

THE ORIGINS OF CONFLICT IN DEPENDENT DRUG TREATMENT: LESSONS FOR PARTNERSHIP WORKING

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Abstract

Although partnership working has been consistently recommended for the treatment of drug dependency, such working practices often remain both fractured and limited (Heath, 2010). Through the analyses of drug policy and guidance documents developed since the publication of the 1998 UK Drug Strategy and interviews with practitioners from the field, this paper seeks to identify the possible origins of such problems. The author illustrates how the reframing of drug policy, as documented by Duke (2013), has resulted in the articulation of inconsistent messages that not only provide opportunities for the development of varying interpretations but may have reinforced the polarised treatment ideologies observed in professionals working with dependent drug users, acting as a potential barrier to the achievement of 'collaborative advantage' (Huxham & Vangen, 2005).

Keywords

drug policy; drug treatment; partnership; inter-professional; multi-agency

Introduction

Partnership working has become an inescapable feature of contemporary social policy (Heenan & Birrell, 2006) but 'nowhere is it more apparent than in the treatment of drug misuse' (Heath, 2010:185). Problematic drug users rarely present with issues relating only to addiction; multiple and complex needs, including mental health, housing and employment, are the norm rather than the exception (McLellen *et al*, 1986; Drake & Wallach, 1989; Hartwell, 2004). If the diversity of these needs is to be addressed it is perhaps inevitable that drug users will require support from a range of disciplines and agencies. Therefore, over the last 20 years policy-makers in the UK and abroad have consistently recommended that public sector agencies collaborate in order to address drug users' needs. However, as the 2010 UK Drug Strategy (HM Government, 2010:5) acknowledges 'although there has been some progress in tackling drug dependence, an integrated approach to support people to overcome their drug and alcohol dependence has not been the priority'.

The aim of this paper is to explore some of the possible origins of the difficulties associated with partnership working in the drug treatment field. In particular, this paper shows how the reframing of UK drug policy and guidance developed since the 1998 Drug Strategy has not only failed to adequately acknowledge the problems associated with partnership working but may have contributed towards them.

Background

Recognition of the multi-faceted nature of problematic drug use and calls for collaboration are nothing new. In an attempt to shift attention away from the narrow medical model of treatment towards a more multi-disciplinary approach the Advisory Council for the Misuse of Drugs (ACMD) in 1982 suggested that:

'individuals with whom the treatment/rehabilitation system is concerned may have various problems arising from the misuse of drugs... These are not solely physical or psychological problems, but also social and environmental problems, being concurrently psychologically dependent on some drugs and physiologically dependent on others, and at the same time having financial or legal problems or difficulties over housing. The response to the needs of drug misuse therefore requires a fully-multidisciplinary approach.' (ACMD, 1982:34).

Similar recommendations continued to be made into the 1990s. In 1993, both the Department of Health (DH) and Home Office identified the need for more effective joint-working (Drake & Wallach, 1989; Reed Report, 1993). In 1995, Tackling Drugs Together (HM Government, 1995) reinforced the partnership approach to local drug strategy and commissioning through the creation of Drug Action Teams (DATs), comprising representatives from agencies such as health, probation, police and local authorities. Similarly, numerous subsequent policy and guidance documents – the 1998, 2002, 2008, and 2010 Drug Strategies (HM Government, 1998 2002; 2008; 2010), Models of Care for

the Treatment of Adult Drug Misusers (NTA, 2002), and Drug Misuse and Dependence: UK guidelines on clinical management (DH, 2007) – have consistently recommended that health, social care and criminal justice agencies work collaboratively to address the complex needs of problematic drug users.

