The new abstentionists

Around Bonfire Night 2007 a rocket shook the peak of England's drug treatment structure – someone asked how many patients ended up drug-free. Clothless as the fabled emperor, '3%' came the reply. Bullish engagement and crime reduction claims were dismissed as irrelevant. Scotland had already suffered a similar attack. The new abstentionists were on the march and the statistics seemed to be with them. But their challenges and the defences put up against them were based on questionable assumptions and misinterpreted or just plain mistaken figures. This forensic examination of the claims examines the good and not-so-good to emerge from this episode.

by Mike Ashton

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This article is dedicated to Bill Nelles, late of The Alliance in the UK and now of the Beach Road Medical Centre in Canada, who exemplifies the methadone patients referred to in the last sentence whose lives "contribute to society in ways those of us who get by on a drip feed of alcohol or nicotine or nothing at all should envy".

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Towards the end of October 2007 the NTA's[1] crime-reduction justification for investing in treatment wilted before the BBC's straightforward assumption that treating addiction ought to be about getting people off drugs.[2] It was an emperor's clothes moment from which the NTA took time to recover. But even after correcting the BBC's blunders,[3] their own figures showed that in England at the end of 2006/7, just 3% of people in treatment for drug problems that year had completed it and left drug-free, confirming the substance of the BBC's attack.

In some ways the BBC's intervention was a welcome return to forefronting what I'd guess most people think treatment should be about. However, there was some collateral damage. The focus on completing and leaving treatment was entirely contrary to recent research and expert opinion supporting long-term care as the appropriate treatment model for many dependent substance users.[4] [5] That it continues indefinitely is a defining feature of methadone maintenance, placing it in the middle of the firing line. The risk is that one of the few effective interventions we have will be eroded and constrained to what for it is an alien and counterproductive agenda.

Tories weigh in

A few months before, David Cameron's New Conservatives had released the fruits of their addictions policy think tank. No barb was sharper than the claim that "maintenance methadone prescribing which perpetuates addiction and dependency has been promoted under current policy while rehabilitation treatment has been marginalised". [6] Maintenance was further condemned as "undermin[ing] the efficacy of criminal justice treatment interventions". The treatment which across the world has done most to curb addiction[7] [8] [9] (leading to methadone's designation by WHO as an "essential medicine"[10]) and with it almost certainly crime[11] was portrayed as sustaining both; ally had become enemy.

Among other things, the "radical reform" needed in treatment is, they said, "about facing the fact that abstinence is the most effective method of treatment."[12] It's a 'fact' which takes some facing because the favoured settings were to be intensive day care and residential rehabilitation, neither with the solidity of the evidence base accrued by methadone.[9] [13]

Their main plank in respect of residential rehabilitation was a Home Office review which found therapeutic communities among the most effective crime-reduction treatments.[14] But none of the studies it reviewed compared these settings with substitute prescribing. In contrast, two studies did compare methadone programmes with residential settings and methadone did as well or better in reducing crime. In England the NTORS study found each episode of methadone treatment cost less than a third as much per crime prevented in the year after treatment entry as an episode of residential rehabilitation.[134]

But to be fair, once the assumption is made that abstinence (defined as from illegal drugs *and* legal substitutes) is the only goal really worth striving for, evidence is largely irrelevant. *By definition*, treatments which embody this objective are also the only ones really worth investing in.

Polarisation in Scotland

Forsaking 'harm reduction', the Conservatives' advisers christened their new policy thrust "harm prevention" – the term also adopted by Australian abstentionists in their bare-knuckle word fight with compatriots who keep faith with harm reduction despite the federal government's backsliding.

In Scotland, where the administration is said to be planning to urge drug users "to ditch methadone and other softly-softly approaches in favour of 'cold turkey'",[15] the polarisation has yet to descend to these depths – but it got close, prompting Holyrood's former deputy justice minister

(also an addictions psychiatrist) to attack "the current anti-methadone direction of the drugs debate in Scotland".[16] MSP and former Scottish health minister Susan Deacon was moved to warn that "the space for sensible and honest discussion seems to be inversely proportionate to the size and complexity of the task".[17]

Sweden with its zero-tolerance policing, largely drug-free treatment model, and highly limited harm reduction services, is the example to which the Australian abstention fundamentalists aspire. In October, senior Swedish politicians swapped notes over addictions policy with the Scottish Parliament.

