 1960s and – by official Home Office data – there were around 1,300 known (recorded) heroin users; the total number of convictions for all drug offences was around 2,600. There was no national drug strategy and – other than some private clinics – no drug treatment system.



Following the introduction of the Misuse of Drugs Act in 1971, the 1970s was a relatively stable decade in terms of drug use – although the mid 1970s saw the beginnings of a significant market in imported 'Chinese' heroin from Hong Kong.

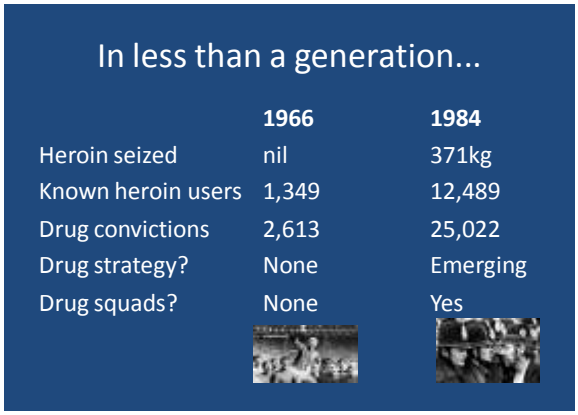
With hindsight, it was the events of 1979 can be seen to have had a significant and profound impact – the Conservative Party under Mrs Thatcher was elected and the Shah of Iran was overthrown. The relevance may not seem immediately obvious.



it wasn't until the mid 1980s that the number of users of heroin and other opiates started to increase, and dramatically, particularly in inner-city deprived areas outside of London. A new source of heroin was arriving from the so-called 'golden crescent' countries of Iran but also Pakistan and Turkey. This type of heroin was originally produced for smoking rather than injecting and followed the rise in Iranian refugees to the UK after the fall of the Shah in 1979.

By the mid 1980s, not only was heroin more readily available but the country was already experiencing unemployment and poverty not seen since the 1930s. Many communities were left traumatised by the closure of manufacturing and other industries, with localised concentrations of high unemployment and deprivation. Although there were significant shortcomings in official data, in the early 1980s the number of dependent heroin users reported by the Home Office was increasing by 20 to 30 per cent a year.

By 1984: heroin seizures were increasing; the number of known heroin users was recorded around 12,500 and the total number of drug convictions was over 25,000; the number of convictions for heroin alone was nearly as many as total drug convictions in 1966.



But it was the concern about HIV and AIDS that led to the then government's decision to open the first needle exchange clinics in 1985 and gave the focus on drug treatment impetus. But initially the government had been slow to act; the fact that the groups seen as most at risk of HIV - homosexual men and intravenous drug users - meant apathy and outright hostility in many quarters. It is easy today to forget the sensationalist, stigmatising and unbelievably offensive reporting and commentary of the time: the then Chief Constable of Greater Manchester Police, James Anderton, referring to people with HIV and AIDS as "swirling about in a human cesspit of their own making".

The following are some actual newspaper headlines at the time - a time of prejudice, media-driven fear and discrimination:

‘BRITAIN THREATENED BY GAY VIRUS PLAGUE’ (Mail on Sunday)

‘AIDS IS THE WRATH OF GOD, SAYS VICAR’ (Sun)

‘COUGH CAN SPREAD AIDS, WARNS DOC’ (Sun)

‘AIDS death shock at BBC’ (Star)

From the mid-1980s Government was taking an unprecedented interest in drugs: a Home Affairs Committee report described the drug problem as 'the most serious peacetime threat to our national well-being'. An Inter-Ministerial Group on the Misuse of Drugs was established, with key elements of strategy that continue today: reducing supply; improving policing: with every police force having a drug squad and the creation of a new National Drugs Intelligence Unit at Scotland Yard; tougher legislation: the maximum penalty for trafficking for Class A drugs increased from 14 years to life imprisonment; and improving prevention and treatment. The government launched a Central Funding Initiative which initially allocated £17 million to the development of community and residential drug services. 1985 saw the launch of the anti-heroin campaign 'Heroin Screws you up’, and there was funding from the Department of Education and Science to appoint a drug trainer in every local authority to co-ordinate drug education activity - a centrally funded resource which is sadly absent today, despite new challenges.

