



c/o 124 – 128 City Road
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Lord Henley
Home Office
Direct Communications Unit
2 Marsham Street
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24 April 2012

Dear Lord Henley

Please find attached a public statement that has been issued by the UK Harm Reduction Association, the UK Recovery Federation and the National Users Network, in response to the document published by the Home Office on 13 March 2012 titled "Putting Full Recovery First - the Recovery Roadmap".

This statement has been supported by a number of organisations and individuals who work or are interested in the drug treatment field. Many of the signatories and our organisations are concerned that the Home Office document ignores the evidence base for good treatment interventions and will have a negative impact on those accessing services.

The UK has long been seen as a leader in the field of drug treatment and harm reduction. We believe it is important that we continue this excellent work and we would welcome the opportunity to meet with you to discuss our concerns.

Yours Sincerely

Alistair Sinclair, UK Recovery Federation
Neil Hunt, UK Harm Reduction Alliance
Francis Cook, National Users Network

cc. Cabinet Office
Department for Education
Department of Health
Department for Work and Pensions
Department for Communities and Local Government
HM Treasury

Ministry of Justice

Statement attached below

Putting Public Health First

In March this year, the Coalition Government released a document entitled 'Putting Full Recovery First', outlining a "roadmap for building a new treatment system based on recovery".ⁱ It describes "a new agenda" focused on "full independence from any chemical" (which will be main measure for 'Payment by Results' in drug treatment). This document is intended to influence services and commissioners, but it ignores decades of evidence in drug treatment and the core principles that underpin recovery within both the substance use and mental health fields.ⁱⁱ It will do more harm than good: increasing drug-related harm (including HIV transmission and overdose) and reducing levels of engagement with treatment services. People living stable, fulfilling lives assisted by opioid substitution therapy (OST) will be placed in jeopardy, and scarce public funds will be wasted by undermining established, evidence-based interventions. There has been minimal input into this Roadmap from people who use drug services or those who provide drug treatment. Given the serious concerns that we outline below, we call for all stakeholders to be given the opportunity to contribute to a more open and inclusive policy.

Predetermined treatment goals are arbitrary, unethical and ineffective:

Some people enter treatment to become abstinent — others may not be able or willing to reach this goal. Some people benefit from long-term OST^{iii,iv,v} — others from abstinence-based programmes.^{vi} Some people's problems stem from the drug(s) that they use — others' from patterns or methods of drug use,^{vii,viii} or from homelessness, unemployment or a history of abuse. Imposing a 'one-size-fits-all' abstinence goal upon this diverse population is dangerous, legally problematic and may contravene medical ethics. The Government's 2010 Drug Strategy described 'recovery' as "an individual, person-centred journey"^{ix}, i.e. it can mean different things to different people, and many different pathways exist (including medication assisted recovery^x). Services must be client-led and empowering, not predetermined in a policy document. This is not "fatalism" (as the Roadmap states) but an approach based on evidence, experience and pragmatism.

The Roadmap wilfully ignores evidence and expert guidance:

Putting 'full recovery' first implies all other goals — including reduced HIV transmission and overdoses — are secondary. Yet interventions such as needle and syringe programmes (NSP) and OST are among the most proven, effective public health responses available. Numerous scientific reviews have concluded in their favour in the UK^{xi,xii} and internationally.^{xiii,xiv,xv} Methadone, buprenorphine and naloxone are World Health Organization "Essential Medicines".^{xvi} The Roadmap acknowledges the "evidence base underpinning effective treatment interventions", yet simultaneously ignores it. For example, OST is cast aside in search of "new evidence" for new approaches (for which the Roadmap includes no provisions for rigorous evaluation).

The Roadmap represents a threat to public health in the UK:

The 1980s Conservative Government embraced harm reduction — a bold and pragmatic move that averted a major public health crisis, as we know from looking at how HIV spread in countries that were slower to respond (such as the USA, Spain and Russia).^{xvii} The Roadmap, however, ignores decades of evidence and states that: "It is self-evident that the best protection against blood borne viruses is full recovery". A person who has achieved 'full recovery' is free from drug-related risks as long as they remain abstinent. But relapse is a reality for many people.^{xviii} The risk of blood-borne viruses returns if injecting resumes, and people who relapse face heightened risks of overdose if support (and take-home naloxone^{xix}) is not provided.^{xx} The Roadmap states that "everybody deserves a second chance", but 'recovery' means much more than just abstinence.

