



# Drug treatment at the crossroads

What it's for, where it's at and  
how to make it even better



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DrugScope

*Drug treatment at the crossroads:  
what it's for, where it's at and how  
to make it even better*

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DrugScope is the national membership body for the drug sector. Our aim is to inform policy development and reduce drug-related harms – to individuals, families and communities.

We provide quality drug information, promote effective responses to drug use, advise on policy-making and good practice, encourage informed debate (particularly in the media) and speak for our members working in drug treatment, education and prevention and other areas.

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# Contents

Acknowledgements	iv
Foreword	v
Executive summary	1
<b>1 Introduction to The Great Debate</b>	<b>7</b>
1.1 Introduction	8
1.2 The background	10
<b>2. Key messages from The Great Debate</b>	<b>17</b>
2.1 Methadone and the parking problem	18
2.2 Being sensible about abstinence	22
2.3 Beyond abstinence versus harm reduction	26
2.4 Social (re)integration – making a reality of recovery	29
<b>3. Moving the debate on</b>	<b>35</b>
3.1 Next steps	36
3.2 Recommendations	38
3.3 Last words	42
<b>4. Appendices</b>	<b>45</b>
4.1 Key facts and figures about drug treatment	46
4.2 Glossary	57

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All quotations in this report are from DrugScope's The Great Debate seminars unless otherwise indicated.

# Foreword

As the national membership organisation for the drug field, it is part of DrugScope's remit to speak to the media about drugs and drug use, as well as to engage in dialogue and discussion around policy responses to these issues. One of our key aims is to raise public awareness and understanding around drug misuse, while informing the debate about drugs and drug policy.

For this reason, our spokespeople were busy in October 2007 when something of a media firestorm was ignited. A BBC report revealed that only 3 per cent of drug users had left drug treatment free of all drugs (including methadone) in 2006/07.

Subsequent press coverage was typical of much media reporting on drug treatment. The language was one of 'failure', of a 'waste of taxpayers' money' and of 'junkies' failing to quit their habits. The real people behind the numbers and their stories were largely unreported – those whose lives had been improved by drug treatment, but also those who felt that the system had let them down.

It is sometimes too easy to lay 'blame' at the media's door. While we are all aware that coverage of drugs and drug issues is frequently exaggerated, sensationalised or agenda-driven, we also have to acknowledge that the media rarely works in a vacuum. Without being fuelled by, or anchored to, a quote from an 'expert', politician or group of some sort, negative or hostile coverage usually fails to gain traction. In October 2007, all three weighed in.

The BBC report provided a catalyst for something which had been coming for some time. The fire took hold precisely because there was a debate developing in and around the drug field about treatment effectiveness, value for money and approach. Many critics of the system shared the view that there was too much focus on 'harm reduction' or 'stabilisation' at the expense of 'abstinence-based' interventions. More broadly, there was growing support for the view that we needed to be more ambitious for people in treatment.

With the effects of the media coverage still being felt, we decided to bring people together to discuss and debate drug treatment. We wanted to hear from people with different viewpoints and opinions, different philosophical and ideological standpoints – but people who also shared experience, knowledge

and a passionate desire to make things better. The lines for The Great Debate events held in 2008 were drawn.

*Drug treatment at the crossroads* is a distillation of the many voices and opinions heard at the events we held in Edinburgh, Manchester and London. Naturally, there was disagreement, but also a surprising degree of consensus between participants – not least the agreement that drug treatment deserves support and investment. And we are encouraged to learn that this belief in the importance of drug treatment is shared by the public. Over three quarters (76 per cent) of the people who responded to an ICM/DrugScope survey (February 2009) agreed that drug treatment is a sensible use of government money, so long as it benefits individuals, families and communities. This is an important and significant endorsement for investment in a system that benefits a stigmatised and marginalised group, at a time of straitened financial circumstances.

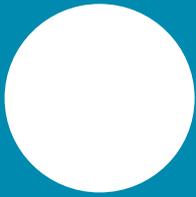
It is crucial that we stand up for drug treatment. There are many successes, of which those working in the sector can and should be proud. But we must ensure that open debate, informed criticism and, yes, expressions of passion, are not silenced or closed down. We must also recognise that the ultimate accolades must go to those drug users (and their families and friends) who have taken steps to improve not just their lives, but also those of their communities.

*Drug treatment at the crossroads* is about making the case for drug treatment and looking ahead to where we go next. It is also about ensuring that – working together – we have the necessary commitment, the tools and the vision, to make drug treatment in this country even better.



**Martin Barnes**  
Chief Executive  
DrugScope

*February 2009*



# Executive summary

In spring 2008, DrugScope hosted a series of seminars on the future of drug treatment. The Great Debate gathered together DrugScope members, along with other experts and stakeholders with direct experience of drug treatment, representing a range of different views and treatment philosophies. The object was to debate the results and prospects of drug treatment, and to inform and shape the wider public and political debate, at a time when sections of the media and some politicians were publicly claiming that the treatment system was failing.

## Key facts about drug treatment

- 1 The last decade has seen a substantial rise in the number of individuals in contact with drug treatment services.** In 1998/99 there were 85,000 clients engaged with treatment providers but ten years later this level had risen to almost 203,000. This represents an increase of about 238%.
- 2 Funding for drug treatment has increased over recent years, but now looks likely to level off.** Funding for drug treatment is provided by government via the Pooled Treatment Budget (PTB), combining monies from the Home Office and the Department of Health. The PTB rose from £142 million in 2001/02 to £396 million in 2007/08. The 2009/10 budget stands at £406 million. However, the numbers of clients in treatment is also increasing year on year. Despite the welcome investment in drug treatment, in real terms the amount of money available to spend per client has been decreasing each year.
- 3 As a service user accessing drug treatment in the UK, you are more likely to be prescribed a substitute drug such as methadone than you are to receive treatment in a residential rehabilitation centre.** In 2007/08, National Drug Treatment Monitoring System (NDTMS) data on treatment modalities shows that 131,110 people received substitute prescribing treatment. During the same period, 5,350 people received PTB-funded treatment in residential rehabilitation centres.

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- 4 **In recent years, the numbers of individuals discharged from treatment 'drug-free', meaning free of all drugs including legally prescribed opiate substitutes such as methadone or buprenorphine, has increased.** However, it is the case that the number of individuals leaving treatment 'drug-free' remains low as a percentage of the total number of people engaged with treatment.

### Key messages

Despite the different perspectives of participants, there was a high degree of consensus on a range of key issues.

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- 1 **Drug treatment is important.** There is clear evidence of the benefits of drug treatment for individuals, families, communities and society and it should remain a priority for public investment.
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- 2 **Choice in treatment should be promoted.** Drug treatment services should support both harm reduction and abstinence-based approaches. Methadone and other substitute drugs have a role in drug treatment, but services must also work with people on methadone prescriptions to help them (re)build their lives and move on in their recovery. Abstinence is a desirable outcome, but only where it is realistic and safely achievable.
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- 3 **The system must put people first.** Care pathways out of dependency must be more individualised, and that means putting service users at the centre.
- 
- 4 **Relationships matter.** As recognised in other fields, such as mental health, the values, competencies and attitudes of staff working in drug services can be as important as the particular intervention they are delivering.
- 
- 5 **We should all be aiming higher.** There is strong support for the increased emphasis on 'recovery' and 'social (re)integration'. Care pathways out of addiction are about a lot more than drug treatment. The emergence of recovery as a key concept for the drug sector provides an opportunity to address issues like housing and access to employment. But there are also risks, and it is important to recognise the formidable barriers that stand between many people in drug treatment services and a decent quality of life.
- 
- 6 **Families and communities need support too.** Drug treatment and the road to recovery are not only the business of specialist services. Families, friends, neighbourhoods and communities are a vital source of recovery capital, but have often been at the margins of debate about drug policy and drug treatment.

## Conclusion

There are certainly disagreements and differences of approach among people involved in the development and delivery of drug treatment services. At the same time, there is a wide area of consensus and the contours of a reinvigorated and enriched drug policy paradigm were discernible at The Great Debate meetings.

There was unanimous support for continued government investment in drug treatment, with some of the biggest critics of current policy, from both 'harm reduction' and 'abstinence' perspectives, arguing for greater investment, not less.

Overwhelmingly, it was agreed that we have made progress in improving access to drug treatment in Britain, and that this has delivered real benefits for the community in terms of health and well-being, social policy and crime reduction. The question is about how we move forward from here. Solid achievements could be lost, if respect for clinical judgement and evidence-based service provision is overridden by a dogmatic and ideological approach.

## Recommendations

The following recommendations were not discussed during The Great Debate events, but have been shaped by them.

### RESHAPING THE DEBATE

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- 1 **Politicians from all parties should publicly commit to an evidence-based approach to drug policy.** The advice of independent experts must be respected.

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  - 2 **The Government should fund, develop and implement a communications strategy to inform the public about the achievements of front-line drug services.** There is an urgent need to address negative attitudes and discrimination against people who are in or who have been in drug treatment.

### RIGHTS AND CHOICES

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- 3 **Drug treatment services must address diversity issues more effectively.** The EHRC and the NTA should work together to improve the responsiveness of drug treatment services to race, ethnicity, culture, religion, gender, sexuality, age and disability.

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  - 4 **Drug treatment should be provided in accordance with the new NHS Constitution.** This means that every service user entering drug treatment should be provided with a statement of their rights and responsibilities.

- 
- 5** **Drug service users should be involved in decisions about their treatment.** Every drug user entering the drug treatment system should have an effective and comprehensive care plan which should be regularly reviewed with a designated key worker. Service users must also receive clear and unbiased information about available treatment alternatives.
- 
- 6** **There should be further research on alternatives to substitute prescribing.** Psycho-therapeutic, psycho-social and abstinence-based approaches should all be investigated along with options for the treatment for a wider range of drug problems.
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- 7** **There should be further work to reduce drug-related deaths.** Abstinence-based services (including services in prisons) should be required to have robust policies for managing relapse and the associated risks, particularly overdose.

## WORKING TOGETHER TO IMPROVE OUTCOMES

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- 8** **All local drug partnerships need to develop effective partnerships with other local agencies.** These would include JobCentre Plus, housing providers and mental health services.
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- 9** **There should be clear recognition of the contribution of families, carers and other support networks to recovery.** Better support should be available to them (including appropriate financial support).
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- 10** **The next round of the Comprehensive Spending Review should introduce treatment outcome targets that include re-integration.** For example, we should be increasing the numbers of drug users moving into quality housing or education, training and employment, as a key policy priority.





# 1

## Introduction to the Great Debate

“There is a fundamental debate taking place out there about our work and our values. We need to lift our heads up from technical discussion and defend our right to develop philosophies of care which are about shaping recovery...

“Is it fair to say our field is in crisis at this point in time? Unfortunately, I believe it is. I believe this is because of two things. First, I think we are divided within. Second, increasingly there are attacks on drug treatment from outside – and these are becoming more virulent, sustained and widespread.”

*Ian Wardle, Chief Executive, Lifeline, The Great Debate, Manchester*

# 1.1

## Introduction

**“Drug treatment is such a large and complex issue, it sometimes seems the only way that we can get our heads around it is by shrinking it. But in the process of shrinking it we reduce its complexity, and by reducing its complexity we reduce our impact on the thing that we’re thinking about, because we’ve over-simplified it. The model that we use to think about a problem shapes our outcomes.”**

*Peter McDermott, Policy and Press Officer, The Alliance, and Non-Executive Director of the NTA, The Great Debate, Manchester*

In spring 2008, DrugScope hosted a series of seminars to debate the future of drug treatment services in the UK.

The Great Debate kicked off in Edinburgh in April and culminated with a session of the All Party Parliamentary Drug Misuse Group in the Palace of Westminster on 1 July. Along the way it took in debates in Manchester, Birkbeck College, London and the 2008 *Drugs and Alcohol Today* Conference at Islington Business Design Centre, London.

