A flag in the breeze

Mike Ashton hoists a small flag in to Britain's addiction treatment policy breeze.

Stick your finger in the air and if you've wet it sufficiently you'll feel a new direction to the drug treatment policy breeze, a potentially powerful confluence of previously unaligned air streams. Old-style abstentionism, resurgent in the wake of receding national imperatives to curb infection and cut crime, is filling its lungs with the fresh air of the 'recovery' movement, and so too are our policymakers, aware that Britain can no longer afford for people *not* to recover – or at least, not *be seen* to recover – get off benefits, exit treatment and make way for patients we couldn't otherwise afford to recruit.

Each lends a mutually reinforcing puff to the other. Recovery advocates, who passionately desire a better life for the patients and for their families, see influential converts and allies. For its hitchhikers, the shiny vision of recovery and its power to inspire, provide renewed impetus and respectability. Abstentionism, ever present in a policy environment built on prohibition, can emerge more forcefully clothed as a prerequisite for an unchallengeable good – recovery from addiction. For the policymakers, recovery provides a benevolent rationale for the new treatment objective: to get rid of the patients.[1]

Ground conceded, ground occupied

Today's abstentionism has co-opted the language of recovery, hitching abstinence to an optimistic vision of a new life, while still insisting that this must be free from illegal drugs and free from their legal substitutes.

Partially aligning themselves with the abstentionists' abhorrence of anything which "would make drug use easier"[2] and of methadone maintenance as "perpetuat[ing] addiction and dependency",[3] the NTA, the government[4] and leading treatment providers[5] also agree that *true* recovery means no longer being prescribed substitute drugs and no longer being in treatment.

No matter how circumspectly, the addiction treatment patient is being stigmatised by virtue of still being a patient, and with them the treatment expressly dedicated to maintaining that status, maintenance prescribing.[6] Yet exiting treatment still using

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1 'Recovery' has had greater currency in Scottish policy circles while in England the new drug policy talked of the overlapping concept of 'reintegration', but at the Drug and Alcohol Today exhibition in London on 1 May 2008, Home Office minister Vernon Coaker repeatedly referred to 'recovery'.

2 Professor Neil McKeganey condemning the prospect of injecting rooms in Scotland.

3 Gyngell G. *Breakthrough Britain. Ending the costs of social breakdown. Volume 4: addictions*. Policy recommendations to the Conservative Party. Social Justice Policy Group, 2007.

4 National Treatment Agency for Substance Misuse board meeting 11 March 2008. Papers describe the new English drug strategy as "equally comfortable with abstinence and maintenance routes *through* treatment, but ultimately always focused on maximising the individual's potential to overcome dependency, *leave* treatment and live a *fully independent life*" (italics added).

5 *Residential Rehabilitation and the national drug strategy.* 19 October 2007. "What [methadone maintenance] treatment does not appear to do, however, is to provide a true exit from the interrelated behaviours, harms, risks and lifestyle norms associated with dependent drug use ... MMT offers better life prospects than class A dependent drug use; it is equally true that abstinence offers better life prospects than MMT."

6 Lavack A. "Using social marketing to de-stigmatize addictions: a review." *Addiction Research & Theory*: 2007, 15(5), p. 479–492: "a person who is stigmatized is a person whose social identity, or membership

illegal drugs doesn't look much like recovery either. The logic of the situation leaves just one truly acceptable outcome – off illegal drugs, off substitute drugs too, and out of treatment.

By virtue of conceding the ground on long-term substitute prescribing, our leaders find themselves on the turf of The New Abstentionists, masters at eliding abstinence with recovery as if one was predicated on the other.[7]

Self-fulfilling prophecy

This would all be fine if as a result of these alliances, recovery with no downsides really was the prospect awaiting our 100,000s of patients, and maybe that's how it will turn out. But maybe not. The problem is that curtailing treatment, and placing recovery on the pedestal of abstinence – not just from illegal drugs but from their legal substitutes – threaten *actual* recovery at the same time as they adopt and amplify its rhetoric.

Patients who could have recovered on methadone may be denied both the practical and the psychological resources to do so. Stigmatised people are *avoided*, not nurtured and embraced in to mainstream society,[8] and because we are our relationships, stigma is internalised as wilting self-efficacy or protective isolation.

The combination is likely to make it harder to leave treatment successfully and to further deter treatment entry (already a near last-ditch resort), leading to greater and less easily reversible deterioration before help is sought. More directly, pressure to terminate treatment could leave tolerance-free ex-patients at greater risk because for them too, the resources are not there to protect them.

