



'There is a choice to be made in drug policy spending, but not between crime and health harm reduction. A pound spent on prison cannot be spent on treatment, residential or otherwise. This conflict in spending priorities is much more important than the rather tired argument between abstinence and harm reduction..'

Distorted evidence

Many drug service users, workers, managers, commissioners and researchers would support a call for residential rehabilitation to be more widely available. However, such a call should not be based on a distortion of the available evidence. Kathy Gyngell and Andy Horwood write that 'drug-free recovery achieved through residential treatment is the only intervention with a real weight of evidence to support the work being done' (*DDN*, 19 November, page 8). This is not true.

Repeated studies of various forms of treatment – many using methods far more rigorous than the NTORS and DORIS studies referred to – have shown that both methadone maintenance and residential treatment are effective in reducing drug use and crime (see, for example, the meta-analysis published in 2002 in *Drug and Alcohol Dependence* by Prendergast *et al*, or the Cochrane review of methadone maintenance of the same year, or even this year's NICE guidance on drug misuse). If there is evidence that residential treatment is more cost-effective than other modalities, let's see it, rather than relying on a guess from a drug service manager, as Gyngell and Horwood seem to.

They also suggest that the report published by the UK Drug Policy Commission sets up a false choice between reducing health and criminal harms. As one of the authors (with Peter Reuter) of this report, I can say that this, again, is not true. In a field where definitive proof of positive

impacts is hard to find, there is evidence to suggest that harm reduction and treatment are effective in both saving lives and cutting crime. There is far less evidence that increasing the imprisonment of drug offenders (as has been done in the UK in the last decade) has a good effect on either crime or health.

So there is a choice to be made in drug policy spending, but not between crime and health harm reduction. A pound spent on prison cannot be spent on treatment, residential or otherwise. This conflict in spending priorities is much more important than the rather tired argument between abstinence and harm reduction which Gyngell and Horwood seek to revive.

Alex Stevens, Senior Researcher, European Institute of Social Services, University of Kent

A life of choice

I read your recent article 'Abstinence – a better way to a brighter future?' with increasing irritation (*DDN*, 19 November, page 8). I have been maintained on methadone by my GP for some years; before this I was an IV user of heroin and cocaine with rapidly collapsing veins and deteriorating health. Methadone has given me the opportunity to live an ordinary life with choices.

I'm lucky enough to be able to pick up my medication weekly so it causes very little disruption to my life and is also cheaper to society at large as it reduces dispensing costs. Yes, sometimes I still smoke heroin but it

no longer dominates my life and as a result I have the time to do a lot of work around service user involvement and sit on multi-disciplinary panels here in Bristol involved in monitoring and improving treatment for me and fellow drug users.

Some time ago I tried for drug abstinence but simply ended up relapsing – the whole process caused much unnecessary pain and disruption. I've always been aware of the option of residential rehab, but it's not something I want. Many service users I work with are drug/alcohol abstinent and I believe that shaping policy on the basis of comments from people who have already achieved this is fatally flawed.

The Conservatives should pay more attention to those of us still choosing to use drugs. Residential rehab is an immensely expensive option and should only be promoted for those that want it – otherwise it's a huge waste of resources! It's well worth remembering that drug users who are not in any kind of treatment *ie* substitute prescribing, are ten times more likely to die.

Richie Moore, Bristol

Need a reality check

I read Kathy Gyngell and Andy Horwood's article (*DDN*, 19 November, page 8) with a certain level of positive anticipation. There is no doubt that residential rehab and abstinence programs have fallen by the wayside as the government focuses heavily on Tier 2 and 3 interventions. However,

apart from a brief nod at the end to 'redressing the balance', the two authors present their argument very much as an 'either/or' debate (an accusation they themselves level at the RSA reports conclusions on crime and health).

The reality of the situation is that Tier 2 and 3 treatment sectors should feed directly into Tier 4. There is no reason why an abstinence emphasis should be mutually exclusive from a harm reduction emphasis – I would go so far as to say, funding issues aside, many areas are already using this double-pronged approach.

Comparisons were made between treatment programs in Holland and Sweden – somewhat fatuous due to the admitted low drug use in those countries. I ask the authors to look at another country with a more comparable drug problem to the UK – the USA. For many years, fuelled by 'the War on Drugs' and an almost fanatical inability to accept the failure of this policy, abstinence programs have dominated. In full, over 90 per cent of American residential rehabs (a much more common treatment option than in the UK) are currently 12-step based. Has it solved the country's problem? Has it come close? I think we all know the answers...

I share some concerns with the authors about workers becoming 'harm reduction Nazis' – if a client tells me that he wants to aim for rehab, I want to help him achieve this. Forcing people to move forward slower than they want to, will do more harm than good – I have seen this and

always despair. However, I have the same concern about the 'abstinence Nazis' – forcing people to go forward more quickly than they are prepared to is simply setting them up to fail.

The '58 per cent of addicts want to become drug free' statistic (bandied about so gratuitously by prominent Tory politicians recently – we should not forget that the authors of this report are politically motivated) reflects my own personal experience of client work. But it doesn't mean that they all want to have immediate detox and rehab as their only option. Most would prefer to have community-based substitute prescribing treatments, and aim toward becoming drug free at their own pace. And where does this 'abstinence only' programme leave the other 42 per cent? Do we just ignore their needs?

In conclusion, the reality of the situation is that there is a rehab funding crisis occurring in the UK at the moment, one that has been well reported in *DDN*. Improving the situation should not be at the expense of Tier 2 and 3 services.