Among the speakers were influential contributors to recent debate about drug treatment, including Professor Neil McKeganey (Centre for Drug Misuse Research, University of Glasgow) and Mike Ashton (editor of *Drug and Alcohol Findings*). It was Mike Ashton’s article ‘The New Abstentionists’, published in *Druglink* in December 2007, that helped to frame The Great Debate. Participants included service users, carers, drug treatment providers, managers, commissioners, GPs and other health service professionals, providers of related services, academics, policy makers and others. Many were members of DrugScope, which is the national membership organisation for hundreds of service providers, managers and commissioners across the UK.

The result was a series of rich, nuanced and constructive debates. By bringing together the testimony of experts involved in drug treatment in a whole variety of ways, this report seeks to scope out the contours and parameters for constructive and informed public debate about drug treatment.

While there were areas of disagreement, there was a high degree of consensus among participants on three key issues:

- 1 There was broad consensus on the importance of continuing to improve drug treatment services, and agreement that this should remain a key priority area for public investment.** Public spending on drug treatment is the right thing to do for a society that is committed to providing routes into society for some of the most excluded and marginalised. It is also highly cost effective and delivers substantial economic and social benefits for taxpayers. There were, however, areas of disagreement on how this money should be spent in future and what the priorities should be in continuing to support and develop drug treatment provision.

- 2 There was widespread concern that public debate about drugs was becoming increasingly and unhelpfully polarised.** The large majority of participants believed both that there had been significant strides forward in drug treatment in recent years and that services can work better still.
- 3 There was agreement on the need to recognise the complexity of drugs as an issue and the complex needs of many people who walk through the doors of drug services.** There was agreement on the value of a more holistic and individualised conception of the recovery journeys of individuals with drug problems, as services work with them to rebuild often chronically damaged lives.

Many contributors also commented on the need to engage with a wider public on drugs and drug treatment; to avoid the jargon and technicality that make for narrow and inward-looking discussion, missing the bigger picture and dodging the fundamental issues; to correct inaccurate and stigmatising portrayals of drug service users, that can feed unhelpful and inhumane policy; to inform people about the work, and to persuade people of the value, of the drug treatment services that are operating in their communities.

It is hoped this report can make a contribution to this broader public debate.

“I am asking you questions and you can’t give me straight answers – and you say the media is giving a very negative image of what goes on in the drugs field. Well, how on earth do you expect lay people to be sympathetic, to be supportive, to be caring, when you’re not communicating with them? I don’t know what you are about or where you are going with this.”

*Journalist speaking from the floor, The Great Debate, Edinburgh*

“Of course the general public do not on the whole understand that maintenance is a positive intervention and of course they think the ideal is getting people off drugs and away from addiction altogether. That’s because largely we don’t ever bother explaining it. We have become so concerned to convince people to invest on the basis of fear, we seem to have forgotten how to ask them to invest on the basis of compassion.”

*Sara McGrail, Freelance Drug Policy Specialist, The Great Debate, London (Birkbeck)*

*The full text of Sara’s contribution to the debate can be found at [www.saramcgrail.co.uk](http://www.saramcgrail.co.uk)*

## 1.2

# The background

It is no coincidence that this series of debates occurred when it did – in spring 2008 – or that The Great Debate events at that time attracted sizeable audiences of people from diverse backgrounds, who were animated and passionate in their discussion of the issues. A lot had been going on, and there was a lot to talk about.

Specifically, the background to The Great Debate was provided by three – closely related – developments. Firstly, the rise in 2007 of what has been labelled ‘New Abstentionism’. Secondly, a growing interest in the concepts of ‘recovery’ and ‘social (re)integration’. Thirdly, the expectation of shrinking resources.

### **New Abstentionism**

When the NTA published its Annual Report 2007–08, it was able to report that 202,000 people accessed drug treatment that year. This represented 138 per cent of the original target for the NTA; the average wait for treatment to start was down to a week. By and large, drug services were retaining people in treatment for 12 weeks or more, defined as the minimum period for treatment to be effective; 77 per cent of people who commenced drug treatment in 2007–08 were retained for 12 weeks or longer.<sup>1</sup>

The question that remained to be answered – as the NTA itself had recognised in its Annual Report the previous year – was about the quality of treatment and about the outcomes that services are actually delivering for service users, families and carers, neighbourhoods and communities. Retention is a reasonable proxy measure for some of this, because the evidence base shows that the longer you keep people in treatment, the better the outcomes are likely to be. But it is no guarantee of good outcomes.

The opening lines of Mike Ashton’s article, ‘The New Abstentionists’, takes up the story: “Towards the end of October 2007 the NTA’s crime-reduction justification for investing in treatment wilted before the BBC’s straightforward

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<sup>1</sup> National Treatment Agency (October 2008), *Effective treatment, changing lives – Annual Report 2007 – 8*, p. 5 (<http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=34>)

“The purpose of this debate is to ensure that the voices of people with experience of drug services – as service users, carers, providers, managers or whatever – are heard, as well as those of politicians and journalists. The purpose is to help people to come to an understanding of what is meant by recovery, re-integration and abstinence – all these words that are around at the moment.

What are the opportunities and risks of rebalancing the discussion in this way? Why is this shift in the debate happening, and why now? What is the political – and perhaps the financial or economic – background? [...] What kind of evidence is there to feed into the discussion? How do we improve quality? What are the implications of all this for real services – for service users and communities?”

Professor Susanne McGregor  
London School of Hygiene and Tropical Medicine  
Chair, The Great Debate,  
Manchester

assumption that treating addiction ought to be about getting people off drugs. It was an emperor’s clothes moment from which the NTA took time to recover ... Their own figures showed that in England at the end of 2006–07, just 3 per cent of people in drug treatment that year were recorded as having completed it and left drug-free.”<sup>2</sup>

“In some ways,” Mike Ashton concluded, “the BBC’s intervention was a welcome return to forefronting what I’d guess most people think treatment should be about”<sup>3</sup> – a view that was being championed politically by the Conservative Party’s Social Justice Policy Group.<sup>4</sup>

In other ways, however, the impact has been unhelpful and has not led to rational and informed debate about drugs and drug treatment. The BBC’s report led to blanket – and highly misleading – claims that the drug system was ‘failing’. *The Daily Mail* complained on 31 October 2007 of a “£1.9 million bill to help just one drug addict kick the habit,” while *The Sun* declared that the “NHS blows £130 million curing 70 junkies” – both these reports viewed anything other than complete abstinence (including abstinence from substitute drugs like methadone) as failure.

David Davis MP, then the Shadow Home Secretary, was prompted by the BBC coverage of the NTA figures to write to the Chair of the House of Commons Public Accounts Committee asking for an investigation into drug treatment. He described public investment in treatment as “massive failed expenditure”, commenting: “this is an absolutely shocking revelation which speaks volumes about the Government’s incompetence and distorted priorities. It is yet more evidence why we should focus spending on getting addicts off drugs, and not just spend money managing their addictions.”<sup>5</sup>

It is entirely legitimate to raise questions about the use of substitute drugs like methadone. It is worrying, however, when the media and politicians enter into what are essentially clinical debates in ways that misrepresent the facts and politicise treatment options. The public should be presented with the full facts:

### **The use of methadone and buprenorphine as treatments for opiate dependency is recommended by the National Institute for Clinical Excellence (NICE).**

It is unusual to find broadcasters, newspapers and politicians attacking a statutory health authority like the NTA for operating within clinical guidelines, or to characterise NICE recommended treatment for

2 Mike Ashton (2008), ‘The New Abstentionists’, *Druglink* Insert, Jan/Feb 2008, DrugScope ([www.drugscope.org.uk/Documents/PDF/Good%20Practice/newabstentionists.pdf](http://www.drugscope.org.uk/Documents/PDF/Good%20Practice/newabstentionists.pdf)).

3 *Ibid.*

4 Centre for Social Justice, Addiction Working Group (December 2006), *The State of the Nation Report – Addicted Britain* (at <http://www.centreforsocialjustice.org.uk/default.asp?pageRef=192>)

5 More recent media stories about prisoners who were refused methadone and effectively subject to forced detox in the prison system have prompted similar responses. When these prisoners were awarded damages of around £4,000 each for a breach of their human rights, one senior opposition politician commented in *The Daily Mail* that “it is a breach of no-one’s rights, let alone prisoners, to be denied drugs to help sustain their illegal habit.” *The Sun* quoted Mark Wallace, a spokesman for the Taxpayers’ Alliance, who declared that it was “disgusting that law abiding taxpayers had to stump up because addicts weren’t allowed to take drugs in prison.” A year later – in November 2008 – *The Sun* in Scotland was declaring “£26 million – That’s what you pay per year to keep junkies on methadone.”

drug dependency as simply a way of helping drug addicts to 'sustain' their 'addictions'. It is also unusual for a report from a health authority that shows that it has exceeded its performance targets, increased treatment capacity and slashed waiting times to be described as a complete failure of the system. There are grounds for some concerns but there is also a need for a recognition of substantial progress and a sense of perspective.

**The public are not being presented with the full picture on the costs and benefits of investment in drug treatment.** There is abundant evidence that investment in drug treatment is an effective way of reducing overall expenditure of taxpayers' money, because of its impact on criminal justice, health and other social costs. Moreover, as the Centre for Social Justice report makes clear, a more abstinence-focussed treatment system would require more public money for treatment, and not less. No one involved on any side in The Great Debate wants to see people left to cope without good quality and evidence based treatment, or doubts that this would be both unethical and a health and social policy disaster.

All this said, isn't it simply obvious that the purpose of the drug treatment system should be to get people off drugs – including substitute drugs?

What about people who are not able to achieve abstinence – at least, not yet? What about people who achieve abstinence for a while, but relapse when things start to go wrong in their lives? What about people who simply can't face the abuse and trauma that has scarred their lives without using drugs, unless they have access to intensive psychological support? Or who can't get it together until they've somewhere to live and something else to live for? What about people who succeed in reducing their drug use or switching to less harmful drugs, but not in getting off drugs completely? What about the tens of thousands of people who have begun to rebuild their lives, to end their dependence on illegal drug markets and/or to move on from criminal lifestyles, by using substitute drugs like methadone and buprenorphine?

**"Sooner or later we are going to have to provide services that are focussed on getting addicts off drugs, even if the treatment industry does not really rate that as a goal."**

*Professor Neil McKeganey, Centre for Drug Misuse Research, University of Glasgow, The Great Debate, Edinburgh*

**"Radical ... reform of treatment is needed towards holistic and abstinence-based approaches. It is about facing the fact that abstinence is the most effective method of treatment and the only appropriate one for many addictions."**

*Social Justice Policy Group (Chairman: Rt Hon Iain Duncan Smith MP), Breakthrough Britain, Volume 4 – Addictions, Policy Recommendations to the Conservative Party, July 2007*

## **'Recovery'**

Another obvious way of assessing the quality of outcomes that the drug treatment system is delivering for its clients and the wider community is to look at the sorts of lives it is supporting people who have experienced drug problems to build or re-build.

How effectively is the drug treatment system working with other key agencies to secure decent and stable accommodation for clients who have nowhere to live? What about their general health and well-being? Is it supporting people to put relationships back together and rebuild family support networks? How many people who enter drug treatment services with skills gaps, and/or who are unemployed, are being helped into education, training or work?

The term 'recovery' was very much the buzz word coming into The Great Debate in spring 2008. It is often used to describe a vision and vocation for drug treatment that is less fixated on clinical indicators and quantitative targets, and more concerned with 'social' (re)integration and qualitative outcomes.