Despite the consistency of these recommendations and recognition that failure to attend to needs in relation to mental health, accommodation, employment, training, and education is likely to undermine progress in other areas, partnership working has yet to be effectively implemented. Research examining the working relationships between drug treatment and mental health services has highlighted major concerns relating to the willingness of agencies to treat individuals with co-existing drug and mental health problems simultaneously (Baldacchino, 2007). The wide range of systems, institutions and agencies involved, that often have very different goals, values, responsibilities, organisational structures and resources, have been suggested as reasons for this reluctance (Hawkings & Gilbert, 2004:30). Weaver *et al* (1999:137), for example, commented that ‘the medical model of psychiatric services, with their recourse to legal compulsion to treat those incapable of making rational health choices, contrasts sharply with the psychosocial orientation of substance misuse services’.

It has been suggested that these types of difficulties have been amplified through the increasing introduction, over the last decade or so, of criminal justice agencies and their punitive mandate into the drug treatment milieu (Matrix Knowledge Group 2008; Heath, 2010). The implementation of Drug Treatment and Testing Orders (DTTOS) encountered a number of difficulties that appeared to be related to the cultural, ideological and philosophical differences between the treatment and criminal justice staff, resulting in fundamental problems around partnership working between the two groups (Turnbull *et al*, 2000; Hough *et al*, 2003; National Audit Office, 2004). Issues of concern related to the use of coerced treatment and the role that drug workers had in enforcement practices (Heath, 2010). There were also concerns about whether treatment should aim for abstinence or harm reduction. Drug treatment services, with their established tradition of tolerance and support, were more likely to accept a reduction in drug use and offending, which conflicted with the goals of abstinence from all drugs and complete cessation of offending thought to be favoured by the criminal justice system (Duke, 2010). However, as this paper will illustrate, the difficulties encountered during the implementation of DTTOS, and other multi-agency initiatives since, may have been exacerbated by a punitive and abstinence-based ethos characteristic of the political agenda that has underpinned their introduction.

The punitive and abstinence-based turn in UK drug policy

As a consequence of the changing profile of the heroin user, addiction during the late twentieth century became increasingly linked to poverty, deprivation and, importantly, crime (Seddon, 2011). During the 1980s consensus between government and those working in the drugs field largely remained as, in an effort to prevent the spread of HIV infection amongst intravenous drug users, drug policy focused on harm-reduction principles. However, by the mid-1990s this consensus dissipated as the relationship between drugs, crime, punishment and treatment became progressively more

pronounced (Duke, 2006), with drug users viewed not only as transmitters of disease but also as a risk to the public in terms of 'drug-driven crime'.

The progressively more pronounced link between drugs and crime is what Duke (2013) has since referred to as a consequence of the redefining of the drugs 'problem' and drug users – a politically driven imperative arising from the UK's relationship with the USA resulting in the transplanting of American ideologies and practices such as coerced treatment, drug testing and drug courts. One of the first of these can be seen in the 1995 drugs strategy, *Tackling Drugs Together*, which marked a fundamental shift in the direction of British drugs policy from the harm reduction principles of the 1980s and early 1990s towards the discourses of 'crime', 'enforcement', 'punishment', and a greater involvement of the criminal justice system. Also influential was the General Assembly Special Session hosted by the United Nations in June 1998 that adopted the slogan 'A Drug Free World – We Can Do It!' Four months later the UK set out a 10 year Drug Strategy, *Tackling Drugs to Build a Better Britain* (HM Government, 1998), where the drugs and crime problems were said to be inextricably linked and that 'because of the complexity of problems, partnership really is essential at every level'.