They came fresh from a visit to Professor Neil McKeganey's centre in Glasgow, the academic gaining a reputation as Scotland's leading addictions researcher and the one most closely associated with the abstentionist revival. As the leader of the team assessing Scotland's drug treatment system in the DORIS study, he has both the data and the opportunity to make his voice heard. According to reports, he used the occasion to recommend Swedish-style measures in Scotland including "'abstinence-based' treatments".[19]

Uncannily, in his address another 3% figure took centre stage as the proportion of methadone patients in Scotland to emerge "clean within three years". According to a *Sunday Times* headline, it meant the programmes "fail" the remaining 97%.[20] The previous December, *Scotland on Sunday* had quoted the same figure as the proportion of patients whom Professor McKeganey had found remained "totally drug-free" [15] three years after starting methadone, one of the findings prompting "a dramatic policy U-turn … senior Labour figures are convinced addicts should be pressured to get themselves clean".

Professor McKeganey exemplifies the fact that in the UK as yet there is no neat split between abstentionists and harm-reductionists with one side condemning everything the other holds dear and vice versa. Now a critic of what he sees as the over-dominance of harm reduction measures, previously he was a strong supporter of what most would see as the extreme end of the harm reduction spectrum, safer injecting rooms. In 2004 he admired the Vancouver facility which permits injectors to inject safely and free from police interference (a "beacon of community health")[18] and in 2006 put his name to a report which pronounced these an "overdue extension to [UK] harm reduction policy".[125] Today he is reported to condemn any moves to provide such facilities in Scotland as "simply wrong for our government to take on a service that would make drug use easier". [126] When sands shift as radically as this it is risky to dub some people as 'new abstentionists' and others not – people and institutions are more complicated than that. Rather it's that some exemplify this tendency more absolutely than others.[127]

Smoke and distorted mirrors

Scattered within these debates were important arguments but equally important mistakes and distortions. Contentions seemingly anchored in hard statistics and solid research were at best questionable, at worst misleading and counterproductive. Certainties are elusive largely because the best UK data we have on drug dependence treatment[21] still derives from the NTORS study in England, whose patients started those treatments over twelve years ago. Still, we can plumb that data mine for clues to what might be happening today and also call on fragments of more recent evidence.

Most of the issues raised in these debates have no secure resolution. Examining them entails questioning some of the certainties we thought we had – not to say they are certainly mistaken, but to question whether we *really* know they are certainly true. Few replacement certainties are on offer.

Recovery returns look poor

The charge that Britain's treatment system fails all but a few rests on the twin assumptions that abstinence is the only acceptable goal, and that only by becoming drug-free can former patients become, in *The Independent*'s words, "productive members of their community".[22]

To a more nuanced degree,[23] the second assumption is shared by the leaders of the UK's most influential treatment conglomerates and national NGOs: "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."[24]

Given these twin assumptions, the returns from treatment look poor indeed. To the man or woman on the omnibus, represented by the BBC's home editor Mark Easton, the more intangible benefits of reduced crime fail to convince. Whatever else it does, if treatment doesn't put the patient back on their feet and if possible effect a cure, it has a hard time looking like 'treatment' at all.

Health minister Dawn Primarolo put up a defence indicative of a great deal of compassion and understanding of the difficulties faced by addicts in rebuilding devastated lives, speaking movingly of "families in chaos" and decimated "social support networks".[25] But neither she nor the NTA's riposte[3] fundamentally challenged the assumptions on which the BBC's attack was based, leaving treatment vulnerable to further attacks on the same basis. We'll test those assumptions one by one.

Abstinence is good?

Though Brian Iddon (chair of the all-party Parliamentary Drugs Misuse Group) notably demurred,[22] other parties to the debate implicitly accepted abstinence as an unquestioned good, the most desired goal if often a distant one. By 'abstinence' here, the BBC, the drugs field leaders, and the NTA, all understood abstinence from legal medications substituting for illegal drugs, not just from illegal drugs.

Their public contributions failed to stress that getting opiate dependent patients abstinent without putting sufficient (and perhaps very costly) investment in to anti-relapse rehabilitation is a very good way to help them kill themselves through loss of tolerance and overdose. Let alone a poor quality of life, too many will have none at all.[26]

The death toll from opiate blocking treatment in Australia is perhaps the worst example. Post-detoxification patients trying to avoid relapse by taking naltrexone faced at least a 1 in a 100 chance of dying within about three months, usually from opiate overdose in the weeks following drop-out or treatment termination. [27] The true figure may have been as high as 8 in a 100, many times the risk associated with substitute prescribing. After this study, a doctor advising patients tempted to try this route to a drug-free (at least, opiate-free) life would, or should, have to warn them that some research indicates they face close to a 1 in 10 chance of being dead within three months.