Stephen, by email

Surely some mistake?

I was delighted to see the 'First National Service User Involvement Conference' on the 31 January, in Birmingham (my old stomping ground) advertised on the *DDN* website. And there in bold letters, 'Nothing about without us'. Well, I am afraid it will be 'without us' – well those who can't afford to pay £88 as service users.

I am not stupid enough not to realise this conference is very costly to put on – hiring the venue, food and drink (smoked salmon and champagne seems to be a favourite as I remember). This conference 90 per cent of British service users will know nothing about. The majority of the ones who will find out about it will not be able to afford to attend.

There are multi-national pharmaceutical companies making billions from service users. There will be organisations who are funded by these companies who will have their stalls out, selling their products. Same old story.

David Wright
Volunteer Welsh Drug advocate

We sincerely hope it won't be the same old story. We're doing everything we can

(as a free magazine) to keep costs of our conference down and are pleased to say that most DATs are meeting us half way and covering the costs for service users – we have places booked from all over the country, from Cornwall to Newcastle. For those who can't get their DAT to pay for a place, please contact us and we will do all we can to help you attend.

Editor

Problematic assumption

Neil McKeganey's letter (*DDN*, 19 November, page 15) contains a significant error. He states that if only 8 per cent of addicts left treatment drug free, then this is equal to 92 per cent of clients leaving with 'an ongoing drug problem'.

Unless we consider all ongoing drug use to be necessarily problematic, which I suspect Professor McKeganey does, then this is an erroneous assumption.

Paul Jacob, substance misuse worker, Brighton and Hove.

No dignity in drugs

In the report of his call for changes, (*DDN*, 19 November, page 6) there is no indication that Martin Barnes mentioned recovery as a viable option. His justified call for users to have 'choice' and 'dignity', does not appear to acknowledge that those still dependent on drugs have relinquished such human rights, with the drug induced erosion of their free will to exercise either – a decay that is irreversible with ongoing use. Their ability to address their mental physical and spiritual problems, together with their fundamental material needs is unable to develop and mature with continued drug use.

Paul Hayes calls for helping people out of 'treatment', while avoiding the reality that those still using are unable to start on the journey of recovery, which includes exercising the choice of using or not. Failure to recognise or acknowledge that simple fact eliminates the desirable goal of helping users to acknowledge and accept that if they choose to use, they surrender their choice to recover, together with their dignity.

Professor David Clark got it right as usual, with his call to focus on the individual and their recovery. In doing

so he pointed out that current protocols were preventing people leaving treatment drug free; that both commissioners and practitioners have yet to develop a clear understanding of how to help service users start on the road to recovery.

It is clear that the current practices, which are, in part, due to the NTA's insistence on politically motivated and convenient targets, combined with their seeming lack of insight into the complex nature of addiction, is denying users the 'choice' and 'dignity', which Martin Barnes rightly called for, inasmuch as any aspiration or hope that users have of becoming drug free is passively, if not actively, discouraged.

The latter view gains substance with the welcome appearance of Kathy Gyngell and Andy Horwood's excellent article in the same issue (page 8). Here they present the untainted facts and truth, together with the no-nonsense opinion of Paul Gilman. In doing so they highlight the superficiality of unsustainable and, in some cases, ludicrous claims of success, in respect of drug-related harms, based on the hopelessly inadequate and shallow 'Drugs Harm Index'.

Peter O'Loughlin,
The Eden Lodge Practice

Speak up about abstinence

I was taken by the different view of recovery of those presenting at the FDAP conference in early November (*DDN*, 19 November, page 6). I think David Clark summed it up when he said the word 'recovery', and noticed that it had not been used by any speaker before him.

It would be naive of me to think that all the woes suffered in the world could be cured by offering an abstinence programme for all alcoholic or addicted people and recovery from addictive behaviours as the daily goal for them all. However, the government, various agencies, and the general public seem to be at odds with cost-effective treatment outcomes, dis and mis-information

about the effectiveness of treatment, and exactly what treatment means. We are caught in a blizzard of language that is at best confusing, and worst deeply unhelpful to the suffering population and the rest of the community as well.

The NTA talks about treatment for heroin addicts as methadone maintenance – or by 'hosing them down with methadone', to use Dr Mike McPhillips' analogy. Cost, the quality of life and the continued dependency issues seem to be swept under the increasingly lumpy carpet. Successful outcomes for government agencies seem to be drinking less units of alcohol a week (measured how?), and still seeing people's health deteriorate and lives never being fulfilled to the potential that abstinence could create.

How much of the general population truly understands the nature of mind and mood altering substances and the effect they have on brain chemistry – and why would they in reality? If the information we now have about the changes that occur in the brain with continued use of cocaine, alcohol, cannabis, heroin, codeine, and all other prescribed and illegal class A, B, and C drugs was generally available and used in education, we might dispel the myth that people who end up addicted bring it on themselves.

Abstinence is not easy. It is a real challenge for most. Relapse is likely without continued support of the change process; it is almost to be expected, but not judged. We, as practitioners, and those in recovery need to come forward and speak the truth loudly about the benefits of abstinence as the treatment of choice. Speak of the cost benefits for those *Daily Mail* readers, lowered hospital admissions, lower crime rate, and lower antisocial behaviour on our streets. It works, and is so much better than maintenance with another substance, which costs money and, often, lives.

Richard Renson,
learning and development specialist,
The Priory Group

We welcome your letters

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