

Abstinence

a better way to a brighter future?

Methadone is a treatment but not what the public expects. It is not about getting addicts off drugs but keeping them on our drugs and out of jail and alive,' said Mark Gilman, the NTA's regional co-ordinator for the North West, speaking at last year's 'Prisons and Beyond' Conference.

Government is using drug treatment to deliver problem-solving, albeit with little success, rather than the recovery that addicts and their families hope for. Our analysis challenges conventional orthodoxy about what current treatment policy has achieved, what constitutes treatment and what it is for. Accounts of the addicts themselves – voices rarely heard above the noise of the experts and the lobbyists – suggest there is little mystery to what we found to be a history of chronically relapsing policy:

'There's no options... I was maintained on methadone for years and years, and not once did the doctor or a drugs worker say, "well, look, have you ever thought about rehab?" I think it would have got my mind thinking in a different way... You're still in that setting, you're still in your home town, with the same people, with the same drugs, the same everything. And you're very blinkered. Common sense will tell you that you need to get out and break the circle... On a methadone script, people still use; you've got no chance at all.'

Our analysis of the impact of harm reduction and treatment programmes on drug-related deaths and other harms exposed many of the prevailing myths.

Investment in failure

Any evidence of reduction in drug-related harms is hard to find on key measures. The Office for National Statistics (ONS) points out: 'Data on mortality risk are needed to measure whether interventions have succeeded in reducing the risk of death... no national data on trends in mortality risk among problem drug users have been available

since 1993.'

The drop in drugs deaths after 2000 was followed by a steep increase in 2004/5, largely accounted for by deaths involving heroin and morphine. Hepatitis C, re-offending, drug prevalence, problem use and the methadone 'cul de sac' – all rising statistics – are detailed and analysed in our report. Moreover the Health Protection Agency reports that new HIV diagnoses in the United Kingdom have doubled since 2000, exceeding 7,200 in 2004 and reaching 7,700 in 2005.

Next, the government's own harm reduction measurement tool – the Drugs Harm Index – is a highly doubtful abstract construction, with weightings based around shoddy treatment calculations, and proper quantitative cost analysis on savings via methadone unable to take account of quality of outcomes. Government treatment targets focus on proxy measures of retention and completion, not on proper 'drug free' outcomes. Increased treatment claims must be viewed with scepticism.

Further, the selective use of NTORS as 'evidence' of treatment cost savings – one which ignored the differential breakdown of 'outcomes' between methadone treatment and residential rehabilitation – lacks any credibility. We showed that the '£1 spent on treatment saves £ 9.50 in harm' mantra, which began life in the NTORS analysis papers as '£1 spent for £3 saved', was similarly flawed.

We also used the original Home Office research and follow-ups on DTTO re-offending rates, which show very poor outcomes for those offenders on the current methadone and counselling DTTO programmes.

Our analysis was based on an examination of the only credible evidence: the two treatment outcomes surveys – the NTORS breakdown and the latest two-year outcome of the DORIS (Drug Outcome Research in Scotland) survey – which

both confirmed that recovery is far more likely to be achieved through residential rehabilitation than through methadone programmes.

Desire for change

'If I'd have been offered this previously, when my illness hadn't progressed to the point that my life was totally unmanageable, if I had been given Castle Craig, or a system like this, then I wouldn't be sitting here today.'

In addition to data analysis we took evidence from over 50 organisations, including DATs, and over 100 individuals – many of them in recovery.

Their testimonies spoke of a systemic failure to take advantage of motivation for change – whether at presenting for treatment, arrest, imprisonment, the birth of a child – when timing is all. As with the DORIS evidence (58 per cent of the sample entering a new treatment cycle aspired to and hoped for recovery from drug use as opposed to 'stabilisation'), our witnesses aspired to being clean – to 'getting their lives back' and not being service dependent. The DORIS findings, Professor Neil McKeganey told us, showed, 'there is absolutely no comparison as to which programmes are most enabling drug users to achieve what overwhelmingly they are saying that they want.' (After three years 30 per cent were abstinent after residential rehab, compared with 7 per cent after methadone programmes). DORIS, NTORS, and the outcomes monitoring surveys conducted by RAPT and Clouds all show that drug-free recovery achieved through residential treatment is the only intervention with a real weight of evidence to support the work being done.

