

A view on drug treatment

The 'maintenance-versus-abstinence' debate is no longer confined to this newsletter or to those in the drug treatment sector. It features in the pages of Sunday newspapers, the discussion boards of influential think tanks, and the airwaves of national radio.

Those involved in treating people with drug misuse problems know that the polarisation presented in the media does not accurately reflect the reality of the current drug treatment system. Practitioners work hard to ensure that individuals are supported to access the type of treatment they need, when they need it. No one type of treatment is going to work for every user, every time. Overcoming addiction can be a long and painful journey, and the role of the National Treatment Agency (NTA) is to ensure that the doors to recovery remain wedged open.

Drug treatment provision in England has come a long way since the NTA was created in 2001, and drug misuse has changed dramatically since abstinence was the dominant practice thirty years ago.

In the mid-1980s, Margaret Thatcher's government took the decision to focus drug strategy on harm reduction, as the existing abstinence-based system had buckled under the strain created by the availability of cheap heroin. The actions taken then succeeded in holding down HIV infection rates, and built the foundation for further additional investment under Labour with the overt aim of using drug treatment to reduce crime.

The drug treatment system created to meet the challenges of the twenty-first century has much to be proud of, and is unrecognisable from the system I first worked with thirty years ago. Now virtually anyone who chooses to access treatment in England can get it, and quickly.

It strives to offer a balance of treatment, which includes harm reduction services, substitute prescribing, psychosocial interventions, inpatient and residential treatments, and new approaches where appropriate. The NTA is looking forward to reporting early in the new year on the pilots exploring treatment incentives, and publishing information next year on developments in psychosocial interventions.

As a core component of the treatment system, methadone has enabled thousands of people to regain control of their lives, improve their health and relationships, and reduce criminal activity. But for most people it is the first step on the road to recovery: not the end result. The government's aim for treatment is for the user to overcome addiction, however long that might take, and whichever types of treatment are used along the way.

Abstinence-based treatment should be one of the options available to users at a suitable point in their road to recovery, as part of a decision taken jointly with the clinician. The NTA has just announced where an additional 2,000 places a year will be created in abstinence-based treatments, as part of £54m of capital grants from the Department of Health.

Presenting these approaches as an ‘either’/ ‘or’ scenario misses the point, and risks undermining the consensus for a balance of provision which has been the cornerstone of treatment policy.

The real challenge we face at this point is to ensure that we match quantity of service provision with quality. Led by the new ten-year Drugs Strategy, launched this year, the NTA will be prioritising making the system more ambitious for users, so that those who can come off drugs, are supported to do so, at the right time and with the right back up. Aiming for abstinence cannot mean risking destabilising individuals, with the knock-on impact on their families and communities.

Targets based on quantity and time spent in treatment only give us part of the picture: what really matters is the difference treatment makes to individuals. That is ultimately the best assessment of what recovery means.

This is why the Treatment Outcomes Profile (TOP), part of the National Drug Treatment Monitoring System, is asking about the impact of treatment on drug users’ lives in four key areas: drug and alcohol use, health, social functioning and offending. We have a shared purpose with GPs in improving the effectiveness of treatment, and we very much want outcomes for individuals to be the driver for improvement.

Ten years on from the first Drug Strategy we take nothing for granted. It is as important now to advocate for drug treatment, in all its forms, as it ever was. We must not lose sight of the reality that whilst we are making progress towards transforming drug treatment, there is still a long way to go to make treatment as effective as it can be. To achieve this we need to offer service users the treatment they need, not the treatment we “believe” in, and ensure that the public are aware of the benefits this delivers to wider society.

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