Drug policy had become high-profile and a clear priority for government and politicians : writing in 1987 in the British Journal of Addiction, Gerry Stimson commented: '…we are seeing the politicisation of drug problems...the arena for debate is no longer confined to professional and advisory committees. The next election is likely to be the first where each of the major parties has a drug strategy to offer the electorate.'

John Major's 1995 Drug Strategy – Tackling Drugs Together - established local Drug Action Teams, which I will say more about in a moment.

With an overall increase in crime during the 1990s, there was clear evidence of a shift of focus in the goals of drug treatment.

It was the Election of the New Labour Government in 1997 that saw a significant increase in the priority and funding given to drugs and drug treatment.

The first ten-year drug strategy, published in 1998, Tackling Drugs to Build a Better Britain, increased money going into the sector, but with the initial emphasis on funding prison drug treatment arrest referral, Drug treatment and Testing Order pilots, with smaller increases in community based treatment. The Drug Intervention Programme, as it became known, was launched in 2003. Centrally allocated funding for drug treatment doubled between 2001 and 2004, from around £60 to £120 million a year. The drug treatment sector was beginning an unprecedented period of growth and development.

But, inevitably, with more funding for drug treatment came a much greater focus on demonstrating impact, value for money and outcomes - and yet more direction by, and accountability to, the centre.

A proposal for a new national treatment agency was first announced in 2000 by then Home Secretary Jack Straw – but initially with little detail as to its role, other than to pool different sources of funding. Jack Straw described the budget for treatment as 'dissipated' and 'not wisely spent'. Options to be examined included: the new agency acting as a clearing house for residential places, as well as setting quality standards and supplying management information systems.

However, it appeared that no one outside the Home Office or the Department of Health had been consulted about the plan for a new agency - commenting at the time, DrugScope said: 'We need to be convinced that the idea of a national drug treatment agency is sound.'

But things moved very quickly and the National Treatment Agency was launched as a special health authority within the NHS in April 2001.

April 2001 – the NTA, and a new CEO:

A key driver for the establishment of the NTA was that the government did not trust the NHS to spend money on drug treatment, even if the money available was increased. Although the government at the time saw drug treatment as the part of the drug strategy with the strongest evidence-base, there was concern about the treatment system, although it was recognised that drug treatment had been characterised by chronic underinvestment.

Interviewed for DrugScope's Druglink magazine in the summer of 2001 the NTA's new chief executive, Paul Hayes, said: 'We need to improve the skill base of the workforce and a qualification process to go along side that for individuals…we also need some sort of accreditation process for services. The expectation is that purchasers would only buy-in those services which have the appropriate 'kite mark'.

The following year, the Audit Commission published a report 'Changing habits': while concluding that drug treatment could be effective and value for money, the report nonetheless highlighted a number of problems:

- Long waiting lists and waiting times; average 35 days; some areas over 100 days;
- Limited treatment options – reflecting 'piecemeal and unplanned development of the treatment sector';
- Low levels of staff training and expertise;
- Poor care management and co-ordination; joint working between treatment providers and other agencies described - perhaps diplomatically - as 'often patchy'.

Audit Commission: 'Changing habits' - 2002

- Waiting times
- Limited treatment options
- Low levels staff training & expertise
- Poor care management
- 'Patchy' partnership working

A reduction is waiting times was an early priority for the NTA – an early report, ‘Making the system work’, noted that lengthy waiting times can result from a complex interaction of factors: not just demand and available resources, but also working practices and the inadequacy of information systems.

Druglink magazine commented at the time: ‘Territorialism and intransient ideologies with no evidence base, are just some of the issues the NTA will have to tackle if waiting times are to fall’.

As I will come on to later, the NTA has its critics, but looking back there was no ambiguity about its stated purpose, and the challenge it would present to the sector: In January 2002 Paul Hayes suggested: "some cherished assumptions and working practices being challenged, some long standing service providers leaving the field, and some individuals choosing to find other employment. Managing these changes will call for high levels of skill and resilience from services and commissioners."

Following the 2001 General Election the Home Office took over lead responsibility on drugs policy - this clearly and firmly linked drug policy and drug treatment with crime.