Recent experiences in Greece demonstrate the danger of overlooking evidence-based responses. HIV incidence among people who inject drugs has risen from between 9 and 16 cases annually in the preceding five years to 190 cases in 2011 alone — an upsurge associated with the economic crisis and the absence of comprehensive prevention programmes.^{xxi} The Coalition Government is gambling with lives by focusing on a singular, narrow vision of ‘full recovery’ rather than the more open and balanced approach described in their Drug Strategy.^{xxii}

The Roadmap devalues evidence-based treatment and threatens patient wellbeing:

The Roadmap claims it will “deliver much better value for taxpayers’ money in the short and longer terms as ultimately payment will be made for full recovery only”. This statement trivialises the complex nature of drug dependence and the common co-morbidities.^{xxiii,xxiv} Financial incentives for ‘full recovery’ could encourage services to exclude those unlikely to achieve this goal. Abuse and stigma risk becoming commonplace, exacerbated by withdrawn payments for ‘recovered’ clients who relapse within a year. Offering insufficient rewards for proven public health services such as NSP, OST and overdose prevention will damage the population the Roadmap aims to help.

Evidence and experience clearly demonstrate that OST can effectively tackle dependence,^{xxv} prevent HIV^{xxvi} and hepatitis C,^{xxvii} reduce illicit drug use,^{xxviii,xxix} prevent overdoses,^{xxx} ensure retention in treatment,^{xxxi} save lives,^{xxxii} reduce crime and re-offending,^{xxxiii,xxxiv} and support employment,^{xxxv,xxxvi} housing status,^{xxxvii,xxxviii} mental and physical wellbeing,^{xxxix} and personal relationships.^{xl} In some cases, OST in isolation has failed to meet wider psychosocial needs, and these programmes must adapt, support a more inclusive goal of ‘recovery’, and constantly improve like any other health service. However, the Roadmap implies that even when OST is working for an individual, this is still not good enough. Successful treatments will be withdrawn based on the Government’s value judgements, and this threatens the autonomy of medical personnel. It also contradicts the evidence and puts patients at unnecessary risk — research shows that withdrawal under duress is ineffective and can increase illicit drug use.^{xli,xlii,xliii}

The Roadmap will waste scarce resources:

The Roadmap bypassed public consultation, yet carries logos from eight governmental departments. It lacks detailed guidance on how services can achieve the prescribed goals, and omits any financial analysis: there are around 200,000 adults in treatment,^{xliv} yet how they will all be supported (and funded) toward ‘full recovery’ remains unaddressed. Cost effectiveness is a major concern, as the effectiveness of psychosocial treatments alone remains unproven.^{xlv} Relapse rates could rise if abstinence is forced upon people^{xlvi} and withdrawing successful prescriptions will undermine progress toward employment etc.^{xlvii} Health costs associated with overdose and infections may also spiral. By contrast, existing UK drug treatment provides around £2.50 in benefits to society for every £1 spent,^{xlviii} and NSP has been found to return AUS\$5 in healthcare savings for every AUS\$1.^{xlix}

In order to protect and improve the lives of people who use drugs, their families and their communities, we strongly oppose a Roadmap that is devoid of evidence to support the changes and ignores the evidence against. It neglects decades of success and best practice in harm reduction and recovery-orientated drug treatment. The ideologically-driven hierarchy (with ‘full recovery’ at the top and any other achievement marked as inferior) profoundly misunderstands the lives of many people who use drugs, the complexity of their problems, and the services that work with them. We therefore call upon the Government to reconsider

the approach described in the Roadmap, to consult with all of the relevant stakeholders, and to develop a more rational, meaningful policy document.

We the undersigned look forward to your response.

Organisations

Association of Nurses in Substance Abuse (ANSA)
Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine
Crime, Culture and Control Research Group, University of Kent
Harm Reduction International
HIT UK
International Doctors for Healthy Drug Policies
International Drug Policy Consortium
International Network of People Who Use Drugs
Methadone Alliance
National AIDs Trust
National Needle Exchange Forum
National Users Network
Public Health Wales
Release
Substance Misuse Management in General Practice
Terence Higgins Trust
Transform Drug Policy Foundation
UK Harm Reduction Alliance
UK Recovery Federation

Individuals

Professor John Ashton
Dr Caroline Chatwin
Dr Jennifer Fleetwood
Paul Flynn MP
Professor Chris Hale
Professor Keith Hayward
Julian Huppert MP
Neil Hunt, Honorary Research Fellow
Dr Jonathan Ilan
Dr Axel Klein
Tom Lloyd, Former Chief Constable for Cambridgeshire
Professor Susanne MacGregor
Bill Nelles
Dr Kate O'Brien
Lord David Ramsbotham
Professor Larry Ray
Professor Tim Rhodes
Professor Toby Seddon
Professor Alex Stevens
Professor Gerry Stimson
Dr Adam Winstock

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