One of the first initiatives to be implemented was the DTTO, which was intended as a high-tariff community penalty requiring offenders to undertake regular testing with the aim of abstinence from all drugs (RSA, 2007:69). Yet, it was through the implementation of these community sentences that disagreement between government and those working with drug users became evident. The DTTO evaluations revealed that two of the three pilot areas used methadone maintenance or other prescription drugs as part of a tailored package of care that was aimed at increasing offenders' motivation and resolving practical issues such as accommodation and monetary problems (Turnbull *et al*, 2000:9). In contrast to the political aims of DTTOs, progress towards abstinence in these areas was expected to be gradual and accompanied by relapses; a philosophy not too dissimilar from that of drug treatment services. The concerns expressed by drug workers during the DTTO pilots, therefore, are perhaps better described as being fuelled by the coercive shift in drug policy that is focused on 'compliance with the law' (Bean, 2002:58), including abstinence from drugs, rather than simply fundamental conflicts relating to the cultural, ideological and philosophical differences between the treatment and criminal justice staff. Despite the somewhat poor results of DTTO pilot programmes, which concluded that the study could hardly portray the pilot programmes as unequivocally successful (Turnbull *et al*, 2000:87), they became a key component of the 2002 updated Drug Strategy. Also included within this strategy was the introduction of the Drug Intervention Programme (DIP) that enhanced the drug testing powers introduced by the Criminal Justice and Courts Services Act 2000 and aimed to coordinate treatment for offenders at every stage of the criminal justice process.

While the discourses of crime, enforcement, punishment and abstinence were prominent in the drug policy developed at the time, ironically, harm reduction and methadone maintenance prescribing remained as key techniques in the treatment inventory. The initiatives being developed required an expansion to existing drug treatment arrangements – a responsibility assigned to the National Treatment Agency (NTA), which

was tasked with the development of Models of Care, a national framework for commissioning the treatment of drug users. Alongside Models of Care, was the DH's (2007) Drug Misuse and Dependence: UK Guidelines on Clinical Management; these guidelines were intended for clinicians and set out the structure and transfer from one tier of treatment to another. Central to both documents was the emphasis placed on the integration of care pathways and multi-agency working. While the aim of abstinence was featured in these documents it sat within a framework that was concerned largely with 'harm reduction' (Department of Health, 1999, cited in NTA, 2002:14) with abstinence featuring as the end point in a hierarchy of other legitimate and acceptable goals.

More recent drug strategies have maintained a strong focus on enforcement and crime reduction but much further emphasis has been placed on abstinence and the notion of recovery. While some have described this as a welcome change (McKeganey, 2012) others have suggested that it only reinforces a pattern that has continued since the mid-1960s, that drug users are seen as a source of risk (Seddon, Williams, & Ralphs, 2012) – previously it was in terms of their capacity to commit crime, now it is in terms of them being a burden on the economy by claiming benefits and failing to contribute as a tax payer – generating challenges for partnership working at a local level similar to those found in the implementation of DTTOs.

Given the complex policy that guides the treatment of drug use, it is perhaps unsurprising that multi-agency working within this field is so challenging. Robust partnerships are often determined by a 'shared work objective' (Corcoran & Fox, 2013:338). Yet, the objectives of the policy that guides such working relationships can often be stark in contrast. Through an analysis of drug policy and guidance documents published since the introduction of the 1998 UK Drug Strategy, this paper sets to explore these challenges further and attempts to expose some of their possible origins. In doing so, it will demonstrate that the difficulties faced by professionals when trying to work collaboratively have not only gone unacknowledged by national drug policy and guidance documents, but that the political agenda that has driven their development may have contributed towards them.

Methodology

While there have been numerous attempts to explain the transformations that have taken place in British drug policy in recent times (Seddon, Ralphs, & Williams, 2008; Duke, 2006; 2013) few studies have focused on the policies themselves and how the messages communicated within them are translated at a local level. Through the use of a qualitative design this paper attempts to address this deficit.

The documents selected for analysis were the 1998, 2002 update, 2008, and 2010 Drug Strategies, Models of Care for treatment of adult drug misusers: Update 2006 (National Treatment Agency 2006); and Drug Misuse and Dependence: UK guidelines on clinical management (DH (England) and devolved administrations, 2007), each of which have identified the importance of partnership working. These documents were selected not on the basis of a systematic review of policy documents, but on the advice of two

practitioners in the field as being the key documents that underpin the commissioning and delivery of drug treatment at a local level in the UK (Bullock, 2011; Noi, 2011).