So, in the early days of the NTA there were dedicated funding streams, with the pooled treatment budget, targets – reducing waiting times and doubling the number of people in treatment by 2008 – and, significantly, also close personal interest by Tony Blair. Quarterly stock-take meetings were held at Downing Street which the Prime Minister usually chaired, attended by the CEO of the NTA amongst others.

With increasing demands on the treatment system, this impacted on expectations from Drug Action Teams and on the sector – the 1998 Drug Strategy stated that Drug Action Teams should be the principle mechanism for local delivery. But DATS were not intended to be (and did not have the legislative authority to become) organisations, but were instead intended to be local alliances of local chief executives from different services and professions. Increasingly, however, DATS appointed co-ordinators (and other staff) to carry out administration, management functions and provide expertise on substance misuse issues. A new local infrastructure was created - held increasingly accountable to the centre, via the NTA.

DATs under pressure...

•Treatment Plan •Young Persons Substance Misuse Plan •Communities Against Drugs •National Crack Strategy •High Crime Areas Initiative •Youth Crime Reduction Plan •Crime & Disorder Reduction Plan.....

Before the NTA took over, DATS were required to submit an annual report and plan to what was called the UK Anti-Drug Coordination Unit based at the Cabinet Office. Early on there were concerns about the ability of DATs to deliver; but equally many DATs were having to respond to increasing numbers of strategies, submissions and requests from central and local government – in 2003, one DAT co-ordinator commented: 'delivery across the country is threatened by the pressure being put on local partnerships'.

As the sector expanded and became more complex - there was an explosion of acronyms!

- SMAS; DAT; DRG; CJIP; DIP;CARAT
- QUADS; NOMS; DANOS; DPAS; NTA
- CDCU; UKADCU; MOCAM; DTTO; DRR
- EATA; LDPF; ACMD; NTORS; NDTMS
- SOCA; NCIS; FDAP; LDAN; NICE; PCT
- DAO; IDTMS; YOT; LSP; LAA.....

The focus of the government and the NTA was explicitly on increasing the numbers in treatment and retaining people in treatment to secure maximum benefits; but it was not until 2005 that official attention started to be given to moving people through - and out of - the treatment system.

In 2005, the NTA announced a 'treatment effectiveness strategy', with a stated recognition that the focus and balance of the treatment system needed to change. Commenting on the strategy, Paul Hayes said in an interview with Druglink magazine earlier this year: "We said in 2005 that getting everybody in isn't enough, that what we need a system that has a back door as well as a front door…We got no where with that; nobody wanted to know….the Treatment Effectiveness Strategy was five years too early, the sector [and he specially references doctors and commissioners] was not prepared to go there".

While the aim and purpose of a treatment effectiveness strategy may have been prescient, it changed little. 2007 became the NTA's *annus horribilis*.

Iain Duncan Smith's Centre for Social Justice published a report, 'Breakthrough Britain', and concluded: "Under the 10 years of Labour's drugs strategy, policy itself has become an intrinsic part of the problem. It has been a costly investment in failure. Its combination of centralised targets and a "medical management" approach to treatment has further entrenched addictions..." It described a "misguided system of social control."

Sections of the media woke up! Suddenly, it seemed, drug treatment - and the NTA (for long not a feature on the media's radar) - had become news.

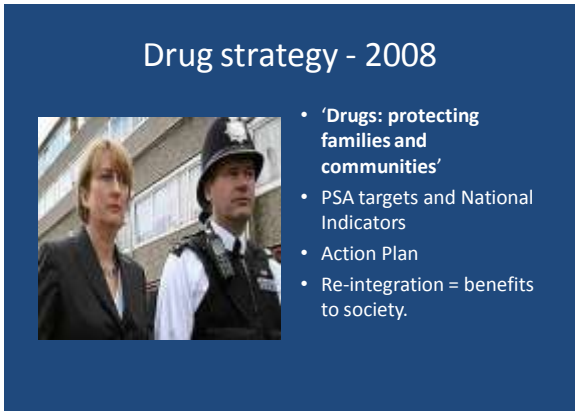
Controversy about the treatment system was further ignited by reports on the BBC's Today programme, including one in October 2007 when the BBC claimed that only 3 per cent of drug users had left treatment free of all drugs (including methadone).

Subsequent media coverage was largely one of 'failure', of a 'waste of taxpayers money' and of 'junkies' failing to quit their habits.