**"What do we mean by recovery? We mean a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society. Furthermore, it incorporates the principle that recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment. In short, an aspirational, person-centred process."**

The road to recovery: A new approach to tackling Scotland's Drug Problem, *The Scottish Government, May 2008*

**"The goal of all treatment is for drug users to achieve abstinence from their drug – or drugs – of dependency. For some, this can be achieved immediately, but many others will need a period of drug-assisted treatment with prescribed medication first. Drug users receiving drug-assisted treatment should experience a rapid improvement in their overall health and their ability to work, participate in training or support their families."**

Developing new approaches to drug treatment and social integration  
Drugs: Protecting Families and Communities – The 2008 Drug Strategy, *Home Office 2008*

**"The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society."**

*UK Drug Policy Commission, Consensus statement on recovery, 2008*

“In Scotland, they’ve found that if you pitch an uncompromising and virulent abstentionist lobby against a passionate and committed harm reductionism, you’ve got a recipe for an argument with the potential to go on for ever and ever. They’re now trying to break that deadlock by taking on board what they call ‘the philosophy of recovery’ and hoping that both can find some common ground there.”

*Ian Wardle, Chief Executive, Lifeline, The Great Debate, Manchester*

## Money

The major expansion of treatment highlighted by the NTA in its 2006–07 report has been made possible by significant increases in spending over the past ten years. The NTA calculates that in 2007–08 the total expenditure on drug treatment, excluding prison-based treatment, was £597 million.<sup>6</sup> Cost benefit claims have been made for drug treatment, with the Home Office website currently citing NTORS research that claims that for every £1 invested in drug treatment, at least £9.50 is saved in criminal justice and health costs.

But will investment continue at these levels in more straitened economic and financial circumstances?

There is a sense in which investment is falling already. While the overall spend on treatment has more than doubled since 2001–02, there has also been a huge expansion in the numbers of people entering treatment. The spend per service user has been falling year-on-year since 2002. The Government has now announced a standstill in the absolute level of central funding until 2011, requiring ‘efficiency savings’ of £50 million a year.

With economic pressures threatening to squeeze public spending, it is easy to envisage a further contraction in investment in drug treatment.

“[The] pooled treatment budget ... will stay static over the next three years and that is a very significant challenge. But remember, although it will stay static over the next three years, in 2000/2001, central government support for drug treatment was sixty million. This year, it’s four hundred million. The reason we believe we can meet these challenges, with a flat budget, is because so much money has already been pumped into the system, we believe we can drive enough efficiencies to deliver this challenging agenda.”

*Paul Hayes, CEO National Treatment Agency, NTA National Conference 2008*

<sup>6</sup> National Treatment Agency (April 2008), *Better treatment, better outcomes – Annual Report 2006–07*, p. 4–5





# 2

## Key messages from The Great Debate

**“When we get better, drug treatment services like to take the credit and when we get worse they like to give us the blame. And my experience is that we’re exactly the opposite way around.”**

*Peter McDermott, Service User, Policy and Press Officer, The Alliance; Non-Executive Director of the NTA, The Great Debate, Manchester*

**“If you are under attack, form a circle, but remember to shoot outwards.”**

*Professor Susanne McGregor, London School of Hygiene and Tropical Medicine, Chair, The Great Debate, Manchester*

## 2.1

# Methadone and the parking problem

**Methadone and other substitute drugs have a role in drug treatment, but services are too ready to 'park' people on methadone.**

**Intervention from floor:** "Does Peter McDermott really think he is on a recovery path using methadone every day?"

**Peter McDermott:** "Yes, I absolutely do. I see it as no different to someone using insulin to manage diabetes. For me recovery is any change in a direction that can improve the quality of your life ... that is a recovery path. Any path that moves people away from chaos, discomfort and the miseries that a chaotic drug user can experience, to any point that is an improvement on that ... is recovery as far as I'm concerned."

**Floor speaker:** "Well, [...]for nearly 20 years I was a service user who was using methadone. I'd been a chaotic user and a career criminal. They said I'd never come off methadone, but I have and I feel recovery is now real for me for the first time. Why are treatment services allowed to tell people that they'll never be able to come off methadone? I think it is disgusting. Everyone should be offered the full range of options. For 19 years I thought I needed to take methadone every day ... but, you know what? It wasn't true ... I now know it was a lie."

**Peter McDermott:** "But denying methadone patients the status of recovery is really stigmatising. We've recruited over a hundred thousand people into methadone. If we now abandon them to some second class status within the recovery movement, that is unacceptable ... [I]t is morally unacceptable for the drug treatment field. And I'm speaking as someone who is really quite excited by the rigour and obvious strength of recovery networks. I think their contribution to the field is absolutely seminal in shifting our opinions and demanding we raise our game in the variety of what we offer, but we absolutely cannot and must not abandon people who are on opiate substitute treatment .... [T]hey're already second class citizens in our society and if, as a result of the change in direction we take we further relegate them, then we are doing them a double disservice."

**“If you are asking people who can just about walk to run a marathon, don’t be surprised if some of them perish in the hot sands ... [W]e must be very careful ... because there is no doubt that the research over 45 years says exactly the same thing – every country, every model: it says drug use reduces when you give somebody a substitute – it says that mortality improves, morbidity improves, people’s lives are healthier and they are more likely to engage.”**

*Speaker from the floor, The Great Debate, Manchester*

There has been particular concern about the widespread use of substitute drugs, particularly methadone (the other main substitutes used are Subutex, or buprenorphine, but methadone is much more widespread).

Methadone is a synthetic opioid, which is used to prevent people from experiencing withdrawal effects from heroin and other opiate drugs. It has long duration effects and does not provide the same ‘high’ or ‘rush’ as drugs like heroin. This means that it can help to stabilise lives, prevent drug withdrawal and end (or meliorate) reliance on illegal drug markets, with the associated costs and risks. Some service users say that the doses of methadone they are given are not sufficient to prevent withdrawal and discomfort. Many experience unpleasant side effects, including nausea, constipation, weight gain, dental decay, insomnia, impotency, blurred vision and depression. However, many are positive about the impact that methadone has had on their lives, and the role it has played in their recovery.

Sometimes people prescribed methadone will also be using street drugs. At Manchester, the parent of a long-term heroin user complained that her experience was that many drug users were “using methadone as a top up when they can’t get heroin.” Peter McDermott said that he had continued to use other drugs when initially prescribed methadone. He saw methadone as something that could “make my life a bit easier and take away the pressure to score street drugs all the time.” By initiating engagement with drug services, it pushed him into “a form of recovery” – within five years he was “no longer using illegal drugs at all.”

Why the concerns about the treatment system’s reliance on methadone?

An NTA audit of prescribing in England was published in June 2006 based on 242 returns to a questionnaire sent to specialist drug services in 2005. These services engaged a total of 51,482 clients, of whom 38,335 (74.5 per cent) were prescribed opioids as part of their treatment. The majority – 30,901 clients – were prescribed methadone. The audit revealed a sharp and substantial rise in methadone and other substitute prescribing, although it noted that this was during a period when the overall numbers in treatment increased sharply.<sup>1</sup>

There are concerns that services are over-dependent on methadone. There is a particular concern about the use of methadone not simply to stabilise people’s lives while other interventions kick in, but over many years (so-called ‘methadone maintenance’).

## Key messages on methadone

### MESSAGE 1

**There is a strong evidence base for substitute prescribing, but that may be partly because more has been invested in researching it.** In a Technical Appraisal published in January 2007, NICE recommends both methadone and buprenorphine as treatments for people with opioid dependencies.<sup>2</sup> It was

<sup>1</sup> David Best and Angela Campbell (June 2006), *Summary of the NTA’s National Prescribing Audit*, Research Briefing 19, National Treatment Agency.

<sup>2</sup> National Institute of Clinical Excellence (2007), *Methadone and buprenorphine for managing opioid dependence* – Technical Appraisal (TA114) at [www.nice.org.uk/Guidance/TA114](http://www.nice.org.uk/Guidance/TA114)

argued by some Great Debate participants that a big investment in research on substitute prescribing itself reflected (and reinforced) a medicalised approach to drug treatment.

“If there is not as much evidence for interventions other than methadone maintenance, this may well be because of a lack of rigorous inquiry, rather than because these interventions are not actually effective.”

*Paolo Pertica, Head of Blackpool Community Safety and Drug Partnership, The Great Debate, Manchester*

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**MESSAGE 2**    **We need to acknowledge the progress people can make on substitute drugs.** We need measures that can capture the progress towards recovery of people who are still on substitute drugs.

“The most pressing challenge ... is that while on methadone or any substitute drug, users describe how they felt more together in themselves, but were not perceived this way by other people. They had made a big change. But the perception of those around them – including peers, family, community, media and some workers – was that they were still ‘junkies’; they had merely changed their addiction from illicit drugs to legally prescribed ones.”

*Jason Wallace, Service User, Scottish Drugs Forum, The Great Debate, Edinburgh*

“My concern ... is that [...] the emphasis on treatment completions and treatment exits will mean that all those people who successfully make progress on recovery while remaining on methadone and in treatment, don’t show up as having been helped – it would be nice to come up with a way to count those successes as well.”

*Speaker from the floor, The Great Debate, Manchester*

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**MESSAGE 3**    **There is a broad consensus that simply ‘parking’ people on methadone is not good enough.** Giving people methadone does nothing directly to sort out other issues in their lives, which often provide the causes and contexts of their substance misuse problems.

“Drug treatment – whether it is focused on abstinence or maintenance – in and of itself is not going to solve the underlying problems that can make drug use problematic. Poverty ... is not

soluble in methadone hydrochloride. Nor is a decrepit education system, or a lack of challenging and satisfying employment, or a shortage of decent housing.”

*Sara McGrail, Freelance Drug Policy Specialist, The Great Debate, London (Birkbeck)*

“There are quite a few people who work in the drug treatment system who do see methadone as about control, ... who have very low expectations [of] and aspirations [for] the people they work with ... [and] who do not have faith in the ability of service users to make positive changes in their lives.”

*Peter McDermott, Policy and Press Officer, The Alliance, and Non-Executive Director of the NTA, The Great Debate, Manchester*

#### MESSAGE 4

**‘Parking’ people on methadone has been encouraged by the crime reduction focus of recent drug policy.** Methadone can end (or reduce) dependence on illegal markets, and therefore the need to raise money to pay for drugs – which can be linked to acquisitive offending such as shoplifting and theft. By focussing on the drug-crime link, this paradigm has reduced public sympathy for service users, and the perception of them as patients who need care and support.

“The more our centre of gravity has shifted towards this criminal justice ghetto, the more punitive and isolated we have become from the hopes and aspirations of the people who use our services. We need to take a long hard look at our philosophies of care – in particular, we need to raise the question of whether our harm reduction philosophies have survived their sustained exposure to a criminal justice model.”

*Ian Wardle, Chief Executive, Lifeline, The Great Debate, Manchester*

“Turning up at the CAT team once a fortnight, being handed a methadone script and going back out the door again ... that is no use to anybody. Effective treatment needs to be substitute prescribing hand in hand with other things ... Effective treatment is about community-based programmes where people can sit down with a key worker, develop a care plan, look to where they want to go and how they are going to achieve it, and regularly reviewing that care plan – substitute prescribing has a role in all this, but it is not a substitute for it.”

*Service user and volunteer with the Scottish Drugs Forum, The Great Debate, Edinburgh*

## 2.2

# Being sensible about abstinence

**There was wide agreement at The Great Debate that abstinence is a desirable outcome, but only where it is realistic and safely achievable – often it is not (at least, not yet).**

**“Only once someone has attained this state of grace – ‘abstinence’ – are they granted assistance with such vital tools as education, training and housing. The view is that someone who is still ‘dirty’ wouldn’t be able to make use of such things.”**

*Dr Eliot Ross Albert, Director of the UK Harm Reduction Alliance and founder member of the London User Forum, The Great Debate, London (Birkbeck)*

**“I have never said that methadone is not suitable for some people. It certainly is. But it is not suitable for 22,000 addicts in Scotland, because that must be virtually everybody in treatment.”**

*Professor Neil McKeganey, The Great Debate, Edinburgh*

**“Detoxification, without all the things that should be going with it, is a bit like jumping off a cliff. Some people smash at the bottom.”**

*Mike Ashton, The Great Debate, Edinburgh*

‘Freedom’ from substitute drugs is certainly desirable where achievable. They often have unpleasant side-effects, and impose other constraints on people’s lives (for example, supervised methadone consumption can make it difficult to take up training or employment opportunities).

