

**Alex Boyt** on how the treatment system is failing those most at risk, and the potential dangers of the recovery agenda in the current climate

# MODELS OF COMPLIANCE?



**I SAT IN A MEETING RECENTLY** – various players, not much said, a few providers reassuring the NTA by talking about ‘the need for an overarching strategic body’ and the NTA talking about replacing models of care with something not called models of care. When I complained about clinical guidelines both protecting and strangling effective intervention, a couple of people made noises to humour me and someone said the word ‘recovery’ was very unhelpful – a few people including me nodded while the NTA made ‘taking this on board’ movements and wrote something down.

A while back I read something about the recovery agenda being hijacked by abstentionists and a pal of mine working in another part of England said there was a battle for recovery credibility between the local 12-step agency and the major prescriber.

Let me tell you a story. It was 1999 and I was on a script, about 70ml of methadone a day that I took home from the chemist with daily pick up. I didn’t want methadone – nasty habit, harder to kick than gear – so I didn’t take it much, putting it in lemonade bottles under the sink. Twice a week when I couldn’t get the gear I needed I took a swig out of the bottle and my partner, who was pregnant, had the odd swig too – she didn’t want a script for fear of having our baby taken away.

We sold a bit or gave a bit to mates and we ticked along ok. The service kept drug testing me, I couldn’t give a clean sample, and they kept putting my script up – 80, 90, 100, 110ml. They thought that if they gave me enough it would somehow have the effect of crack and smack and I wouldn’t use on top, then they got fed up. It was supervised consumption and I was taking 110ml a day that I didn’t want and didn’t need while my partner had nothing. I disengaged with services and didn’t go back, my behaviour got wilder and more desperate, and I ended up in jail again.

A few years later I wanted help. I’d had enough, so I went to my family. They had a few quid and got me into a rehab in days. I staggered in, having given my flat to a dealer, and arrived in the middle of very chaotic using. My detox started at 80ml – the timing was right and I’ve done ok since. What does all this prove? Nothing much, I guess.

I read the other day that the number of drug-related deaths has gone up over the last five years. Some people expressed surprise but I didn’t. The drug treatment system has grown and it has stabilised and retained hundreds of thousands, even getting a few abstinent – shouldn’t knock it, really. About 50

per cent in treatment, but which 50 per cent – those most at risk? I doubt it.

In my work I talk to a lot of service users and in other parts of my life I know users and ex-users. I’m not a researcher but I hear a lot of stories and some undeniable patterns are glaring at me – the more dangerous your using, then the less likely services are to engage you.

Take alcohol, methadone and dispensing clinics. You rock up for your daily dose, you’ve had a can or two to get you out of bed and you get breathalysed – too dangerous to give you your methadone. Better go buy some gear and have a hit – that should be safer. Another scenario is you’ve been in services for a while and managed to convince them you’re stable – they test you, catch you out and you’re back on daily supervised consumption for your own safety. With the ritual daily humiliation, you drop out of treatment.

Or maybe something happens – you nearly die or your partner dies or you get nicked again, and you decide you’ve had enough. Window of opportunity – you go to a service for the first time in ages and say you want to go in somewhere to clean up. They tell you they need to stabilise you for a few months first, but if you could stabilise you wouldn’t need rehab. You walk away confused.

Or you know you want to stop one day. You’re working towards it in your mind, you know that the methadone is going to be harder to kick than the gear and you want to reduce the methadone the service is giving you. You’re using on top – of course you are, you always have – but the service says you have to stop before they reduce you.

You make an appointment to get assessed for treatment. It’s taken you two years to get there and you arrive an hour late. Sorry, you’ll have to make another appointment for next week. Or you’re in a tier 4 residential something – detox or rehab – with a 20-year crack and smack habit. You’ve been in three weeks, the detox is pretty much over, you’ve been abstinent for a week. You have a puff on a spliff – suddenly your care plan becomes ‘you have half an hour to pack your bags’.

All of these stories I’ve heard many times, in different areas of the country. Of course there are clinical guidelines and service rules to keep clients safe, but the reality is that those not in treatment are ten times more likely to die a drug-related death and more likely to pick up a BBV or go to prison. The treatment protocols designed to keep clients safe can have the reverse effect.

So back to the recovery agenda – an increased focus on stability, an increased focus on abstinence for some, an increased focus on getting better faster. Of course there are aspects of the recovery agenda that are positive – moving those that are ready back towards the employment market, helping to move forward those that have undeniably been parked on methadone. The retention targets that generated treatment funding made substitute prescribing too easy an option, and the notion of a greater emphasis on moving through the treatment system is good in theory.

But are many users for whom losing limbs, liberty or loved ones does not trigger stability. The reality is that there is a large section of the drug-using population that is damaged and traumatised and not able or willing to embrace stability, abstinence or recovery, whatever shape that takes.

The Conservatives are using rhetoric about introducing abstinence-based drug rehabilitation orders to break the cycle of addiction and offending, and saying a focus on abstinence is a fundamental distinction between Labour’s failed approach of maintenance and management and theirs. So not only are we failing to engage those whose using is the most risky, the recovery agenda is in danger of mutating into a beast that requires such strict treatment compliance that many who are engaging under the current system will also be lost.

The word recovery was considered unhelpful by some because of its ability to mean such different things to different people – I worry that it will move from being unhelpful to being outright dangerous. The NTA was until recently a champion of fighting for the cause and proclaiming the effectiveness of substitute prescribing. In the changing political climate, if they survive, I hope they don’t hijack their own recovery agenda to appease the political masters on whom their future depends. Let’s hope models of care are not replaced with models of compliance.

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