But the BBC report was a catalyst for a debate which had been growing within the sector for some time. The fire took-hold precisely because of concerns about treatment effectiveness and a need to be more ambitious. And an increasing frustration against simplistic 'harm reduction' and 'abstinence' discourses. But the sector - bigger and better funded than ever before - lacked a clear and consistent framework to engage, debate and discuss, without appearing to be fighting amongst itself.

So DrugScope took on the challenge and embarked on a process of facilitated consultation - including a series of regional events - to create 'safe spaces' for discussion and debate.

In 2008 the Labour government's last drug strategy did not refer to recovery, but it outlined aspirations similar to those in the current drug strategy - with a greater focus on securing benefits to society by helping the individual.



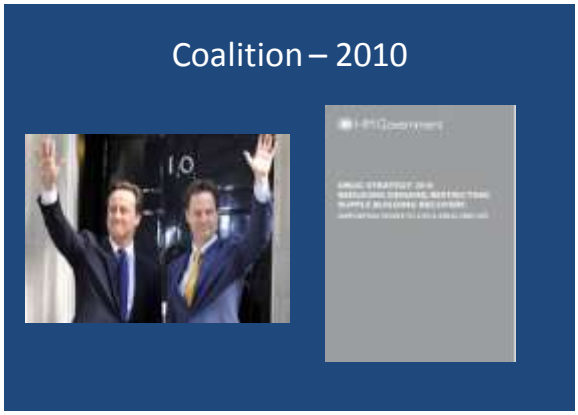
Following the consultations the previous year in early 2009, DrugScope published a report 'Drug treatment at the crossroads – What's it for, where its at and how to make it even better'. The key messages may appear simple and obvious in hindsight, but they captured and reflected the growing consensus within the sector:

- Choice in treatment should be promoted – methadone has a role, but services must also work with people on methadone prescriptions to help them rebuild their lives and move on in their recovery;
- The system must put people first;
- We should all be aiming higher – care pathways out of addiction are about a lot more than a narrow view of drug treatment;
- Families and communities need support too – families, friends, neighbourhoods and communities are a vital source of recovery capital, but have often been at the margins.

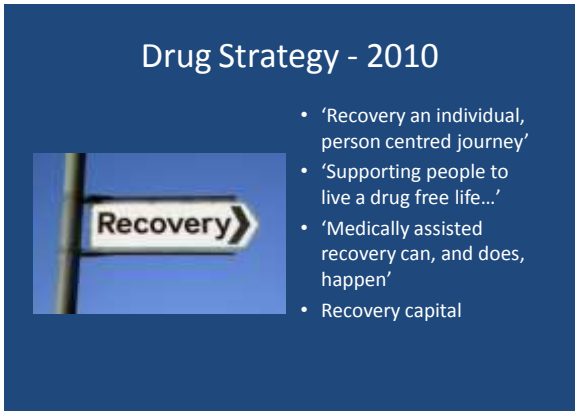
Despite the welcome shift in the 1998 strategy, the previous government was not averse to politicising drug treatment policy. Despite apparent objections from the Department of Health and the Home Office, the government announced plans to make it a condition of benefit entitlement for people with a drug or alcohol dependency to be engaged in treatment. This was seen - I think not unfairly - as a lightning-rod to show tough credentials on welfare and welfare reform, focusing on the least-liked and most stigmatised benefit claimants. Although, late in the Parliamentary process, the Government stepped-back from making treatment a requirement to receive benefit, it nonetheless introduced through primary legislation powers which would have required benefit claimants to answer speculative questions about possible drug and/or alcohol use; if the JobCentre had a 'reasonable suspicion' that someone may have problems with drugs or alcohol, they could be required to undergo an assessment; and JobCentres were also given the power - again on speculation - to require someone to undergo drug-testing. Failure to co-operate could have resulted in a benefit sanction.

One of the current Government's first announcements on drug policy was that it would not proceed with the new powers. However, while welcome and important, that did not prevent negative and stigmatising media headlines, sourced from the Department and Work and Pensions, about people with drug and /or alcohol problems receiving benefits. When DrugScope raised this within the DWP, it was agreed that the coverage was not 'the language of recovery'.