Not only have we been here before, but so have others. When in the late 1990s New York's mayor Rudolph Giuliani moved to curtail methadone treatment, to predict what might happen, researchers trawled through the back catalogue of studies of discharge from the treatment. They concluded that as things stood, it would be "unwise to structure methadone programs and their financing so as to discourage or impede long-term maintenance, and at the same time to pressure patients overtly to accept abstinence by heralding its supposed desirability or superiority".[9] Post-discharge relapse was the norm and with it death, disease and social deterioration.

The paper's subtitle – "Lessons Learned, Lessons Forgotten, Lessons Ignored" – is as applicable to some in Britain today as it was then to New York.

Another lesson learned there is that denigrating methadone patients as by definition *un*recovered self-fulfillingly impedes their recovery. In the mid-90s experts who reviewed the literature for the state of New York concluded that what held patients

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in some social category, calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others" – reminiscent of the not "fully independent" formulation of the NTA.

7 For an example see: McKeganey N. "Recovery is key." *Druglink*: February/March 2008, where he moves in six quick steps from recovery through overcoming dependence to no illegal drug use to drug-free, then to abstinence and finally to defining that as also excluding substitute medication, as if each was either the same as or predicated on the other.

8 Lavack A. "Using social marketing to de-stigmatize addictions: a review." *Addiction Research & Theory*: 2007, 15(5), p. 479–492: "A stigma is usually attached to undesirable qualities, and a defining immediate reaction to stigma is avoidance of the stigmatized person … resulting in … social exclusion."

9 Magura S. et al. "Leaving methadone treatment: lessons learned, lessons forgotten, lessons ignored." *Mount Sinai Journal of Medicine*: 2001, 68(1), p. 62–74.

back from working and doing all the other things the rest of us do (in today's language, what obstructed their recovery) was not the medication or their dependence on it, but stigma in relation to the addict and the treatment. "Negative societal responses may be more significant contributors to any functional limitation patients may experience than any directly detrimental effects of chronically administered opiates, which our review suggests are of minimal or no functional significance."[10]

Tainting the new breeze is the whiff, not of recovery and reintegration, but of the relapse, exclusion, illness and overdose repeatedly documented in the studies. No one actually wants this to happen. But there's a strong possibility it will, as the product of mal-aligned forces within the drug policy arena and deficiencies and resistances outside. Coincidentally, at the same time the tools are being made available to obfuscate the consequences and the responsibility.

Water to wine

At a population level, the sole national indicator[11] dedicated to measuring the success of the treatment system allows us to declare victory regardless. Its standard for successful emergence from treatment – a planned discharge – often means nothing of the sort. In Cheshire and Merseyside (regions with unusually long series of data compatible with the national monitoring system), an even higher standard – drug-free planned discharge – was quickly followed by relapse and return to treatment at about the same rate as unplanned drop-out.

As currently constructed, such failures are not just hidden from the indicator, but could be recorded as successes. Only the final discharge status within a year is counted, closing the indicator's eyes to relapses within the year, and relapses and returns to treatment across years are recorded as yet another successful patient recruitment, which can once again be followed by a successful planned discharge or retention.

What this does to the system was expressed recently by a drug action team coordinator, local conduits for the national policy: "... yes we keep them for 13 weeks, yes they then get discharged, yes they end up back in treatment again within about three months. Do we spend DAT meetings talking about this? No, what we talk about are the central targets not the effect the targets are having on our services and not what the targets should be looking at." [12]

The interesting thing is that all this dangerous failure can happen without affecting target-meeting, so can be ignored by those responsible for meeting the targets. Not surprisingly, their attention is drawn to the national indicator instead, which dominates the funding allocation to their areas.

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10 Gordon N.B. *et al.* "Functional potential of the methadone-maintained person." *Alcohol, Drugs and Driving*: 1995, 11(1), p. 31–35.

11 In PSA Delivery Agreement 25. There are of course other related national indicators and local performance benchmarks. But this one matters because on it depends 75% of the allocation of central funds to local areas (McGrail S. Ever Decreasing Pools. 12 January 2008. http://homepage.mac.com/smcg1967/Sara%20McGrail/page14/files/4fb83a7485081de7989e4ef462293581-15.html)

12 Inspecting the field - Harm Reduction and Commissioning Systems. http://homepage.mac.com/smcg1967/Sara%20McGrail/page14/files/876a42b7f0139865094b3e52afc3e243-32.html, 12May 2008.

At an individual level, we have decided we can blame the drug user if the treatments we provide fail to engage them, or if they fail to emerge (staying is no longer good enough) transformed and recovered.