Data for the analysis also draws on 20 face-to-face semi-structured interviews with drug treatment practitioners from two drug action team areas in the North West of England, and include personnel from drug treatment services, the NTA, police, probation and local authorities. This data was collected as part of a larger doctoral project examining the treatment journeys of dependent drug users, which was funded by the Economic and Social Research Council. Therefore, participants were selected through the use of a purposive sampling approach to ensure diversity in terms of the range of professionals who come into contact with dependent drug users during their treatment journey.

The interviews were carried out by the author and lasted, on average, around one hour. While the findings of the documentary analysis of policy and guidance documents inevitably guided some of the questions asked of professionals much of the content of the interviews was concerned with collecting data about multi-agency working more generally. Therefore, questions were tailored around roles, routines and relationships with other agencies, and knowledge about the various services and referral pathways available to them.

Ethical approval for this study was gained from the NHS National Research Ethics Service (NRES), reference 07/Q1407/Q73. In accordance with this approval, written consent was obtained and interviews were conducted in private, recorded with permission, and transcribed. While illustrative verbatim quotes appear in this paper the interviewees' identities are protected through the use of a pseudonymous name.

While the field work produced a lot of high quality data, the methodological approach does, inevitably, have some limitations. The research was a small scale, localised study that included interviews with a relatively small group of professionals. The views presented in this paper, therefore, do not necessarily represent the views of others from the same profession. Had this been a study with few resource restrictions more interviews would have been conducted.

Theory of Collaborative Advantage

Due to the potential advantages to be gained from partnership arrangements, the subject has been extensively researched and contributions have been made from a number of disciplines (Gray, 1989; Kanter, 1994; Das & Teng, 1997). Few, however, explicitly address the practice of collaborating, which is central to Huxham and Vangen's (2005) 'Theory of Collaborative Advantage'. This theory explores the nature of partnership working but focuses specifically on the reasons why such initiatives tend to challenge those involved. Given the somewhat limited and fractured implementation of partnership working in the field of drug treatment the theory of collaborative advantage provides a helpful framework to explore the challenges facing such partnerships.

Huxham and Vangen (2005) identify several issues that present particular challenges to collaborative initiatives, and which, they argue, must be managed to achieve

'collaborative advantage', an expression used to describe 'the desired synergistic outcome of collaborative activity suggesting that advantage is gained through collaboration when something is achieved that could not have been achieved by any organisation acting alone' (Vangen & Huxham, 2003:562). These issues include the establishment of a common set of aims; having a balance of power among the collaborative members, trust; partnership fatigue; managing change; and effective leadership. Using these issues as the overarching framework for analysis, the author identified several inconsistencies between the policy and guidance documents that perhaps not only fail to address the problems identified by Huxham and Vangen (2005) but potentially exacerbate them. The most overwhelming examples of these inconsistencies were found in the documents' messages about the aims and objectives of drug treatment. Consistent with Huxham and Vangen's (2005:61) advice, if partners are to work together effectively it is necessary to have common aims as a starting point. However, the variety of organisational and individual agendas that are present in collaborative situations often makes reaching such agreement difficult:

'Most of the problems which ran through the implementation stemmed from the fundamentally polarised views of the key partners which surfaced repeatedly at each level. The tensions and conflicts which bedevilled implementation are one consequence of this polarisation which, once it was locked into the strategy, had been difficult to shift.' (Easen, 1998:6, cited in Atkinson *et al*, 2002:8)

The following discussion explores these types of problems with reference to two key debates in the drug treatment field: the use of the criminal justice system to divert drug using offenders into treatment; and abstinence versus harm reduction approaches to treatment, both of which have been previously identified as barriers to successful partnership working (Turnbull *et al*, 2000; Hough *et al*, 2003; National Audit Office, 2004). Not only are inconsistent messages about the aims of drug treatment identified in the documents but also illustrated is how such messages are then translated at a local level.