Many service users say that their aim is to become drug-free. But if this was easy to achieve, then drug problems and drug treatment would be a lot more straightforward than they actually are. Attempting abstinence prematurely or without proper support can undermine confidence, result in a disengagement from services, set back recovery and result in significant harms to service users, families and carers and the wider community.

In extreme (but, regrettably, not infrequent) cases, drug detoxification without proper support is associated with drug-related deaths: if people start using drugs again, a loss of tolerance can result in overdose. For example, high rates of drug-related deaths among recently released prisoners are often the tragic consequence of people returning to opiate use after a period of abstinence or reduced consumption.

A recent Probation Circular (PC23/2007) called *Reducing the risk of drug-related deaths* states that newly released male and female drug-using prisoners are 29 and 69 times more likely, respectively, to die during the first week of release from prison compared to their peers in the community. A key risk factor is loss of tolerance. It explains that “on release from prison an offender could

overdose by using the same amount of the drug that he/she used before they went to prison.”<sup>1</sup> (It is also explained that methadone-related overdoses among recently released prisoners are generally the result of released prisoners buying methadone illegally from people in treatment who may have significantly higher tolerance levels than them.) There were a total of 1,382 drug-related deaths in 2005.

## Key messages on detox and abstinence

**MESSAGE 1** **The relationship between detoxification, methadone and drug-related deaths is not straightforward.** Detoxification increases the risk of drug-related harm from loss of tolerance and overdose.<sup>2</sup>

This does not mean detoxification is a bad thing, it means that it has to be done at the right time, with the right people and in the right way. So Tim Leighton argued at Edinburgh that there is no evidence of a link between “properly supported abstinence” and higher rates of mortality. He continued that “crass abstinence-based treatment can really traumatise people ... and I’ve been working within the system to try and minimise that. Men and women are at risk of being dumped into something for which they have not been prepared and which can have a harmful effect on them.”<sup>3</sup>

Another contributor to the debate at Edinburgh argued that the risks of drug-related deaths and health problems had to be understood in the wider context of people’s lives – with many clients having multiple needs and problems (for example, homelessness or lack of access to primary care services). She said that “people who die of drug-related deaths have multiple complex issues” and that “methadone – and their drug use – are only a small part of the overall issues that are affecting them.” She complained that “often it is about services not communicating with each other to identify those people that are at highest risk ... When you turn up to drug-related death meetings everybody has got copious amounts of information on the person who has died, but very few of the services have actually been talking to each other.”

- 1 Probation Circular PC23 (2007), *Reducing the risk of drug-related deaths*, p. 2 ([www.probation.homeoffice.gov.uk/files/pdf/PC23%202007.pdf](http://www.probation.homeoffice.gov.uk/files/pdf/PC23%202007.pdf))
- 2 See, for example, the NTA guidance *Reducing Drug-Related Deaths (2004)*, which explains that ‘recent evidence suggests that detoxification may carry a significant overdose risk for those who are “successful” (in initially achieving abstinence)’. In particular, it cites, *Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow-up study*. John Strang, Jim McCambridge, David Best, Tracy Beswick, Jenny Bearn, Sian Rees, Michael Gossop. *British Medical Journal*, May 2003; 326. The evidence on links between detoxification and drug-related harm (including drug-related deaths) are also examined in Mike Ashton’s ‘The New Abstentionists’.
- 3 In Manchester, Paolo Pertica argued that we need to take a longer term view of the relationship between treatment modalities and risks of drug-related deaths. “How many of those on methadone maintenance are using other drugs as well?” he asked. “What will the long term effects of methadone maintenance be on the liver?” (He also questioned whether it was appropriate to compare people who had *dropped out* of abstinence-based programmes with people who were *still in* maintenance programmes.) A debate participant who was involved in research into drug-related deaths, argued that “not very many people die of methadone... Of those who do, the point has already been made that much of it is illicit.”

“Someone said that detoxification kills. As is often the case when we have a headline like that – and that is a headline – he then went on to say this applies if it is supplied by cowboys, who don’t know what they are doing, to the wrong people.”

*Brian Kidd, Deputy Chair, Scottish Association of Alcohol and Drug Action Teams, Chair, The Great Debate, Edinburgh*

**MESSAGE 2**

**There is broad agreement that abstinence is marginalised within drug treatment provision.**

For example, one floor participant in Manchester who described himself as a ‘hard core harm reductionist’, was nonetheless concerned that “when people say they want to stop using, they’re told that ‘you are not ready yet’”, adding “I’ve worked in the field for twenty years and I don’t think it is my decision to say to someone ‘you are not ready.’”

Richard Phillips, speaking at the London (Birkbeck) Great Debate, felt that “there appeared to be a crisis within the residential rehab sector ... this form of treatment has been severely marginalised in the overall drug treatment system to the point that it has been in decline for the last few years [...]. In this country”, he concluded, “it has been the abstinence-based services that have been in decline and outside of the policy and planning loops.”

“You can have a system that can support those who are not willing or able to get ‘clean’ – and you can help them with interventions such as methadone prescribing – but at the same time we should be able to help and support those who wish to become drug-free. Aside from anything else, this is about client choice. Yes, by all means, there are clients who wish to be on methadone, but there are also others who do not want to be, and there should be services for them too.”

*Paolo Pertica, Head of Blackpool Community Safety and Drug Partnership, The Great Debate, Manchester*

**MESSAGE 3**

**Service users must be involved in decisions about their own treatment.**

The fact that many service users say they would ideally like to become drug-free does not mean they are ready for abstinence. Conversely, service users have the right to have their own informed decisions about treatment taken seriously by service providers. In other areas of medicine, patients may opt for treatments that have some risks attached because they believe these are outweighed by the potential benefits.

“I think we have become very risk averse in substance misuse. We have got to a point, because people say detoxification kills, where we are not prepared to let people try and come off drugs because we are terrified that they are going to die... But ... the

challenge is about detoxifying people in the right circumstances, ... involving people in decisions about their care, and setting the risks before them. If you had cancer, a doctor would sit down with you and lay out the options for you, ... treating you like a human being and allowing you to make choices about that.”

*Brian Kidd, Scottish Association of Alcohol and Drug Action Teams, Chair, The Great Debate, Edinburgh*

“I started asking ‘What is your service about? What do you mean by treatment? How can my son access this treatment? How do you evidence this treatment? [...] What is the success for outcomes of people moving on from methadone?’ The thing that shocked me most is that people closed ranks on me. I would say, if there is anything to learn from today, it is that people do need to have evidence of outcomes. We do need solid research. We also need to listen to what service users are saying. It is about having meaning and connection in their lives, it is about understanding how they are going to be able to move forward.”

*Carer, speaking from the floor, The Great Debate, Edinburgh.*

## 2.3

# Beyond abstinence versus harm reduction

**Drug treatment services should support both harm reduction and abstinence-based approaches. There are many routes into drug dependency and many journeys out of it.**

**"We should be moving people who have been on methadone, who have attained the much wanted stability ... into a drug-free environment where possible, because that gives them the opportunity for full recovery, not just stabilised ongoing drug use."**

*Professor Neil McKeganey,  
Centre for Drug Misuse  
Research, University of  
Glasgow, The Great Debate,  
Edinburgh*

**"I have to confess, I have no little trouble fathoming how on earth we have ended up here, once again engaged in the obsessive navel-gazing that is the debate about whether the focus of treatment should be abstinence or maintenance?"**

**"It's just not a question that I can identify with, because people experiencing drug treatment need the opportunity to choose the interventions that work best for them. This might change through someone's drug using career, with needle exchange, drop in, prescribing, inpatient and community detox and residential or community rehabilitation services coming into play at different points for different people. Sometimes, as we know, people will not move through these interventions in any convenient linear mappable way, but may well drift in and out of treatment over a protracted period of time.**

**"So is the aim abstinence? Yes. Is it maintenance? Yes. Do we need harm reduction? Yes. Is prevention important? Yes.**

**"There is no right or wrong answer and really there should be no debate about this. There is no "one size fits all" solution to the problems people who use drugs face. I have as little time for people who say everyone needs a script as I do for those who say everyone needs to go to a fellowship group."**

*Sara McGrail, The Great Debate, London (Birkbeck)*

There were differences of opinion at The Great Debate meetings on the best balance between abstinence and harm reduction approaches, but nobody at any of the sessions argued (at least explicitly) for either extreme abstinence (and the exclusion of harm reduction services) or extreme harm reduction (and the exclusion of abstinence-based services). The need for both types of service is a matter of broad consensus, it is the appropriate balance and relationships between them that is at issue.

“... within the political sphere, I think there is reason to be anxious. [...] There is a real question about how the field positions itself in this debate and within the political argument to make sure that we don’t allow the politics to pose a threat to continued investment in harm reduction. But we need to be clear that abstinence-oriented services are at risk too. There has been a real terms reduction in overall numbers of people going into residential rehab over at least a two year period and a reduction in the overall number of beds within the sector. It is very difficult to reopen these facilities once they’ve been closed ... I believe we all need to defend the existence of abstinence-based provision within a system with an overall focus on harm reduction.”

*Richard Phillips, Independent Consultant – Substance Misuse, The Great Debate, London (Birkbeck)*

## Key messages taking us beyond abstinence versus harm reduction

**MESSAGE 1** **There are a variety of routes into drug dependency and a variety of journeys out of it.** Recovery journeys are various, complex and require different forms of support and engagement at different points, in what can be a long process. We need a range of evidence-based services that provide the right kind of help in the right way at the right time.

**MESSAGE 2** **Care pathways out of dependency must be individualised, which means service users themselves must be at the centre of the process.** If a range of services is available, how do we decide which service is best for a particular individual at a specific time? This requires a combination of needs assessment (for example, through care planning) and a responsiveness to informing and supporting service users to make their own decisions.

A GP working with drug users commented at The Great Debate in London (Birkbeck) that neither abstinence nor harm reduction were ‘best’ in any abstract or generalisable way. This was because “people’s recovery needs to be individualised and tailored to the approach most suitable to their needs,” working from a position of “What is right for them?”.

“Treatment services can be incredibly egotistical about their role and their importance in someone’s recovery ... We get bogged down in a debate about harm reduction or abstinence that probably does not mean a huge amount to a lot of service users. We should be focussing on the individual service user’s perspective and how they define their pathway to recovery.”

*Speaker from the floor, The Great Debate, Manchester*

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**MESSAGE 3**    **The way services are delivered and the way they relate to service users is important.** As in other fields, such as mental health, the values, competencies and attitudes of staff working in drug services is as important as the particular intervention they are delivering and possibly more so.

“People can change, their lives can be turned around, but by special people who stick with their clients and can instil optimism and hope, and whose relationships often go well beyond treatment to include more subtle things – intensive case management, supported housing, support into employment, etc.”

*Paolo Pertica, Head of Blackpool Community Safety and Drug Partnership, The Great Debate, Manchester*

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**MESSAGE 4**    **The relationship between harm reduction and abstinence-based services is important.** Services are too inclined to work in silos, failing to facilitate the kind of recovery journeys that make best use of the full range of available services given the particular needs and choices of service users.

“What we should be doing is drawing abstinence-based and harm reduction services closer together and understanding what the relationship between them should be.”

