

A PHONEY WAR ON DRUGS – AND THE MYTH OF ADDICTION TREATMENT PROVISION

Has pouring £300million a year into methadone helped – or quicksanded the UK into the worst drug problem in Europe? Deirdre Boyd reacts to Kathy Gyngell's rigorous research overleaf.



UK DRUG FACTS AT A GLANCE*

The UK drug problem is the worst in Europe. It also has one of the highest levels of recreational drug use. There are at least 10 problem drug users per 1,000 of the adult population compared to 4.5 in Sweden or 3.2 in the Netherlands.

The UK has one of the most liberal drug policies in Europe. Both Sweden and the Netherlands – despite popular misconceptions – have a more rigorous approach.

The age of children's initiation into drugs has dropped. 41% of 15 year olds and 11% of 11 year olds have taken drugs.

Drug death rates continue to rise and are far higher than the European average. The UK has 47.5 deaths per million population aged 15-64 compared to 22 in Sweden and 9.6 in the Netherlands.

THE STORY OF DRUG 'TREATMENT'

- The election of the Labour government in 1997 marked a new direction for drug policy.
- Focus was switched from combating all illicit drug use to problem drug users. Cannabis was downgraded. Spending on methadone prescriptions trebled between 2003-2008, after the National Treatment Agency for Substance Misuse was created in 2001.
- Only 2-3% of people seeking help are given an option to access drug-free treatment/rehab.

* Source: Phoney War on Drugs

Image: Jeff Gynane

Just as Gordon Brown attempts to address the UK's disastrous record of debt by borrowing more, his government has been addressing its record of having the worst drug problem in Europe by pushing £300million of (substitute drug) methadone scripts a year, be they clinically appropriate or not.

Let's be clear. The issue is not about abstinence 'versus' harm reduction – it is about good practice being sacrificed for pandemic bad practice. It is about the hope for healthy lives being sacrificed.

To say otherwise – as ideologists, tick-boxers, bad practitioners, promoters of psychoactive drugs, pharmaceutical financial beneficiaries and others with vested interests do – is a deflection from this truth. Good practice must be reinstated.

Where good practice reigns, engagement, harm reduction, brief treatment leading to the goal of long-term sustainable abstinence, and aftercare all work seamlessly together with the clients' best interests in mind. All the treatment provider and commissioning/purchasing organisations meet regularly, then start to work more collaboratively as they familiarise themselves with each other and each other's client profiles and services. In the UK, we have started to witness such good practice in the north west, under the leadership of Mark Gilman. Others have spoken to me of wishing to recreate his recovery-oriented integrated system elsewhere around the country.

Where good practice reigns, people get well. Their families flourish. Their employers reap financial benefits, as does the taxman. They contribute to the communities in which they live, instead of draining them. If they have been abusing substances, they can cut back or cut out. If they have a "dysregulation of the mesolimbic dopamine system" – if their physiology includes an addictive disorder – they learn to replace artificial chemicals with healthier alternatives. This long-term learning to turn their lives around can come from professionals and/or mutual-aid groups, the most successful of which have been anecdotally and empirically proven to be 12-step linked.

Where bad practice reigns – well, the data in the research on the next three pages demonstrate the outcomes, some of which are seen in the column on the left. Harm reduction is redefined as "treatment" and thus misused. 'Treatment' budgets are really drug-maintenance budgets. Recovery is redefined by vested interests not in recovery in such a way as to remove drug-free goals. Ideologists quote methadone research as 'evidence' that their service works – without acknowledging that the research was into successful methadone environments offering a very different service to theirs, settings where substitute prescribing is seen as short-term engagement, leading to or accompanied by psychosocial support and drug-free goals.

Where bad practice reigns, commissioners refuse to use or even visit rehabs; like the emperor's new clothes, some title this a "masterclass" rather than denial. 'Professionals' including even some psychiatrists cannot differentiate between detox and rehab, blurring both referrals and outcomes. Patients are prescribed a 'care' plan without even being diagnosed as abusing drugs, being dependent on them – or having an accompanying mental-health disorder. Depending on the research you read, 80-92% of women in rehab were sexually abused as children – how can the effects of childhood abuse be best treated? How can they be treated without an accurate diagnosis in the first instance? People seeking to improve their lives are betrayed, left to die or numbed on drugs with their cognitive abilities deteriorating the longer they are prescribed, and their children neglected.

Good practice starts with assessment, assessment, assessment. It is implemented only when all providers and commissioners meet constructively around a table, in practice not merely figuratively.

Bad practice is being exposed, despite Damian McBride-style efforts. Much impetus comes from the shock that 19 rehabs have closed, and the urge to address a system which accelerates such losses. We can create change. Just look at the film clips of UKESAD experts at www.inexcess.tv to witness how far grassroots recovery has progressed in the past year, to the highest echelons of society.