The new English drug strategy was at pains to be "clear that drug users have a *responsibility* to engage in treatment in return for the help and support available". Once engaged, "In return for benefit payments, claimants will have a *responsibility* to move successfully *through* treatment and into employment". (All italics added.) Holding them accountable via the benefits system creates a win-win situation for the Treasury if not for the patient: if they succeed, we save money because they are out of treatment, off benefits and back at work; if they fail, we cut their benefits anyway.

Just feel the numbers

Underpinning all this is the persistence of a perverse national objective – to see an increase in the number of our citizens who get so deeply in trouble that they need to resort to 'structured' addiction treatment, an unpalatable step many take only when things have deteriorated to the point where their lives afford no other hope of relief.

Through stigmatisation, criminalisation and exclusion, we push people deeper in to these holes and strip away the supports they might haul on to pull themselves out of their troubles, ourselves creating the 'chronic relapsing condition' we locate within the patient. If you want to know how that feels, listen to the voice of this DIP-recruited methadone patient:

"I really did think in my heart that I would be able to make it. But, I got backed into a corner every time. Every angle or way I tried to get up that ladder, I got kicked down. Because I have a criminal record, because I needed training, because I needed experience, because I never had a CIS card, I never had this, I never had that. I was always without a job, no matter how hard I tried to get a job, I could not get a job. I had too much time on my hands ..."[13]

Partly as a result of this process, numbers in treatment mount, and national objectives are met. To maintain, let alone continue to increase this tally, more must emerge the other end, dignified as successful treatment completion and recovery. Now we intend to make it these patients' responsibility to climb out of the holes we have helped push them in to – or else; or else not just prison, but further impoverishment and exclusion.

Circles to squares

There is within the current drug policy universe, a logic to these positions; from the point of view of someone trying to reconcile the irreconcilable, they make sense.

According to the only estimates we have, spending per patient[14] has been falling since at least 2002, and now we have a standstill in central funding until 2011, which means further cuts. Yet still we want the treatment entry rate to rise.

Squaring this circle means getting more people out the other end. As the NTA board were told in 2005, "Moving people *through* and *out* of treatment also improves

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13 Keene J. *et al.* "A case-study of substitute opiate prescribing for drug-using offenders." *Drugs: Education, Prevention and Policy*: 2007, 14(5), p. 443–456.

14 Taking in to account inflation and local contributions as well as central funding.

the efficiency of local treatment systems enabling the system to engage with newly presenting clients without having continually to expand capacity" (italics added).

But that is unacceptable unless we can declare them recovered successes. Otherwise we will have to admit that our treatment risks robbing them of the main protection they had (their tolerance to opiate drugs) without this being replaced by robust, individually tailored, above all, expensive anti-relapse supports which could sustain recovery, leaving them more vulnerable than they were before.[15]

Here's another circle to square, because not only are treatment resources more and more squeezed, but beyond the clinic, recovery resources are scarce and likely to get scarcer as the economy falters,[16] housing becomes even harder to find,[17] and socially excluding stigma restricts access to such resources as there are.[18]

In the clinic, spending a few minutes a week on someone's needs is already often the best we can do.[19] Expect that to get worse and notwithstanding the rhetoric, the drive for efficiency savings[20] to push us towards McDonaldisation[21] rather than individualisation of care.

Outside the clinic, the environment generates relapse more effectively than it does recovery. Our treatment leaders in the NTA know that's what it's like[22] but have little idea what to do about it.[23] Their hands are not on these reins. Generally, all they can do is hope that somehow, out in the cities and shires, it will happen – houses unlocked, colleges thrown open, employers open-armed, or at least, enough movement in those directions safely to mop up the 'planned discharges' we hope to increase in number.

A "revolution" across society which replaces stigma with compassion, and in doing so releases the freely given practical and emotional resources of our communities (including those most directly affected) might truly square this circle, and this is the

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15 As one part of the NTA wants to get patients out of treatment another recognises that "Retaining patients in optimised treatment is protective against overdose". McCarthy T. et al. *Reducing drug-related harm*. Presentation to National Needle Exchange Forum, 4 April 2008.

16 "A flimsy fightback." *The Economist*: 15 May 2008. http://www.economist.com/displaystory.cfm?story_id=11377022.

17 Local Government Association. "Social housing waiting lists 'rising'" http://www.lga.gov.uk/lga/core/page.do?pageId=565136, accessed 16 May 2008.

18 For several items highlighting increasing awareness of this in Scotland see *SDF* (Scottish Drugs Forum) *Bulletin* March/April 2008.

19 Best D. "Why would anyone claim to be a 'new abstentionist'?" *Druglink*: 2007.

20 Expected to be £50 million per year.

21 The reader is challenged to read this account of the process in Germany and consider if that country could be replaced by the UK without invalidating the story: Kemmesies U.E. "What do hamburgers and drug care have in common: some unorthodox remarks on the McDonaldization and rationality of drug care." *Journal of Drug Issues*: 2002, p. 689–708.