*Richard Phillips, Independent Consultant – Substance Misuse, The Great Debate, London (Birkbeck)*

## 2.4

# Social (re)integration – making a reality of recovery

**People with serious drug problems are often stigmatised, socially excluded and marginalised. It is important to recognise the formidable barriers that stand between them and a decent quality of life.**

**“What is needed, ultimately, is decent social policy to meliorate the dire social conditions, endemic poverty and decrepit housing and education systems which leave so many of the under-privileged seeking solace and escape from their social world.”**

*Dr Eliot Ross Albert,  
Director of UK Harm  
Reduction Alliance and  
founder member of London  
User Forum, The Great  
Debate, London (Birkbeck)*

**“When people start getting into that hole of addiction, we push them further down and then we haul up the ladder so they can’t get out ... We systematically dismantle all the things they could haul themselves out with. Their homes are gone, they are criminalised, they are stigmatised, they lose touch with their families. No one wants to know them, no one wants to house them,[...] they have no hope of a job. This is something that society does to them. It makes it impossible for them to recover and then society says ‘ah you have got a chronic relapsing condition, haven’t you?’ ... Of course they relapse when we treat them in this way.”**

*Mike Ashton, Editor, Drug and Alcohol Findings, The Great Debate, Edinburgh*

Many people in the drug treatment system have multiple needs and damaged lives. People will struggle to tackle a drug problem successfully if they face stigma and marginalisation, homelessness and/or have no access to training, employment, or other meaningful activity.

Care pathways out of addiction are about a lot more than drug treatment *per se*.

A valid objection to a system that is over-reliant on ‘parking’ people on methadone is that it has done too little to support service users to access social capital and move on with their lives.

A valid objection to simplistic variants of New Abstinence is that it is not realistic to expect people to become drug-free, so long as problems from their past are unaddressed (such as experience of trauma and abuse), problems in their present persist (such as homelessness), and they see little prospect of a better future for themselves (for example, of meaningful employment or of reconnecting with families).

“What services need to realise is that they [should] be answering the question ‘is their service contributing to a client believing that life is better in treatment than it was when they were using drugs?’”

*Speaker from the floor, The Great Debate, London (Birkbeck)*

“To focus on whether somebody is using drugs is to miss the point ... What matters is the quality of their lives and their contribution to society.”

*Dr Eliot Ross Albert, Director of the UK Harm Reduction Alliance and founder member of the London User Forum, The Great Debate, London (Birkbeck)*

“Part of the reason I think we get into such confusion over this is we are using the wrong language, the wrong models – the wrong everything – for the wrong debate. We are talking about ‘harm reduction’ ... about ‘treatment’ ... about ‘abstinence’, but these are all medical ideas. Drug use is a poverty issue ... It is largely an issue of deprivation ... When we have a child with asthma we give them an inhaler. We don’t go around to their house and get rid of their damp.

“We are all on little islands trying to deal with individuals living in absolute poverty – not just poverty of money, but poverty of aspiration and education. That is a huge job and it is why people relapse. When we use language like abstinence, treatment and recovery, we are using medical language for what is a social care issue.”

*Speaker from the floor, The Great Debate, Edinburgh*

## Key messages on recovery and (re)integration

**MESSAGE 1** **Recovery does not have to mean abstinence.** If people only have access to things like housing and meaningful activity after they have become drug-free, then they get access to the social capital they need to beat dependency only after it has already been beaten. It is a Catch 22.

“Focusing on abstinence as a requirement for other services, such as housing, denies people whose short term goals will never include abstinence the opportunity and support to further move on in their recovery. In particular, we feel that moving people away from inadequate housing would help to move drug users on to becoming drug-free in the long term.”

*Jason Wallace, Service User and Volunteer, Scottish Drugs Forum, The Great Debate, Edinburgh*

**MESSAGE 2** **For many service users, recovery is a long and winding road – not one bound and you’re free.** The NTA’s *Models of care for treatment of adult drug misusers: Update 2006* states that “drug treatment is not an event, but a process usually involving engagement with different drug treatment services,

perhaps over many years.” The NTA cites evidence from the United States which concludes that an average time in treatment for problem drug users is five to seven years. Few problem drug users who enter treatment will be ready to leave the system in a few weeks or months.

“The situation is very similar for ex-homeless clients: you can’t remove the substance use without all the other services being in place. Harm reduction or abstinence doesn’t matter, it comes down to the need to improve an individual’s quality of life over all else. This means recognising the complexity of people’s lives and support needs and that, for some people, success will not be measurable in a twelve week period. It may take two to three years to see improvements and individual treatment successes.”

*Speaker from the floor, The Great Debate, London (Birkbeck)*

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**MESSAGE 3**    **The barriers that prevent problem drug users from accessing things like housing and employment are serious and entrenched.** Where are housing and employment for people with serious long-term drug problems going to come from? What about the stigma and discrimination that confronts people in drug treatment as they work to (re)build their lives? What about people whose needs are so complex and acute that they will not be ready to (re)enter the mainstream economy for the foreseeable future?

“I think there is a consensus now about services moving away from medicalised treatment to these new social approaches, but there is not yet really a recognition that they are going to have to be very intensive and resource heavy if they are going to work, because you are addressing the needs of people with multiple and complex problems.”

*Speaker from the floor, The Great Debate, Edinburgh*

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**MESSAGE 4**    **Employment is important – but it is very difficult for many people in drug treatment to get into education, training or work.** In Edinburgh, a service user volunteer with the Scottish Drugs Forum made clear that work was a priority for many drug service users. Areas that service users wanted more help with included “housing and council tax arrears, money and finance advice and information, access to volunteer work, access to education and training.” Specifically, he said that “a big barrier in moving into education and employment is having to collect a daily script and the stigma attached to just being on one rather than the ability to actually move on.”

“In terms of recovery it is absolutely crucial to get drug users – recovered drug users – into employment because employment

opens up a whole range of opportunities to build a non-addict identity, to form relationships with people who are not involved in drug use.”

*Professor Neil McKeganey, Centre for Drug Misuse Research, University of Glasgow, The Great Debate, Edinburgh*

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**MESSAGE 5** **Many drug users have highly damaged lives, difficult personal histories and complex needs – recovery is about much more than drug treatment.**

Many of the people who use drug services arrive at the door with problems that are like big and complicated knots that have to be carefully unpicked. For instance, drug service users may be homeless or have mental health problems; they might have been abused as a child or worked in the sex trade.

“When we’re talking about recovery, we should be asking how do you recover if you’re a woman and you’ve been abused by your father, you’ve been put in a paedophile ring, and heroin takes you away from that, it helps you not to think about that?”

*Speaker from the floor, The Great Debate, Manchester*

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**MESSAGE 6** **If we are going to do recovery, we need to be doing it properly.** Realising the positive potential of the recovery or (re)integration agenda requires serious investment and fundamental changes to the way many services operate. A widespread fear is that these concepts will serve a primarily ideological role in the development of public debate and public policy – with the focus on the responsibilities of service users and the role of drug services, and not upon the wider causes, contexts and consequences of problem drug use.

“Whatever happens, it is a fair prediction that we’re going to see a lot more managers with recovery in their title and a lot more recovery champions – whatever the flavour of the month or year, it tends to get reflected in the job titles that people are given, without necessarily having much impact on anything that actually gets done.”

*GP from the floor, The Great Debate, Manchester*

“If we believe in recovery as anything more than a rebranding ... then we have to be much clearer about how important it is to help people turn their lives around and that a decision to engage in that enterprise is actually fundamental to the lives of citizens in this country who find themselves in trouble with drugs.”

*Ian Wardle, Chief Executive, Lifeline, The Great Debate, Manchester*





# 3

## Moving the debate on

**“I am concerned about [...] the perception of this as a very polarised debate. There is the idea that a chasm is opening up between those who believe in abstinence and those who believe in harm reduction. But if this is allowed to become a binary debate it is going to be very damaging for us as a field. It will make us much less able to defend what has been achieved over the last few years in both harm reduction and abstinence.”**

*Richard Phillips, Independent Consultant – Substance Misuse, The Great Debate, London (Birkbeck)*

## 3.1

# Next steps

It would be misleading to pretend that there were not significant disagreements at The Great Debate sessions. Key areas of debate included:

- the value of methadone maintenance;
- the nature of the relationship between abstinence-based approaches and drug-related deaths;
- the appropriate balance between abstinence and harm reduction services; and
- the relationship between abstinence (or progress towards a 'drug-free' life) and recovery (including access to specific forms of social capital such as housing and employment).

At the same time, there is a wide area of consensus and the contours of a reinvigorated and enriched drug policy paradigm were discernible at The Great Debate meetings. In particular, there was unanimous support for continued government investment in drug treatment, with some of the biggest critics of current policy – coming from both harm reduction and abstinence perspectives – arguing for greater investment, not less.

There was also general agreement that:

- **the drug treatment sector should provide a range of services**, including both harm reduction and abstinence-based approaches.
- **there are various routes into drug dependency and many routes out of it** – typically, service users will need different kinds of intervention at different points in their recovery journeys.
- **most people seeking help with drug problems have other problems**, which are the causes, contexts and consequences of their drug problems – these can include a history of trauma and abuse, mental health issues, housing problems, lack of skills, unemployment, poverty and experience of stigma.
- **we need to develop a more social model of recovery**, which is about repairing damaged lives and giving people things to live for, not simply treating addiction.

- **this requires a sophisticated approach to care planning, that recognises that linear care pathways will often not be effective for people with multiple needs.** It is not realistic to expect people to come off drugs before they access basic social capital such as housing and employment.
- **this is about services that are much more responsive to the specific problems and motivations of particular service users at definite points in their recovery journeys;** it is about more individualised and personalised models of care.

There are real opportunities at present, and solid commitments in both the Scottish and English drug strategies that hold out the prospect of further progress. At the same time, there is concern that the opportunities to move things forward presented by the current focus on recovery and social (re) integration could be lost.

They could be lost if respect for clinical judgement and evidence-based service provision is over-ridden by a dogmatic and ideological approach, that pitches abstinence against harm reduction. They could be lost if politicians come to see drug treatment service users as an easy target for populist and stigmatising rhetoric and policies. Delivering social inclusion for such a marginalised, excluded and stigmatised section of the community is going to require significant investment – so where is the money to come from? Or, perhaps more realistically, how are existing resources going to be used, and access to them improved, to accommodate this new source of demand – for example, in housing, in education or employment?

If we are willing to make the investment and develop robust, evidence-based policy, the gains to drug service users, families, neighbourhoods, communities and society as a whole are potentially huge.

This brings us to the final challenge – to argue for investment in drug treatment on the basis of compassion and not simply fear. Yes, some problem drug users commit crimes to finance their dependency. Yes, some problem drug users on welfare benefits make little effort to find employment. These are legitimate political concerns. But we are talking about a group of people who often have highly damaged lives. We are talking about a group of people who can find it incredibly difficult to get into housing, education, training or work – who experience high levels of social stigma, marginalisation and exclusion. We are talking about broken families, severed community ties, stigma, marginalisation and often chronic exclusion.

This task may seem daunting, but we have plenty of good work to build on. We have made huge strides forward in improving access to drug treatment in Britain, and this has delivered real and substantial benefits for the community. Paolo Pertica, Head of Blackpool Community Safety and Drug Partnership, quoted the Joni Mitchell lyric ‘you don’t know what you’ve got ‘til it’s gone’ to make the point that, for all the concerns, there is a lot to celebrate in the drug treatment sector. It is about how we move forward from here.

## 3.2

# Recommendations

**The following recommendations were not discussed at The Great Debate meetings, but emerged from DrugScope’s subsequent reflections on the debate.**

### RESHAPING THE DEBATE

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- 1** **Politicians from all parties should publicly commit to an evidence-based approach to drug policy.** The advice of independent experts, such as the ACMD and NICE, must be respected. Only evidence based treatment will deliver positive outcomes for drug users, families and carers, neighbourhoods and communities. In this respect, the same principles apply to drug treatment as to the treatment of cancer, heart disease, diabetes, depression or schizophrenia. Where investment in drug services is driven by research and evidence, it delivers for taxpayers and is cost effective too.
- 2** **The Government should fund, develop and implement a communications strategy to inform the public about the achievements of front-line drug services.** If government is to continue to deliver the substantial public benefits achieved through investment in drug treatment, it needs to ensure public support for treatment services. The Home Office and the NTA must support local partnerships to develop communications strategies that engage with their local communities, local government, local media and local politicians. Furthermore, there is an urgent need to address negative attitudes and discrimination against people who are in or who have been in drug treatment. Work should be undertaken – for example, by the EHRC and the NTA – to address this, perhaps through the creation of a campaign similar to the SHiFT campaign for mental health. Negative perceptions of people who are in, or who have been in, drug treatment remain a major barrier to social (re)integration and yet the government has made no public commitment to addressing this. The EHRC could take a lead in mapping and addressing the attitudinal barriers that work against people with a history of substance misuse as they try to get their lives on track.

