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The Great Debate: where should drug treatment go?

Drugscope recently organised three conferences around the country focussing on the debate of the future of drug treatment, particularly regarding the opening division between those who believe abstinence and those who believe harm reduction are the ways forward. These followed on from Mike Ashton's thought provoking paper '*the new abstentionists'*, which can be found in the January edition of Druglink or can be downloaded from DrugScope: http://www.drugscope.org.uk/OneStopCMS/Core/SearchResults.aspx

The national debate on treatment effectiveness was given fresh impetus in October 2007 when the BBC challenged the government over the abstinence record of English treatment services. At the same time in Scotland, results from a national study on treatment efficacy created a similar controversy.

The first seminar was at the Scottish Parliament building in Edinburgh. At the debate's heart was the fundamental question of abstinence - not just from illegal drugs, but from substitution medications: should it be seen as the 'gold standard' treatment goal? Some fear that a goal of 'abstinence above all else' threatens the harm reduction gains associated with treatments such as prescribing the heroin substitute methadone, which caters for people unable to entirely do without opiate-type drugs.

All the debates were started by Mike Ashton laying out his analysis as outlined in his paper. This was followed by speakers from either side of the debate. After the presentations delegates then engaged in a 'Question Time' style debate. Issues discussed included the position of methadone within the drugs field, the changing language around drug treatment and the increased political focus on the concept of recovery'. Definitions of concepts such as 'recovery', 'treatment', 'abstinence' and 'harm reduction' were also questioned and debated. The impact of stigma on drug users was also discussed.

Mike Ashton opened the sessions up by saying there has been a lot of misinformation in relation to the drugs field. He stated that whilst funding for treatment had risen the number of patients in treatment had increased much more steeply therefore creating a reduction in the amount of resources available per patient. The only way for services to square this funding dilemma was to move people out of treatment. This was why 'moving people out of treatment' was now seen as the way forward as efficiency savings could be had and retention is now seen as 'bad' because of its costs. He claimed that evidence was being systematically corrupted; using the example of needle exchange statistics many years ago, which he argued , didn't actually prove their effectiveness as claimed. He also highlighted NTORS' claim that the economy gained £3 for every £1 spent on treatment but didn't include the economic benefits of crime (e.g. to those who buy stolen goods) and the recent Scottish research saying only 3% of Scottish drug users achieved abstinence as opposed to 25% of English patients despite the fact that the studies had used different definitions of abstinence. He said that evidence has always and continues to be corrupted either for political gain or unwittingly. He also stated that 'recovery' is not the same as abstinence, although many were using the term interchangeably. Mike Ashton pointed out that the English Drug Strategy places duty on the user to recover and get back to work, and that there are many problems with this approach – many people die following detox and many do well on methadone maintenance treatment (MMT). To say that people in recovery can't be on MMT has the potential to deny the real gains people can make in MMT, and may possibly discourage people from making such changes.

Several of the speakers tried to imply that there were two separate camps, although the audience pointed out (see also Gordon Morse's article in the current *Network* '*Why are we fighting?'*) that

harm reduction and abstinence should be seen as part of a continuum of recovery and people need to be supported to find out where they are best (and safest) on the spectrum. This view, and the philosophy of recovery, is much further developed in the US and in the mental health field in this country. The current orthodoxy within the drugs field is very much palliative, with the chronic disease model having the potential to lead to learned helplessness. Ian Wardle from lifeline suggested that we are seeking quantative rather than qualitative outcomes.

Recovery in the US places the person is at the heart of the enterprise. The recovery networks are very powerful, including an emerging 'medication assisted recovery' network, and this has brought home the importance of involving users at every level in the organisations, including the statutory services, who are there to support them. ,'Front office sharing' is a concept that has been adopted, meaning all the services under one roof.

To quote Sara McGrail, who spoke at the London debate '…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 and mapable 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.'

She went on to say 'Of course the general public do not currently 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.'

The conclusions from the debates included the view that we need to stop arguing amongst ourselves about whether maintenance is better than abstinence or harm reduction is better than prevention, and bring our ample communication skills to bear to address the outside world. To quote Sara again 'we need to challenge our own tendency to factionalise and fragment. We must stop being so defensive that every challenge to the drug treatment system causes us to turn in on ourselves and argue.'

There were also some criticism for the Ashton paper being against treatment through the criminal justice system and some speakers argued that research showed many drug users did want abstinence (but without any analysis of what this statement meant i.e. people often present when the problems of drugs outweigh the positives and see abstinence as the only option). Others were critical of the rise in criminal justice services, which they felt had made us more punitive in our approach. Ian Wardle felt that leaders are not doing a good job of defending the strategy and it appeared that they are ashamed of service users. 'Our harm reduction philosophy has been worn out and got tired and is now run by the home office' and he concluded 'we need to look beyond our boundaries and infuse our work with optimism from adjacent sectors'

Several speakers felt that evidence was used selectively to support particular discourses and that the government 'invests in drug treatment because it protects young people and communities'. Some felt that 'the moral model' is increasing seeing drug use as a personality failing suggesting a disease model. They argued that drug dependency may be a chronic relapsing condition but this doesn't not mean change and improvements can't happen.

But do we agree on what is effective treatment? As SMMGP we think it's about supporting choice for the person through a good relationship and proper dialogue between patient and worker. This will involve trust, time and opportunity to access whatever it is our patients need to keep them safe and to help them choose to move on, whether that's towards abstinence or maintenance.