The use of the criminal justice system

Programmes designed to engage drug-using offenders into treatment have been characteristic of drug treatment policy following the 1998 Drug Strategy (Stimson, 2000; Hough, 2002). To some, initiatives such as DIP are essential tools to encourage drug users into treatment (Oerton *et al*, 2003; Hellawell, 1995), to others, they have resulted in the criminalisation of drug policy (Duke, 2006) and the premise on which they have been developed – that drug use causes crime – is seriously flawed.

Undeniably, there is a strong link between drug use and crime in many societies. Offending and drug use are often done by the same people in the same places. A number of studies have shown that drug users tend to offend most frequently during periods of intensive drug use (Gossop, Marsden, & Stewart, 1998; Jones *et al*, 2007). Others, the most influential being Goldstein (1985), illustrate how the two issues are causally related. However, as Stevens (2010) has effectively argued, evidence supporting causality between drug use and crime is over exaggerated and has rarely been tested empirically. Research

findings, he suggests, have been used selectively to support the crime-driven drug policy agenda and this has had a profound effect on the provision of drug treatment.

Despite these questionable links the Home Office, through the 2002 Drug Strategy, emphasises the causal relationship between drugs and crime suggesting that:

'The use of drugs contributes dramatically to the volume of crime as users take cash and possessions from others in a desperate attempt to raise the money to pay dealers.' (HMSO, 2002:3)

In an effort to protect society from so-called 'drug-driven crime', the 2008 Strategy outlined a policy of:

'Prioritising access to treatment for those drug-misusing offenders who enter through DIP and those leaving prison.' (HMSO, 2008:29)

Yet the DH, in the UK guidelines on clinical management, explicitly states that:

'Drug misusers in the criminal justice system should neither receive higher priority for their treatment nor should their legal status deny them access to care equivalent to that available in the community.' (DH, 2007:75)

While the DH (2007:75) recognises the relationship between drug use and offending, 'there is considerable overlap between those misusing drugs and those committing crime', the tone of their recommendations, 'the involvement of the accused is voluntary. It is not an alternative to prosecution or due process' (DH, 2007:76), contrasts sharply with Home Office rhetoric:

'A new initiative will come on stream to allow drug-misusing offenders to be given the choice by the courts, of entering treatment where appropriate, or being denied bail.' (HMSO, 2002:5)

The inconsistency of these messages appears to not only detract from the process of developing the clear shared vision that Huxham and Vangen identify as essential for effective partnership working but perhaps exacerbates what has been a point of conflict for some of the diverse professions working in the drug treatment field. While the focus of drug strategies on the link between drugs and crime may well have resulted in a substantial investment in drug treatment worth about £1.2 billion per year (Morse, 2010:4) it has nevertheless created opportunities for individuals within partnerships to drive forward a crime reduction agenda which focuses on drug using offenders but that might be incompatible with the agendas of other partners, as an NTA representative and DAT manager explained:

'The Chief Executive of a council is interested in community safety... antisocial behaviour and...crime reduction. So if the million pound [investment] reduces crime by 50%, well that's a good investment for him.

Whether anybody gets well or not is largely irrelevant. Now the people working in the services, that's a very uncomfortable message for most of them particularly because the message that is being communicated is that... the intervention can be successful and the investment will be repeated even if, in theory, the patient gets worse.' (NTA representative)

'There is some conflict because, obviously treatment services, their aim is to treat somebody but because the emphasis is on reducing drug-related crime more than there is to reduce general drug use; this has no doubt impacted on partnership working.' (DAT manager)

Perhaps unsurprisingly, drug treatment to a police sergeant was regarded simply as an additional crime reduction tool. What was surprising, however, was his view that crime reduction should be the aim of all partners/agencies and those who did not have this as a priority were then deemed difficult to work with:

'Our pledge is to reduce crime and this [drug treatment] is a crime reduction tool ... Non-statutory agencies can be particularly difficult to work with, they don't sometimes understand that they can be more guarded about their client group, which makes it harder to work with them. And I understand that but when the one thing that everybody's trying to do, whatever your agency is, is to reduce crime then there comes a point where you just have to say, well if you're not going to work with us on this, then we can't work with you. So there comes a point when I think you've just got to realise it's all about reducing crime. Yes it's about protecting clients, but the bottom line is, it's public money and public money wants reduction in crime.' (Police Sergeant)

While the reframing of drug policy away from the harm reduction principles of the 1980s towards the discourses of 'crime', 'enforcement', and 'punishment' may have resulted in a greater emphasis on partnership working, particularly between drug treatment services and the criminal justice system, it has nevertheless allowed for the creation and reinforcement of polarised ideologies in professionals working with dependent drug users. The links that have been forged between drugs and crime have, as Crawford (1997) may have predicted, enabled those working within a criminal justice framework to exploit the skills and knowledge of the drug treatment workforce to resolve crime for the benefit of the wider community, which contrasts sharply with ideologies found in health that place emphasis on the 'care' process such as personal choice that reflects 'client needs and experience' (Effective Interventions Unit, 2003:2).

This type of rhetoric has also impacted the provision of drug treatment in ways that were, perhaps, unpredictable (Mold, 2008). Despite the abstinence-based ethos that seems to have accompanied the rhetoric of 'enforcement' and 'punishment' found in criminal justice interventions developed since the 1998 Drug Strategy, ironically, it has been the use of methadone that has dominated the drug treatment inventory, not least because it has proved successful in reducing offending behaviour (Lind *et al*, 2005; Gossop, 2005;

Millar *et al*, 2008). The extent to which drug treatment should aim for abstinence or harm reduction, therefore, has remained a subject of debate and it is this that I wish to turn attention to next.

Abstinence versus harm reduction

Debates relating to the relative merits of abstinence or harm reduction approaches to treatment have been recently presented in a special edition of *Drugs: Education, Prevention and Policy* (Russell, 2012; McKeganey, 2012; Peele, 2012; Wardle, 2012; Robertson, 2012; Ashton, 2012). Also highlighted in this edition was the apparent existence of competing philosophies of drug treatment providers, demonstrating that we are some distance from achieving an agreement about the overarching aims of drug treatment:

'Attitudes prevalent among addiction treatment providers regarding the ontological truth and falsity of competing philosophies of the goal of addiction treatment...stand as the most significant impediment to transitioning services towards use of eclectic, pragmatic treatments which incorporate methods from both philosophies to maximize clients' opportunities for recovery.' (Russell, 2012:275)

Rather than seeking to reach a shared understanding about whether drug treatment should aim for harm reduction, abstinence or some mixture of the two, the direction of policy and the messages contained within guidance documents appear to exacerbate the debate by communicating, again, apparently inconsistent guidance. Both the 2008 and 2010 Drug Strategies stress the importance of abstinence:

'The goal of all treatment is for drug users to achieve abstinence from their drug of dependency.' (HMSO, 2008:28)

'Our ultimate goal is to enable individuals to become free from their dependence; something we know is the aim of the vast majority of people entering drug treatment. Supporting people to live a drug-free life is at the heart of our recovery ambition.' (HMSO, 2010:16)

These goals are in line with the more recently published document *Putting Full Recovery First* (HM Government, 2012:2-6), where the Chair of the Inter-Ministerial Group on Drugs, suggested that the government's 'goal is to enable individuals to become free from their dependence, to recover fully and live meaningful lives' and that 'people on substitute prescribing will also be expected to engage in effective recovery activities to ensure that they move towards full recovery as quickly and as appropriately as they are able to'.