### RIGHTS AND CHOICES

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- 3** **Drug treatment services must address diversity issues more effectively.** The EHRC and the NTA should work together to improve the responsiveness of drug treatment services to race, ethnicity, culture, religion, gender, sexuality,

age and disability. Recent debate about abstinence and substitute prescribing has pushed other important issues to the margins of the public debate about drugs and drug treatment. It is striking, for example, how little consideration has been given to cultural differences in perceptions of the respective roles of abstinence and maintenance prescribing. Again, there is a role for the EHRC and an opportunity for the NTA to give a higher profile to these issues with the introduction of new single equalities legislation.

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- 4** **Drug treatment should be provided in accordance with the new NHS Constitution.** This means that every service user entering drug treatment should be provided with a statement of their rights and responsibilities as well as clear and unbiased information about available treatment alternatives. Service users are entitled to make decisions about treatment. This should include a right to choose a treatment approach that potentially delivers a preferred outcome (for example, abstinence), but at a higher risk of failure than some alternatives. But respect for choice is fundamental within health services. It can contribute to positive treatment outcomes by building therapeutic relationships and boosting motivation and self-esteem.
- 
- 5** **Drug service users should be involved in decisions about their treatment.** Every drug user entering the treatment system should have an effective and comprehensive care plan which should be regularly reviewed with a designated key worker. Their needs should drive the care planning process, and they should be fully involved in it. This should include plans for people on substitute drugs to move off them, when they are ready and appropriate support is in place. People with drug problems often have complex needs. They need individualised pathways out of dependency alongside support from a variety of agencies. An NTA review found that care planning was 'good' or 'excellent' in only 26 per cent of local partnerships. This must be addressed. A good starting point would be more detailed research on current provision of care planning. This would also ensure that people are not indefinitely 'parked' on methadone and services are pro-active in facilitating social (re)integration.
- 
- 6** **There should be further research on alternatives to substitute prescribing.** Psycho-therapeutic, psycho-social and abstinence-based approaches should all be investigated, by a body such as NICE, along with options for the treatment of a wider range of drug problems. There is broad consensus in the drugs field that the treatment system is over-dependent on substitute prescribing. No substitute drugs are available to help with many of the most damaging forms of substance misuse. We need investment from the government into research on alternatives to substitute prescribing but also into how the provision of 'social' support (for example, housing) contributes to successful drug treatment outcomes. We need to back up the findings of research with investment in evidence-based practice.
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- 7** **There should be further work to reduce drug-related deaths.** Abstinence-based services (including services in prisons) should be required to have robust policies for managing relapse and the associated risks, particularly overdose. There is a significant increase in risk of overdose following detoxification or after

a period of abstinence (for example, in prison). This does not mean that people should not be detoxed when they are ready, but it does mean that abstinence-based services need to have clear protocols for managing risk (including referral routes to harm reduction services).

## WORKING TOGETHER TO IMPROVE OUTCOMES

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- 8** **All local drug partnerships need to develop effective partnerships with other local agencies.** These would include JobCentre Plus, housing providers and mental health services. For example, it is often the case that drug treatment service users need somewhere to live before they can make progress with drug problems. But many housing associations and domestic violence refuges will not accommodate people who are not abstinent. Evidence from participants in The Great Debate suggests that relationships between services are much better developed in some areas than others. As long as drug treatment works in a silo, we will fail to deliver on key recovery and social re-integration objectives. It may be necessary to create new roles or redesign existing ones to provide a better structure for developing and maintaining relationships between key stakeholders and agencies (an example could be the creation of drug co-ordinators within JobCentre Plus).
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- 9** **There should be clear recognition of the contribution of families, carers and other support networks to recovery.** Better support should be available to them (including appropriate financial support). Families and other informal networks play a huge role in supporting recovery and providing recovery capital – such as housing. We need further research to identify the benefits provided by these networks, and the support that is available to them. They need to be helped to move in from the margins of the drug policy debate.
- 
- 10** **The next round of the Comprehensive Spending Review should introduce treatment outcome targets that include re-integration.** For example, we should be increasing the numbers of drug users moving into quality housing or education, training and employment, as a key policy priority. The Public Service Agreement on reducing the harms caused by drugs and alcohol (PSA 25) includes two crime reduction measures, but no indicator of treatment outcomes other than reduced offending, and no indicator of social (re)integration. Elsewhere, the Public Service Agreement on chronic adult social exclusion (PSA 16) does not identify people with drug dependency problems as a key target group. This should be addressed in the next round of the Comprehensive Spending Review.

During The Great Debate sessions, there was also general agreement that to move forward, we need to widen the debate to look at emerging patterns of drug use and different forms of intervention. It was felt that the NTA should lead on the development of a drug treatment system that can improve the lives of people with a wider range of substance misuse problems, including polydrug and alcohol misuse.

Recent debate about drug treatment has really been about heroin treatment. There are no viable substitute drugs for stimulant use, nor do we have a coherent regime for polydrug problems. But if we persist with a narrow definition of problem drug use we are unlikely to be well equipped to meet new challenges as drug trends change. Those young people gearing up to be the next generation of 'problem drug users' appear to be developing problems linked to cheap alcohol and cocaine, maybe along with cannabis, ecstasy and tranquillisers. The question is, to what extent are drug services equipped for this and how flexible can they be? We also need to think seriously about a joint drug and alcohol strategy.

Participants at The Great Debate almost all agreed that prevention was an issue that needed both more research and more investment. There was broad consensus with the idea that the Government should fund research to identify ways that we can get upstream and reduce both problematic drug use and the demand for drug treatment. A framing assumption for current debate is that there will be an endless supply of new entrants into the system but the problems that these new entrants bring might not resemble those of their predecessors. At present, drug treatment provision is almost exclusively fixated on 'acute' and 'crisis' services. In the future, we might seek to balance 'low visibility, acute need' treatment service provision with higher visibility, community services, that are accessible to people who may be beginning to develop drug problems or have concerns about others. To this end, we should also be working to improve the engagement of primary care services with the delivery of drug treatment interventions.

## 3.3

# Last words ...

**“Actually we’ve found that there is much more common ground than there are disparate views. Often, the same issues are raised [...]. It is not about whether abstinence or replacement prescribing was available. It is about whether what the person needed at that time ... was available at the right time and whether that support was flexible enough to move with that person as they moved.”**

*Brian Kidd, Scottish Association of Alcohol and Drug Action Teams, Chair, The Great Debate, Edinburgh*

**“We want a more detailed and sensitive discussion that is informed by evidence, but also by values of care and compassion.”**

*Professor Susanne McGregor, London School of Hygiene and Tropical Medicine, Chair, The Great Debate, Manchester*

**“I think we do know what treatment is. I think anyone who’s been involved in effective treatment – as a punter or as a worker – knows exactly what it is. It’s a good relationship, a proper dialogue between client and worker, the trust, time and opportunity to access whatever it is our clients need to keep them safe, keep them alive and help them choose to move on. Whether that’s abstinence or maintenance.**

**“It’s probably time we stopped getting so screwed up about our traditional rivalries. We need to defend what we do, not by looking inwards at debates like this, but by opening an honest dialogue with the rest of society and beginning to say out loud the things we all know. People are different. Good drug treatment responds to that difference, offers choices, is not rigid or doctrinaire but works flexibly with the individual. That’s how drug treatment changes people’s lives. And that’s what we do.”**

*Sara McGrail, Freelance Drug Policy Specialist, The Great Debate, London (Birkbeck)*





# 4

## Appendices



## 4.1

# Key facts and figures on drug treatment

The wealth of data available on drug treatment, particularly since the establishment of the National Drug Treatment Monitoring System<sup>1</sup> (NDTMS) in 2001, is invaluable, but it can be overwhelming. The next few pages detail some key facts and figures surrounding drug treatment in England in order to provide an accessible guide to the subject and place The Great Debate in context.

The majority of data has been sourced from the annual 'Statistics from the NDTMS' reports, published by the NTA since 2003/04<sup>2</sup>. References are provided where other sources have been consulted.

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1 National Drug Treatment Monitoring System (<http://www.ndtms.net/>)

2 The full reports can be downloaded from the NTA 'Drug treatment activity' web page: [http://www.nta.nhs.uk/areas/facts\\_and\\_figures/national\\_statistics.aspx](http://www.nta.nhs.uk/areas/facts_and_figures/national_statistics.aspx)

## Background: the structure of drug treatment in England

If someone needs help with a drug problem, there are various routes into treatment available. Users can access these services via a GP referral or drugs advice service or through the criminal justice system.

In England, the NTA introduced the *Models of Care* framework in 2002 (updated in 2006). This framework provides four tiers of different drug treatment services, classified in a way that is easy to understand. The framework should, in theory, mean that individuals can choose from a range of services available to them and move through the tiers according to their needs.

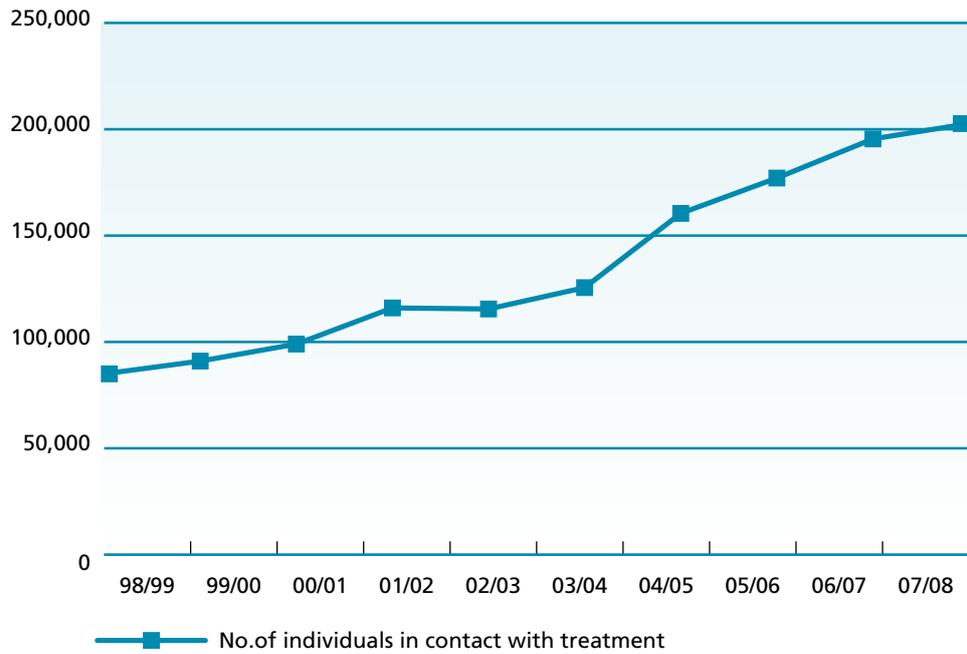
A breakdown of the types of intervention and treatment providers available in each tier of treatment is as follows:

Tier	Type	Examples of interventions	Examples of providers:
1	Non-specific (General)	<ul style="list-style-type: none"> <li>• info and advice</li> <li>• screening for drug misuse</li> <li>• referral to specialist services</li> </ul>	<ul style="list-style-type: none"> <li>• general practitioners</li> <li>• probation services</li> <li>• housing providers</li> <li>• helplines</li> </ul>
2	Open access	<ul style="list-style-type: none"> <li>• info and advice</li> <li>• harm reduction interventions</li> <li>• referral to structured drug treatment</li> <li>• brief psychosocial interventions</li> </ul>	<ul style="list-style-type: none"> <li>• specialist drug services</li> <li>• drop-in clinics</li> <li>• pharmacies</li> </ul>
3	Community Services	<ul style="list-style-type: none"> <li>• substitute prescribing</li> <li>• structured day care</li> <li>• counselling and therapy</li> <li>• community detox</li> <li>• harm reduction as part of a care plan</li> </ul>	<ul style="list-style-type: none"> <li>• community drug teams</li> <li>• some GPs offer substitute prescribing</li> </ul>
4a	Specialist residential services (residential)	<ul style="list-style-type: none"> <li>• inpatient treatment</li> <li>• residential rehabilitation</li> <li>• opiate detox</li> </ul>	<ul style="list-style-type: none"> <li>• residential drug services</li> <li>• hospitals</li> </ul>
4b	Highly specialist (non-substance misuse)	<ul style="list-style-type: none"> <li>• liver units</li> <li>• forensic services</li> </ul>	<ul style="list-style-type: none"> <li>• hospitals</li> </ul>

### Individuals in contact with drug treatment

The last decade has seen a substantial rise in the number of individuals in contact with drug treatment services. In 1998/99 there were 85,000 clients engaged with treatment providers but ten years later this level had risen to almost 203,000, representing an increase of around 238%.