The Coalition's 2010 drug strategy was widely welcomed within the sector.



Despite subsequent attempts to redefine recovery, and questions about methadone prescribing and possible time limits, the strategy remains the overarching and defining document. It is important not to be distracted from that.



Recovery is about so much more than a narrow traditional view of treatment - it's about jobs, education, housing, peer support and families; building recovery capital.

So, where are we today?

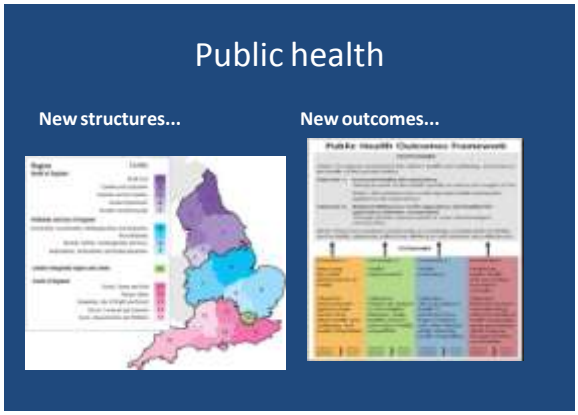
A commitment to drug treatment and supporting recovery goes to the very top of Government. Although the Home Office is the department with lead responsibility for the Drug Strategy, around the table at the Inter-Ministerial Group on Drugs are the Department of Health, Ministry of Justice, Cabinet Office, Department for Work and Pensions and (at least occasionally) the Department for Education.

However, the 'collegiate' feel of the Inter-Ministerial Group (which includes, surprisingly perhaps, attendance and contributions from special advisers) does not always provide the needed leadership, coordination, momentum or force for positive change necessary to deliver the clear objectives of the Drug Strategy. It can – whether collectively intended or not – be divertive from the goals of the Drug Strategy, and too close to ideological, rather than driven by evidence. It can therefore create a difficult, inconsistent and unpredictable environment in which to operate - not least when seeking to provide steady and evidence-based representation for a diverse and complex sector.

The introduction of the new public health system in April, with the transfer of responsibility for drug and alcohol services to upper-tier local authorities is the most important change for the sector since the 1980s.

Given the sector's relatively short history, it arguably is the most important change the sector has faced. It does create opportunities. The responsibility of Health and Wellbeing Boards to provide strategic leadership and planning, has the potential to better integrate health, public health and social care. Embedding treatment and recovery within public health has the potential to open hearts, minds and eyes to the importance of prevention and upstream factors – and to enable better join-up with housing, employment and tackling health inequalities and exclusion.

However, there are also challenges and substantial risks with the new structures, responsibilities and commissioning arrangements. Despite the high political commitment to treatment and recovery, a curious thing has nonetheless happened: Government has enabled a situation where the investment in drug treatment and recovery is particularly exposed and therefore vulnerable to cuts. Localism – although it can mean different things to different departments – is a key driver.



DrugScope has been highlighting the risk of disinvestment since publication of the Health and Social Care White Paper in 2010. This has not been self-interested 'shroud waving', but a reasoned assessment of risks – if you like, a classic example of 'horizon scanning' or 'future-proofing', basic methods, tools and analysis which should be at the core of good policy making.

Last year the Government gave an assurance, in writing and at the DrugScope Chief Executives' Forum, that 'a protection' would be built into the new public health budget, providing a clear incentive for local authorities to continue to invest in treatment and supporting recovery. However, since the announcement on public health budgets in January, it has become clear - although it required DrugScope to patiently persist, over some time, with formal correspondence with officials and Ministers at the Department of Health - that no effective incentive mechanism exists; it has been buried and neutered under the complexity of the funding formula.

Drug and alcohol services are one of 17 public health responsibilities for local authorities - alongside preventing winter deaths, sexual health, smoking cessation, childhood obesity, and so on. The initial estimate was that previous spending on drugs and alcohol represented from April 34 per cent of the new public health budget. However, figures published this summer by the Department for Communities and Local Government suggest that in terms of planned spending, the percentage equivalent may be as high as 37 per cent.

The responsibilities of the National Treatment Agency were transferred to Public Health England in April. Around 160 former NTA staff - 'less one' - are now employed in an organisation with over 5,000 staff.