Recovery is possible

'When I first came here, I thought "I need to get off drugs", and that was it. But then I learnt that it was about learning life skills, which I never learnt

Abstinence works – the evidence is in the outcomes, say **Kathy Gyngell** and **Andy Horwood**, members of the Social Justice Policy Group, which compiled the *Breakthrough Britain: Addiction* report in July. Here they draw on their research to show that current treatment policy is doomed to relapse.

from being on heroin and methadone for 22 years... I just turned 40, and I'm thinking there's stuff that I don't even know... And I am just sort of like cramming it into a year.'

Addicts' testimonies confirmed the efficacy of abstinence treatment, particularly in the context of therapeutic community or 12-step style programmes. Yet they told of how they were routinely met with negative views about their 'readiness' for rehab or ability to change:

'I used to go and they said, "look, you don't turn up on time, you're very disorganised, we can't get in touch with you" – and I remember sitting there and saying, 'look, you know, I'm suffering from a condition... these are the symptoms of the condition.'

They told us how treatment services all too often close rather than open doors to change; of repeated emergency 'detox' and years of unchallenged methadone maintenance and drinking:

'It was always just about detoxing, getting detoxed and then getting back into society again – which didn't even touch the mental side of it. I'm 42 now, maybe when I was like 35 I would have got my life back then.'

Gulf between provision and need

The Home Office Drug Treatment Demand Model (the planning tool to help DATs match resources to local needs) anticipated that only 2.3 per cent of community treatment would be residential rehabilitation, and that a minuscule 0.7 per cent would be in-patient detoxification. For those very, very few that get rehab, funding is for unrealistically short periods of time:

'Aye, in 28 days I was physically better, you know I was well fed and all the rest of it, but I'd only scratched the surface mentally. Because the biggest thing I think is that people just don't understand the illness enough.'

The gulf between provision and need is huge

and has got worse. In a period of otherwise unprecedented investment in other treatment services and bureaucracy, effective treatment has been run right down. With only 2,400 rehab beds to start with, (in a treatment system claiming some 195,000 people) units have closed, beds have lain empty and their funding has remained unresolved.

Funding changes have hit effective family treatment too. In recent years 13 residential centres have shrunk to just five across the whole country. One CEO said in this treatment climate they could not invest in expansion, despite their 90 per cent successful recovery outcomes for keeping families off drugs and intact. 'I would promote this place until I drop dead to be honest,' one young father told us. Given the impact of adult addiction on family breakdown – 58 per cent of the 350,000 children of addicts are not living with their parents, 22 per cent of young women between 15 and 19 presenting for treatment have a baby – the failure to invest in proven services that change lives is woeful.

The one adolescent residential unit in the country – just 12 young people at any time – is also currently operating at half capacity because of the funding crisis. Yet at least 1,000 teenagers have 'hard' drugs problems; unacceptably the numbers maintained on methadone and graduating to the adult 'treatment' process is growing.

Time for a radical rethink

'I never thought that I would get to the stage... I see people come through this door, and see them progress, and it's unbelievable. Every user should have the opportunity to come through into rehab.'

The bottom line is that the primary policy goals of 'initiation of abstinence' and 'prevention of relapse' found in countries like Holland and Sweden, where problem drug use is significantly lower, have been lost from UK strategy and 'models of care'. Local treatment plans, commissioning and

tendering programmes as a result leave little room for straightforward rehabilitative care, although more than one drugs charity CEO has commented: 'It's probably the most cost-effective thing you can buy.'

Our analysis of published treatment plans for all the DATs in the South East region for 2005/06 showed that DATs commission over ten times more Tier 3 interventions than Tier 4. It found that less than 30 per cent of the treatment budget is spent on structured day care, counselling and residential rehabilitation, as opposed to 70 per cent on clinical need and harm reduction interventions. It showed that treatment outcomes, in terms of recovery for the individual and its knock-on impact for families, children and communities, are relegated to an incidental consequence in current policy.

The recent RSA report *Illegal Drugs, Communities and Public Policy* and the UKDPC Report present the policy battleground as an 'either or' distinction between crime and health harm reduction. The failure of the Home Office led drugs strategy has reinvigorated both the public health and decriminalisation lobbies.

Our evidence-based conclusion, by contrast, shows this is sterile ground; neither health nor crime drivers will work outside the concept of, and commitment to, recovery. This means radically redressing the balance in services, and focusing on quality over numbers – cutting back on target-driven bureaucracy and formulaic maintenance managerialism. It means investing more appropriately to meet the needs and aspirations of addicts, their families and communities, with the goal of recovery.

'Breakthrough Britain: Addiction' was compiled to provide policy recommendations to the Conservative Party. Download the report at www.centreforsocialjustice.org.uk/client/downloads/addictions.pdf