**Number of individuals in contact with drug treatment services between 1998/99 and 2007/08**



**Figure 1: Number of individuals in contact with drug treatment services 1998/99 to 2007/08**

Year	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08
No. of individuals in contact with treatment	85,000	91,000	99,000	116,000	115,500	125,545	160,453	177,055	195,464	202,666

### Investment in drug treatment

Recent years have seen an increased investment in drug treatment services. Funding is predominantly provided by government via the Pooled Treatment Budget (PTB) and local-level funding.

The PTB is combined funding from the Home Office and the Department of Health, allocated annually to local Drug Action Teams (DATs). Up until and including 2007/08, the amount allocated to each DAT was based on a formula which calculated local need utilising key deprivation factors. However, concerns over the wide variation in PTB allocation per head, led to a revised formula being introduced in 2008/09.

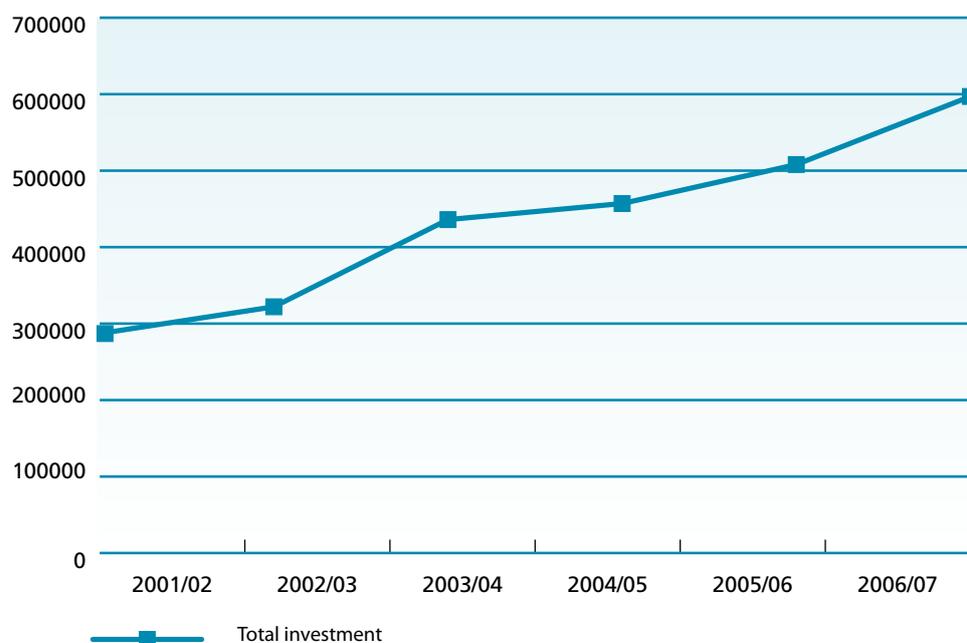
As part of the NTA's attempt to 'introduce a fairer criterion for allocating funding', the new formula takes into account factors such as the caseload complexity of local treatment populations, the mix of cases of problem and other drug users, and area cost differentials that exist.

PTB funding rose from £142 million in 2001/02 to £396 million in 2007/08. In a letter announcing the record £396 million 2007/08 PTB in January 2007, NTA Chief Executive Paul Hayes said it was 'unlikely' that there would be further increases in PTB funding during the period 2008-11 and consequently "...continued expansion and improvement of the system will therefore be dependent on growth in local funding, and in particular on more effective use of existing resources."<sup>3</sup> It was therefore welcome news when the 2009/10 budget was announced (February 2009) – it will stand at £406 million. It is important to note, however, that while funds have been increasing, the number of clients in treatment has also risen year on year. In real terms, the amount of money available to spend per client has actually been decreasing.

At local level, DATs also receive funding from organisations such as Primary Care Trusts, local authorities and probation services who work with client groups affected by substance misuse. During the period 2001/02 to 2006/07 local funding allocations rose from £145 million to £212 million. At time of writing figures for 'local funding' and 'total investment' were only available up to 2006/07 on the NTA website.<sup>4</sup>

DATs use this combination of central government and local funding to commission drug treatment services from NHS, voluntary sector and sometimes private sector providers, to meet their local needs.

**Total investment in drug treatment services 2001/02 to 2006/07**



<sup>3</sup> [http://www.nta.nhs.uk/about/funding/docs/nta\\_ptb\\_announcement\\_phletter\\_290107.pdf](http://www.nta.nhs.uk/about/funding/docs/nta_ptb_announcement_phletter_290107.pdf)

<sup>4</sup> [http://www.nta.nhs.uk/about/funding/drug\\_treatment\\_services.aspx](http://www.nta.nhs.uk/about/funding/drug_treatment_services.aspx)

**Figure 2: Investment in drug treatment services 2001/02 to 2006/07**

Expenditure on drug treatment (excluding prison-based treatment)	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
Pooled Treatment Budget	£142m	£191m	£236m	£253m	£300m	£385m	£396m
Local funding	£145m	£131m	£200m	£204m	£208m	£212m	n/a*
Total investment	£287m	£322m	£436m	£457m	£508m	£597m	n/a*

\*As mentioned above, at time of writing figures for 'local funding' and 'total investment' were only available up to 2006/07 on the NTA website.

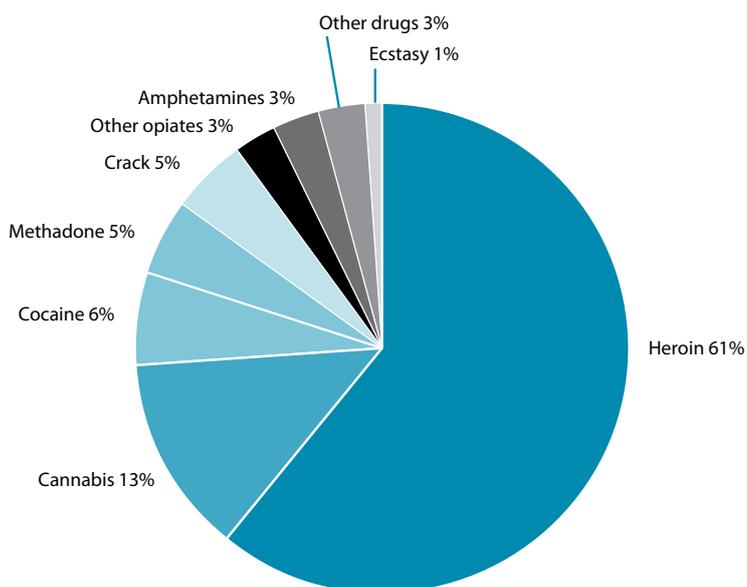
Some treatment services run by voluntary sector providers may gain additional funds through fundraising as charities. There are also several private sector providers, particularly of residential rehab services. Normally people who attend these clinics pay for the treatment themselves although sometimes DATs may buy places in these services where necessary.

### Number of problematic drug users in treatment

According to the NDTMS there were 150,075 problematic users engaged in drug treatment in 2007/08<sup>5</sup>. The most reliable gauge of problem drug use estimated that there were around 328,767 opiate and/or crack cocaine users in England in 2006/07.

The majority of individuals (123,522) in contact with treatment in 2007/08 cited heroin as their primary drug of use. The next most common primary drug cited was cannabis (26,287).

### Primary drug of misuse of individuals in contact with treatment 2007/2008



5 Home Office (November 2008), *National and regional estimates of opiate use and/or crack cocaine use 2006/07: a summary of key findings*

**Figure 3: Primary drug of misuse of individuals in treatment 2007/2008**

Primary drug of use	Percentage	Number
Heroin	61%	123,522
Cannabis	13%	26,287
Cocaine	6%	12,613
Methadone	5%	10,112
Crack	5%	10,994
Other opiates	3%	5,447
Amphetamines	3%	5,703
Other drugs	3%	6,170
Ecstasy	1%	1,059
TOTAL	100%	201,907

### Clients retained in treatment for twelve weeks

Research-evidence indicates that drug treatment is more likely to be effective if clients are retained in treatment for 12 weeks or more<sup>6</sup>. Retention for this period (or longer) can lead to significantly improved treatment outcomes including reductions in drug use, drug-related crime and drug-related deaths.

Since 2005/06, the NDTMS has collected data on the number of clients who entered treatment each year whose treatment journey lasted longer than 12 weeks. Beginning in 2006/07 national targets have been set for retention, although these have yet to be met.

**Figure 4: Clients beginning a treatment journey who were retained in treatment over 12 weeks**

Individuals being retained for over 12 weeks	2005/06	2006/07	2007/08
No of clients beginning treatment	83,030	80,280	82,381
No who were retained in treatment for over 12 weeks	62,972	60,392	64,440
Percentage retained for over 12 weeks	76%	75%	78%
National target for retention	n/a	77%	83%

<sup>6</sup> NTA (2005) Retaining clients in treatment: a guide for providers and commissioners [http://www.nta.nhs.uk/publications/documents/nta\\_retaining\\_clients\\_in\\_drug\\_treatment\\_2005.pdf](http://www.nta.nhs.uk/publications/documents/nta_retaining_clients_in_drug_treatment_2005.pdf)

### Individuals discharged from treatment drug-free

The NTA publish statistics on individuals ‘discharged from treatment’. Clients who are on a methadone (or other substitute drug) prescription are considered to be ‘in treatment’ so are not included in these discharge figures.

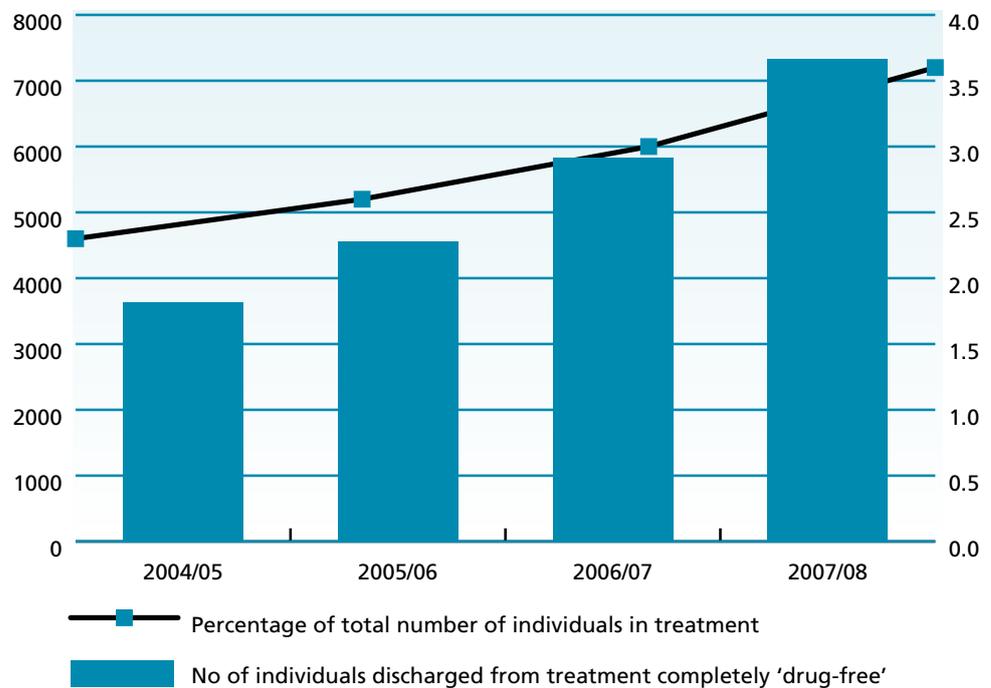
The NTA record an individual as having been discharged ‘drug-free’ if they have “completed their treatment no longer dependent on their drug of misuse and are not using any other illegal drugs.”<sup>7</sup>

As such, the definition provides a measure of drug users leaving treatment having achieved abstinence from the use of all illegal drugs. However, it does not account for clients discharged from treatment who no longer use their primary drug of choice but still use other substances.