Some people in the sector were not sad to see the NTA go. However, whatever your views about its approach, the NTA was nonetheless effective in holding local drug and alcohol action teams and commissioners to account: on where the money was spent and on performance. While there was never a water-tight or legally binding ring-fence around the 'pooled treatment budget', it was nonetheless a form of designated funding – which could be tracked, monitored and held account to. The NTA never had the formal authority to tell people what to do, but it acted forcefully.

The explicit approach of Public Health England is that it is not in the business of telling local authorities what to do, nor 'performance manage'. Although former NTA staff have been transferred, internal lines of management and accountability have changed; in some areas, former NTA regional staff are being subsumed into new and competing areas of activity. PHE centres are apparently 'operationally independent'.

The 2010 Drug Strategy was intended as a high level document – unlike its predecessors, it sets goals and aspirations, but does not have an action plan. However, even despite this, it is becoming increasingly less important what Ministers at the centre think and wish in terms of delivery locally. The pendulum on localism may swing back, but currently the momentum underlines the importance of the views of local councils, officials and the local media.

Public Health England recognises the political importance nationally of drugs and recovery. The issue and test will be how this translates into influence and leadership. And whether the planned new Health Premium does genuinely incentive local authorities to maintain investment now - or will it become 'buried' under too much detail? .

There are some more formal buffers in place against disinvestment. For example, the NHS Constitution applies to public health. The NHS Constitution's potential force, relevance and influence needs to be addressed by the sector. Should a local authority take a policy decision not to fund certain types of drug or alcohol treatment - for example, residential rehabilitation - that may be open to challenge.

Service users and people in recovery have influence. I have not given the importance of service users and people in recovery sufficient priority today, but that is not to understate how they can shape, inform and help deliver the ambitions for recovery, nationally and locally. There is a growing and positive local movement - formally, there needs to be more focus on the opportunities to engage with Healthwatch. Nationally, there is a need to build and sustain a strong, collaborative and inclusive national voice.

Some final thoughts:

There are new and emerging issues to address, including new psychoactive substances and harms associated with so called club drugs.

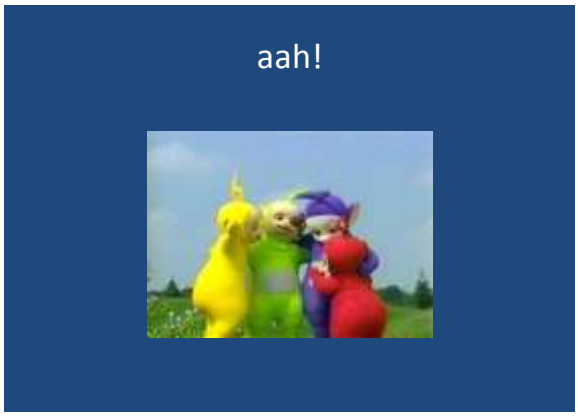
Commissioners and the sector have the opportunity - and should give - a much greater focus on meeting the needs of diverse and equalities groups: vulnerable women - including women involved with prostitution and survivors of domestic violence; LGBT groups - recognising the diversity and complexities when applying such a label as 'LGBT; and also with BAME - Black Asian and Minority Ethnic groups; people with disabilities and the needs of older people. People who can experience double if not treble-stigma.

The sector has made massive progress in recent years in working more collaboratively.

I genuinely believe that DrugScope has played a massive if not key role in that - with an emphasis on partnerships, collaborations, putting the interests of the sector, our members and particularly those impacted by drugs and alcohol first; even if at times this has not always been in the narrow or selfish best-interests of the organisation.

There are of course differences of view, philosophy and the sector is inevitably commercially competitive, and will become more so. But progress has been made. In these uncertain and challenging times, it is important that we avoid a return to polarisation - 'harm reduction' v 'abstinence' (and community v residential rehabilitation) - and that we avoid this...

but work closer to something (although perhaps a bit extreme and naive!) this.



And finally, a couple of quotes from one of my heroes which are perhaps pertinent to the environment today.

And finally...

- 'To see what is in front of one's nose needs a constant struggle.'
- 'It is curious how people take it for granted that they have the right to preach at you and pray over you as soon as your income falls below a certain level' – *George Orwell*

Thank you!"

December 2013