Ironically, this document also asserts that 'the existing evidence base underpinning effective treatment interventions for substance misuse is set out in a number of influential publications including NICE guidance and the 2007 UK Clinical Guidelines' (HM Government, 2012:8). Yet the recommendations of such guidelines take a more equivocal

approach, by highlighting different treatment options and emphasising the benefits of a harm reduction:

'Whether clients wish to be maintained in the community on substitute opioid medication or wish to be drug-free, drug treatment systems should be well integrated with other systems of care and social support.' (NTA, 2006:10)

'These goals can be interrelated, For example, they may include the attainment of abstinence at the same time as achieving improvements in psychosocial functioning in areas unrelated to drug use. The treatment goals will depend upon the motivation and circumstances of each individual. Some may be willing to commit themselves to a determined effort to become abstinent. Others may be unwilling to do so, but may still be prepared to make some changes (such as reduction in risk behaviour).' (DH, 1996, cited in DH, 2007:25)

These documents also recognise that addiction is a chronic and relapsing condition characterised by relapses requiring longitudinal care (NTA, 2002), which seems to contradict the sentiments of the Putting Full Recovery First document and the 2010 Drug Strategy which emphasise time limited treatment; ideas that have since been criticised as alarming for 'those in treatment who already fear the threat of time-limited sanctions' (Daddow, 2012). It is perhaps of little surprise, therefore, that despite the much stronger emphasis on 'full recovery' drug workers are still somewhat unsettled about what their practice should entail.

Some drug workers expressed an investment in the 'recovery agenda' emphasising that it had been a goal of theirs for many years. A Senior Substance Misuse Practitioner and a Criminal Justice Treatment worker insisted that the aim of maintaining people on methadone was not one that sat comfortably with them:

'I was never really interested in keeping people maintained on methadone...so this whole new approach now, of moving them on and getting them out is kind of more up my street.' (*Senior Substance Misuse Practitioner*)

'Our agenda's changing at the moment, the last ten years the model has all been about harm reduction and that was hard for me to get my head around because I came from a rehab background so I had the whole abstinence thing instilled in me, so when I came here I was a bit like, people take methadone for 10 years, what's going on, why aren't we getting them clean.' (*Criminal Justice Treatment Worker*)

Conversely, many workers maintained the importance of harm reduction emphasising principles of safety, as a Detox nurse and a Substance Misuse Liaison worker, explained:

'On the recovery side, when you first do the detox role, you want to be very encouraging and give a really good review of recovery, how great it is. But on the other side you're kind of thinking, well, look at this client, stable, they're able to parent their kids, they're managing their money, alright they're on methadone but actually they're doing alright.' (*Detox Nurse*)

'If you came into this service thinking all the clients I see I'm going to get them drug free, then you might as well give up because that isn't going to happen. And I tend to work on the more holistic basis, if you like, am I going to help them improve their lives, am I going to help them reduce the amount of harmful substances that they're using? Am I going to educate them about what injecting does and what the risks of overdose, harm minimisation? I'm more into that...harm minimisation and improving the quality of their life.' (*Substance Misuse Liaison*)

As the RSA (2007:169) points out, one major difficulty with current drug policy is that, while much of the rhetoric is prohibitionist – that is, it advocates total abstinence from drugs – much of the implementation of policy accepts that drugs will be used and seeks to reduce the amount of harm they cause. Not only do these divided treatment ideologies, which have potentially manifested from the reframing of drug policy, prevent services from providing 'pragmatic treatments which incorporate methods from both philosophies' (Russell, 2012:275) but they also isolate drug workers from each other (Wardle, 2008) and, as Huxham and Vangen (2005) indicate, potentially other agencies.

Discussion and conclusion

There are a number of practical and conceptual challenges to partnership working. These challenges have been well documented in 'how to do it' manuals and guidelines. Huxham and Vangen (2005), for example, highlight the importance of, but difficulties in achieving, shared values necessary for successful partnership working. However, as Newman (2001:112) indicates:

'problems are experienced within partnerships themselves but their origin may lie elsewhere: in the interaction between the external and internal collaborative environment created by such factors as the policy approach of government... However well a group may work at building collaboration and trust, it may nevertheless come unstuck because of external shifts and ambiguities.'