For example, an individual who leaves drug treatment no longer using heroin or crack cocaine but still uses cannabis recreationally is not considered ‘drug-free’ under the current definition.

In recent years, the numbers of individuals discharged from treatment ‘drug-free’ has increased. However, despite this rise, some within the drug sector and the media have highlighted that the actual number of individuals leaving ‘drug-free’ represents only a small percentage of the total number of people engaged with treatment.

Individuals discharged from treatment drug-free 2004/05 to 2007/08



7 House of Commons Hansard: Written Answers for 10 Sep 2008 <http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080910/text/80910w0026.htm>

**Figure 5: Individuals discharged from treatment 'drug-free'**

	2004/05	2005/06	2006/07	2007/08
No of individuals discharged from treatment completely 'drug-free'	3,632	4,559	5,829	7,324
Percentage of total number of individuals in treatment	2.3%	2.6%	3.0%	3.6%

As of April 2009 a new coding system will be introduced which will define treatment completed 'drug-free' as "no longer using heroin and crack cocaine, or any other drugs for which treatment is being received"<sup>8</sup>.

## A comparison between substitute prescribing and residential rehab

Questions of access, effectiveness and investment in abstinence-focused drug treatment and maintenance-based measures were central to The Great Debate. Discussions revolved around treatment modalities that embody each approach – the 'drug-free' ethos of residential rehabilitation and the most commonly used maintenance treatment, substitute prescribing.

The following pages briefly outline both approaches and detail key statistics comparing the levels of provision and estimated costs of each treatment.

What is the difference between rehab and substitute prescribing?

### Residential rehab

Residential treatment programmes usually insist on residents being drug-free on admission. In most cases this means the entrant has undergone detoxification before entry, although some programmes provide this facility on admission. Programmes usually last three to six months although some 12-step programmes (such as those associated with the Narcotics Anonymous model) can last 12 months.

Programmes vary widely in concept and practice, but generally attempt to provide group or individual support in a drug-free environment.

8 National Treatment Agency (October 2008), News Release: *New national statistics reveal more drug addicts in treatment – and they are staying the course*  
[http://www.nta.nhs.uk/media/media\\_releases/2008\\_media\\_releases/new\\_national\\_statistics\\_reveal\\_more\\_drug\\_users\\_in\\_treatment\\_media\\_release\\_021008.aspx](http://www.nta.nhs.uk/media/media_releases/2008_media_releases/new_national_statistics_reveal_more_drug_users_in_treatment_media_release_021008.aspx)

## **Substitute prescribing**

These programmes look to prescribe heroin/opiate users with a substitute drug to stabilise or reduce an individual's drug use in the long term. However, buprenorphine (brand name Subutex) is also used in some cases and diamorphine (pharmaceutical grade heroin) is prescribed to a fraction of clients.

Substitute prescribing interventions are usually delivered in community settings and take the form of maintenance or reduction programmes.

With methadone maintenance programmes the aim is not to eliminate drug use in the short term, but to stabilise the use by prescribing methadone as a substitute for heroin. The idea is to reduce the need for criminal activity, reliance on illicit drug markets and the harm caused by injecting and to stabilise the user with a view to them giving up drug use in the longer term.

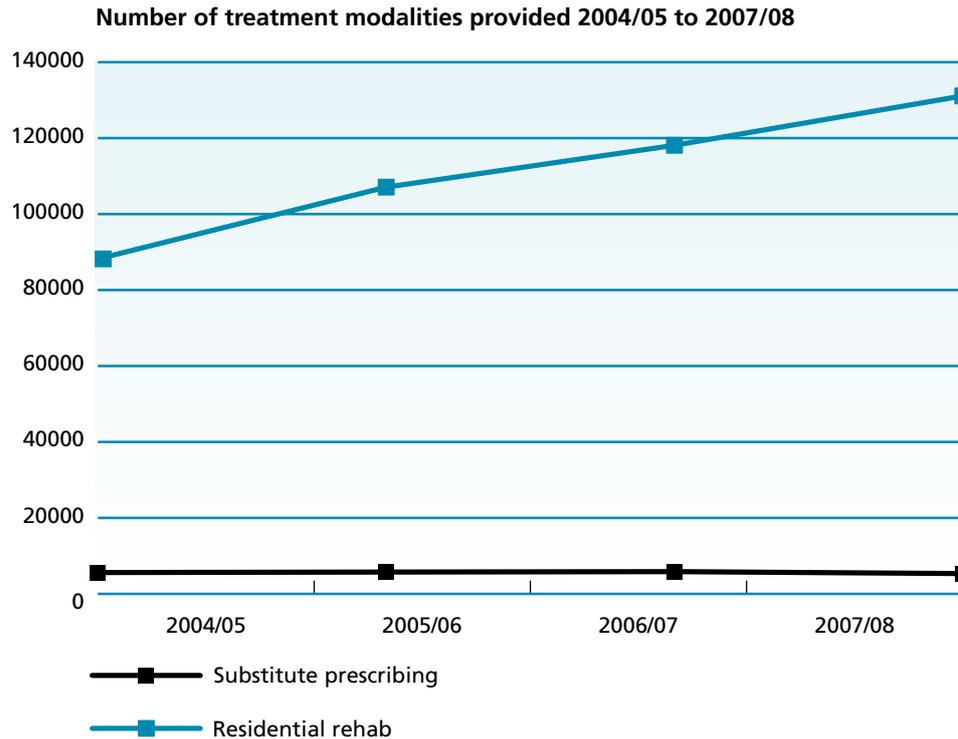
Methadone reduction programmes usually take place in community settings and involve the prescribing of methadone to opiate users to control withdrawal symptoms. The aim is to gradually reduce the quantity prescribed until the user experiences no withdrawal symptoms and is drug-free.

## **Levels of provision of each modality**

The NDTMS gathers data on the number of times a treatment modality was provided to individuals engaged with drug treatment. Year-on-year data shows that levels of substitute prescribing have risen steadily in recent years, while residential rehab levels have remained relatively stable.

However, when considering this data it should be noted that:

- a) individuals can use a number of different treatment modalities during the year so these figures do not equate to a one individual = one treatment type, equation.
- b) The NDTMS does not record the specific substitute drug prescribed and while the majority of clients will have received methadone, others may have received buprenorphine.
- c) These figures are likely to be an underestimate of the level of residential rehab activity. Around one-third of providers in England do not submit any returns to NDTMS, as independent voluntary sector providers of residential rehab are not obliged to provide data to the NTA.



**Figure 6: Number of treatment modalities provided 2004/05 to 2007/08**

No. of treatment modalities provided	2004/05	2005/06	2006/07	2007/08
Substitute prescribing	88,196	107,093	118,107	131,110
Residential rehab	5,620	5,749	5,859	5,350

## Cost comparison

In January 2009 Liberal Democrat Shadow Home Secretary Chris Huhne asked a Parliamentary Question about the average cost of a week's drug treatment in residential rehabilitation services. Minister of State for Public Health Dawn Primarolo responded and said that, as of November 2008, the average cost of a week in a residential rehabilitation service was £500 per resident.<sup>9</sup>

Ms Primarolo said that the £500 per week figure is based on self-reported unit cost data gathered from the residential services who return data to the NTA. This is estimated to cover around 75% of all residential services in England and Wales and, according to the minister, "as such it does not represent a comprehensive or necessarily robust picture," but was the most reliable figure available.

<sup>9</sup> <http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090112/text/90112w0114.htm#09011437007395>

In 2007, the Personal Social Services Research Unit estimated the average unit cost of voluntary sector residential rehabilitation for drugs or alcohol was £755 per resident week.<sup>10</sup>

This figure was based on data collected in 1994/95 as part of the National Treatment Outcome Research Study (NTORS) with costs inflated to 2006/2007 levels. The estimate included capital costs (e.g. buildings, equipment), revenue costs (e.g. staff salaries) and the use of the facility by the client.

The same report estimated the average cost of maintaining a drug user on a methadone treatment programme to be £55 per patient per week. Again, the figure was based on data from the NTORS research, adjusted to 2006/07 prices and included capital costs, revenue costs and prescription costs of methadone.

Treatment for drug or alcohol misuse	Average cost
Voluntary sector residential rehabilitation	£500-755 per resident week*
Methadone treatment programme	£55 per patient week

\*Based on the range between NTA data and NTORS estimates.

10 Curtis L, Netten A (2007): *Unit Costs of Health and Social Care*. University of Kent: Personal Social Services Research Unit; <http://www.pssru.ac.uk/pdf/uc/uc2007/uc2007.pdf>

**abstinence:** Different definitions of the term according to perspective. However, commonly understood that when an individual refrains completely from using all drugs they are said to have achieved abstinence. An 'abstinence-based service' offers a drug treatment programme that aims to help the individual stop using drugs for the rest of their lives.

**detoxification, detox:** The process by which a drug user withdraws from the effects of a drug. It usually refers to withdrawal in a safe environment (a detoxification/detox centre), with help on hand to minimise the unpleasant symptoms.

**harm reduction:** Describes activities and services that acknowledge the continued drug use of individuals, but seek to minimise the harm that such behaviour causes. The provision of clean needles for injecting drug users is one example.

**methadone:** A synthetic opioid prescribed to prevent people experiencing withdrawal effects from heroin and other opiate drugs. It lasts longer and does not provide the same 'high' or 'rush' as drugs like heroin.

**methadone maintenance:** An individual in receipt of prescriptions of methadone over a long period of time is said to be receiving 'methadone maintenance'.

**New Abstinence:** Coined by Mike Ashton in 2007 to refer to a growing movement in politics, media and the drug sector, arguing that the only goal of drug treatment should be complete abstinence from all drugs, including substitute drugs such as methadone.

**overdose:** The use of any drug in such quantities that acute adverse physical or mental effects occur. It can be deliberate or non-deliberate; lethal or non-lethal.

**recovery:** Often used to describe a vision and vocation for drug treatment that is less fixated on clinical indicators and quantitative targets, and more concerned with social (re)integration and qualitative outcomes.

**relapse:** When someone in drug treatment or who is abstinent returns to using illicit drugs.

**service user:** Someone who uses drug treatment services.

**substitute drugs:** Drugs such as methadone or buprenorphine (Subutex), prescribed to drug users to help them manage withdrawal symptoms or to replace illicit drugs.

**withdrawal:** The body's reaction to the sudden absence of a drug to which it has adapted. The effects can be stopped either by taking more of the drug, by managed detoxification or by letting the effects subside naturally ('cold turkey'), which may take up to a week.

## **Abbreviations**

ACMD	Advisory Council on the Misuse of Drugs
CAT	Community Addiction Team
DAT	Drug Action Team
EHRC	Equality and Human Rights Commission
NICE	National Institute for Clinical Excellence
NTA	National Treatment Agency for Substance Misuse
NTORS	National Treatment Outcomes Research Study
PTB	Pooled Treatment Budget



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