Back in the UK a study of drug injectors (primarily heroin) who had undergone inpatient detoxification in Glasgow between 1982 and 1993 found that over their injecting careers they were 22 times more likely to die than people of the same age and gender in the general population.[129] On average they ran a 1 in 10 risk of dying after 10 years of injecting. Once they had been detoxified the risk was 2 in 10. Overdose was the main cause of death.

In Glasgow the inpatient programme had been introduced because of the high failure rate of the

previous outpatient programmes. This might have been unfortunate, because the more 'successful' a detoxification, the higher the risk of subsequent death. At a specialist London unit 11% of in-patient detoxification treatment successes had died within a year compared to none who failed to complete.[132] As the authors observed, the 'successes' will have lost their protective tolerance more completely than the 'failures'. In the massive VEdeTTE study of 10,454 heroin users entering treatment 1998–2001 in Italy, risk of subsequent death increased fourfold when patients completed detoxification compared to drop-outs.[131] Six of the seven deceased were detox completers, just one a drop-out. In contrast, all the deaths following methadone maintenance were among drop-outs.

The fact that being (not *having* been) in methadone treatment saves lives is its clearest and most consistent benefit,[26] demonstrated at a city-wide level recently in Barcelona. In the '90s the life expectancy of heroin users entering treatment there increased by 21 years, largely due to the expansion of low threshold oral methadone maintenance programmes.[28] Without the protection afforded by methadone, and even though all the study's subjects had entered specialist addiction treatment of some kind, heroin users were seven times more likely to die.

Returning to Glasgow in the 1990s, starting methadone maintenance was associated with at least a halving in the proportion of patients experiencing a non-fatal overdose in the previous six months.[130] The fall was particularly dramatic among those in continuous treatment over the year of the follow up; before entering treatment a quarter had overdosed, afterwards, virtually none. The falls were linked to reductions in opiate and non-opiate injecting.

Drug-free treatment completion equals success?

Though the attempt at abstinence leaves bodies in its wake, still the majority survive. In the NTA's figures, these are among the people recorded as having completed and left treatment drug free.[29] No longer in treatment, they are also presumably no longer being prescribed substitute drugs. Free from both illegal drugs and legal substitutes, for the new abstentionists, these surely are the success stories.

If they were, we would expect them not to burden the statisticians again or not for a long time, because a return to the statistics means a return to treatment, which means relapse to dependent drug use. At the end of 2004/5 in England, 3626 individuals[30] had completed treatment drug-free without having to return.[31] But during that year there were 5759 drug-free, treatment-completed discharges. So even within the same year, many drug-free discharges probably ended in relapse and return to treatment.[32]

But what of the 3% the BBC taunted the minister with – in 2006/7, the 5829 patients and clients who completed treatment drug free and *did* make it through to the end of the year without having to return?

For a clue to their fate we have to turn to Cheshire and Merseyside, regions with unusually long series of data compatible with the national monitoring system.[33] At the end of 1998 about 6% of patients were recorded as having been discharged drug free after completing treatment. Of these, 57% returned over the next six years. Judging from this, their relapse rate was *greater* than people who failed to complete their treatment, 54% of whom later returned. In the very next year, 46% of drug-free treatment completers in 2001/2 (last year for which data was presented) returned to treatment, just 3% fewer than the drop-outs.

For these regions at least, if by 'success' we mean treatment which helps patients construct lives satisfying and stable enough to avoid relapse and further treatment, there is no evidence[34] that drug-free completion is any more indicative of success than the 'failure' of premature drop-out. Using these indicators of success or failure may be entirely to miss the point.

This is no great surprise. Some treatment studies find quality of life related to abstinence but others find the relationship weak or entirely lacking, and treatments which look preferable on one criterion may not look good on the other.[35] The implication is that abstinent ex-patients may still be leading profoundly dissatisfactory lives which threaten their lasting recovery.

Chicken and egg

In Scotland the renewed focus on abstinence seemed justified by an impressive accounting of its "benefits" in that country's own version of NTORS, the DORIS study.[36] Three years after entering treatment there were sometimes vast differences between the abstinent and non-abstinent in social integration (education/employment and crime), self-perceived health, and mental health in the form of suicide attempts or self-harm – and they all favoured abstinence. It underlined "the benefits for both the individual and the wider community of drug users having an extended period of abstinence", concluded the researchers.

Set aside for the moment the criterion for abstinence (of which more below), the more fundamental issue is whether abstinence *caused/enabled* those other gains – as 'benefits' implies – or whether it was the other way round, or some other causal configuration.