Such external shifts and ambiguities were clearly evident in the policy and guidance documents examined in this paper. Changing policy agenda, or what Duke (2013) has referred to as the reframing of drug policy, has inevitably led to the communication of inconsistent and, sometimes, conflicting messages, particularly about the aims of drug treatment, having important implications for the way in which partnerships work at a local level. These ambiguous messages inevitably provide opportunities for individuals within partnerships to selectively choose aspects of the documents that support their own agendas and wishes to develop services in certain directions, which may be incompatible

with the agendas of other partners. The 2002 and 2008 drug strategies emphasise the need to reduce drug-related crime, potentially attracting the attention of those working within the criminal justice system. Whereas, the documents produced by DH, which emphasise the need to treat individuals, are perhaps more likely to appeal to those working within a health and social welfare framework. The implication of the use of the documents in these ways is that such agencies, which play a large part in partnership working within drug treatment, may begin to pull in different directions, resulting in the establishment of differing aims and objectives, a barrier to the success of collaborations (Huxham & Vangen, 2005). Therefore, the failure of collaborations to develop 'concrete attainable goals' (Mattesich & Monsey, 1992), and to 'identify and appreciate a common sense purpose' (Gray, 1995), may be at least partially due to the ambiguities articulated in strategy and guidance documents; ambiguities that have come about as a consequence of changing political agenda.

Partnership working is difficult, especially in a field which produces numerous policy and guidance documents, involves numerous organisations, all of which may have, unsurprisingly, differing priorities and agendas. This paper has shown that rather than helping to resolve the difficulties experienced by those working in partnerships, the national drug policy and guidance do, to some extent, contribute towards them. The overwhelming message and one which is presented by research into collaboration is 'don't do it unless you have to' (Huxham & Vangen, 2005:13). However, in a system which continues to promote partnership working as a response to the complex needs of drug users, this conclusion is neither useful nor acceptable. Drug users present to treatment with a diverse range of issues which clearly require the intervention of professionals from an equally diverse range of specialism.

Perhaps it is necessary to accept that in the drug treatment field the development of shared visions and clear sets of aims and objectives, which facilitate successful partnership working, cannot be easily achieved. As Duke (2013) suggests, in some policy areas, disagreement and debate can be resolved with reference to evidence but in the field of drug misuse this can be difficult due to the value judgements of policy makers involved. Given the more recent policy shift from crime and the criminal justice system to the notion of 'full recovery' and the promotion of abstinence-based approaches to the treatment of drug dependency (HM Government, 2012) the abstinence versus harm reduction debate seems set to continue (Russell, 2012). Hence, a consensus about the overarching aims of drug treatment is unlikely to be achieved anytime soon which will continue to present as a threat to successful partnership working.

In order to achieve, therefore, what Huxham and Vangen (2005) describe as 'collaborative advantage' a more pragmatic solution to these problems is required. For example, where collaborations are having difficulties in developing a clear set of aims the stance taken by management theorists is that joint working should move forward in carrying out their tasks, the argument being that 'joint action should be the beginning of a virtuous circle in which successful action breeds mutual understanding and paves the way for the emergence of joint aims at a later stage' (Huxham & Vangen, 2005:216). Therefore, emphasis should be placed on the implementation of good local arrangements that

recognise the various problems of partnership working, acknowledges the inconsistent messages articulated in strategy and guidance and, importantly, understands the reasons why such inconsistency exists, but is robust and flexible enough to work through them. In other words, parties should seek to gain at least *enough* agreement for them to move forward by seeking a *common ground* rather than trying to agree an all-encompassing statement of aims. For example, as Ashton (2012:301) acknowledges, 'the distinction between harm reduction and abstinence-oriented based approaches can neither be eliminated by good intentions nor resolved by evidence; it is a matter of values – what matters most to the person making those judgements'. The *common ground* sought, therefore, might be the intention to improve the health and wellbeing of the individual in question. While the route taken to achieve this might be very different the outcome should be alike.

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