22 National Treatment Agency for Substance Misuse. *Business plan 2007/08:* "Access to wider systems of social support, housing, employment and education, for example, has not grown as rapidly as the treatment system itself … trapping people in treatment who could exit the system if they had access to a job and a home."

23 National Treatment Agency for Substance Misuse. *Business Plan 2007/08*: "However, there is only a limited amount that can be achieved via national initiatives in this area. Increasingly, the focus for facilitating drug misusers' access to local systems of support will be located within the local partnerships that directly control access to resources."

vision of the most vocal of the recovery advocates.[24] The problem is that pinning treatment's colours to fear of crime and before that to fear of infection may not have fostered much in the way of compassion for the 'theys' who threaten 'us'.[25]

Meantime these irreconcilables can be squared and made to seem to fit, first by not recording the failures, then by reserving the right to blame the patients if things go wrong. No wickedness or even intention need be involved or is being imputed – it's just the way the pressures pan out.

From unthinkable to reality (and back again?)

In Britain now is a strange time when neglect and/or the confluence of forces which before held each other in check are creating realities out of the previously unthinkable.[26] 'It couldn't happen here' no longer seems convincing. It could, and it might.

Within the drug treatment sector, a strong wind is blowing us towards a future in which we and the patients could lose the gains of the harm reduction era without in reality the compensating prize of recovery; an era even more comprehensively geared to harm production than the current one yet without its ameliorating focus on limiting at least some of the damage it creates.

But a wind at our backs is all it is – we are far from there yet and not even fully embarked on the journey. We can still hold the best from our current ground, supplement it with the best from the new recovery movement, and consign its unhelpful hitchhikers to the margins.

Despite under Labour feeling the wind most sharply, under the SNP, Scotland seems to have done just that. There Minister for Community Safety, Fergus Ewing, recently told parliamentarians that stabilisation on methadone was "a form of recovery" and stressed it was important that these patients were not "stigmatised and labelled". "You will not hear any of that language coming from us," he said.[27]

In New York Giuliani backed down under a tide of expert opinion which generated hostile media reaction to his plans.[28] Ironically, the net result was at least partially to reverse the stigmatisation of methadone patients who, unlike 12-step's successes, prefer to keep themselves and their achievements hidden. As in Scotland, another

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24 Clark D. *The way forward*. Wired In: 2008.
http://www.dailydose.net/archives/OverallStrategyMay08_v1.04_Final_DC_110508.pdf

25 McGrail S. *The Great Debate?* 18 April 2008.
http://homepage.mac.com/smcg1967/Sara%20McGrail/page14/files/b917acf3e9471265da0dd8471284286d-27.html: "The investment we've been paying our rent of the back of for the past few years has been predicated on the ability of senior people in the field to 'sell' the concept of drug treatment to the public. This has largely been done on the basis of fear. Firstly fear of disease and secondly fear of crime. Both of these approaches have one thing in common – and that is, that they are based on the assumption that the public will not accept that people who have problems with drug use deserve treatment because they are human beings and have a right to help and support."

26 Examples. Northern Rock, an unthinkable collapse followed by an unthinkable rescue, the first bank nationalisation in modern history. A gaffe-prone "loose cannon" even his own party thought a no-hoper, becomes major of London. (Merrick J. "David Cameron fears 'loose cannon' Boris Johnson will hit his hopes of winning the next election." *The Independent*: Sunday, 4 May 2008).

27 Scottish Drugs Forum. "New drugs strategy will focus on fivekey priorities." Scottish Drugs Forum Bulletin: May 2008.

28 Winick C. "A mandatory short-term methadone-to-abstinence program in New York City." *Mount Sinai Journal of Medicine*: 2001, 68 (1), p.41–45.

result was to focus on fostering recovery *on* methadone as well as off it, combining recovery with maintenance.

In choosing England's future direction, it may help to stick a flag as well as a finger up to the breeze so we can all see more clearly where it's coming from and where it could be taking us.

Mike Ashton (mike.ashton@blueyonder.co.uk)

Editor, Drug and Alcohol Findings (http://findings.org.uk), writing in a personal capacity.

Note: many of the issues raised in this article are expanded on in the fully referenced paper *The New Abstentionists* (http://www.drugscope.org.uk/Documents/PDF/Good%20Practice/Ashton_M_30.pdf). To save space only new or essential citations have been repeated here. The same issues were also addressed in a series of four debates organised by the Conference Consortium (http://www.conferenceconsortium.org) and DrugScope (http://www.drugscope.org.uk). Check their web sites for documents arising from the debates.