Abstinence was measured over the past three months, its 'benefits' over the past 17. Already one essential ingredient for establishing causality is missing – cause must be shown to come before effect. It seems equally conceivable that someone lucky or determined enough to land a job or to overcome self-destructive impulses had enough stake in life to then abandon illegal drug use – or as Professor McKeganey, the lead researcher suspects, a complex process in which abstinence reinforces life changes and vice versa.[37] Unfortunately this important qualification was omitted from the published paper, leaving abstinence looking like the active ingredient in life change.

This is no nit-picking but has important practice implications. For example, if abstinence is required for social reintegration then we should go for abstinence in our interventions and let the rest follow. Aiming for social reintegration first would simply be a waste of time without a foundation of abstinence to build on. If it was the other way round, then we'd do better to focus at least as much on social reintegration regardless of whether the individual was currently abstinent.

Just such a debate has been going on in the USA where 'housing first' advocates have tested the assumption that multiply problematic substance users[38] need to be drug-free before they can benefit from housing. The answers were that they don't, and that providing housing first helps them reintegrate, stabilise and improve their quality of life even if they are not yet drug-free.[39] In other populations and other circumstances this might not be the case, but it does illustrate the unreliability of the 'abstinence is essential' assumption and the potential for counterproductive denial of services when it is taken as gospel.

Even methadone patients want to become abstinent?

The drive to reinstate abstinence as the kite mark of successful treatment is legitimised partly by research showing this is what the patients want.[40] 'Who are we to cold-water their ambitions?' runs the argument, and it is a powerful one backed by some evidence. Yet, the critics say, cold-watering is precisely what's happening. According to their accounts, thousands of patients are being denied a chance at achieving their objectives by ideologically driven "so-called experts"[15] wedded to harm reduction and workers unwilling to move beyond this comfort zone to conform to the desires of patients[41] and families. Above all, the embodiment of this betrayal are the methadone maintenance programmes which proliferated in the post-AIDS era. Here at the crux of the allegation the evidence becomes weak and contradictory.

Abstinence across the treatment board

This particular argument kicked off when the Scottish version of NTORS reported the "surprising" finding that 57% of patients opted for abstinence as their sole goal for changing their drug use. [41] Stabilisation and harm reduction were further down the list. In fact, given the make-up of the sample it would have been 'surprising' to find anything else: 44% were starting drug-free and/or explicitly abstinence-based treatments and a similar proportion were in prison, including many who started on methadone.[42] In both cases, abstinence (in prison, after a methadone-based detoxification[43]) would normally have been the only sensible objective.

In England, early results from DTORS (the 'new' NTORS) strongly indicated that stopping drug use altogether is the dominant treatment objective. Published in 2007, about half the sample[44] of structured drug treatment clients said their primary or sole goal was to "Stop taking all drugs", by far the most common objective.[45]

These studies suggest that across tier 3 and tier 4 services stopping drug use is the most common drug-focused objective. Omitted here are the remainder seeking help from drop-ins and other less formal treatment options. And in both cases the (for the current purposes) crucial question is left unanswered – how many patients are being fed methadone for decades when to be rid of it and all other drugs is their overriding ambition?

Abstinence and methadone

We get closer to this in the Scottish report where even in methadone programmes, 43% endorsed abstinence as their sole objective. But among these would have been patients on methadone reduction regimens. It's also the case that nearly 60% of methadone patients endorsed stabilisation and harm reduction goals even if they also wanted to become drug-free.

But these are quibbles compared to the issue of exactly what the patients meant when they ticked the "abstinence/drug free" option. The question was, "What changes in your drug use do you hope to achieve by coming to this agency?" Would patients just starting on methadone really include this among their 'drug use'? If so, it begs the question of why some agreed to this treatment if all they wanted was not to be on it. More plausibly, they meant the drugs *causing* them troubles, not the medications helping overcome these. And if they did include methadone among their drug use, on what time scale did they want to abandon it? Straight away, or at some time in the future when they were ready? No one knows.

In England a rather more specific question was put to methadone patients.[46] Asked about their treatment goals, as many wanted to stay on their current dose or reduce it as wanted to stop – and in this case, the question was specifically about *long-term* goals. What if it had been about starting to stop right now and ending drug-free in a couple of weeks time?

The drift towards maintenance in supposedly methadone reduction programmes in NTORS suggests ambivalence about such a proposition, and these were patients who on the face of it had opted for reduction. In so far as reduction *was* implemented, outcomes were poorer. "The more reductions in methadone that were given during treatment, the more likely the patient was to be a regular heroin user at follow-up," the sole treatment feature related to this outcome.[47]

Similarly in Scotland, having been asked what they wanted from the treatment they were starting, over the next eight months 35%[48] to 41%[49] of patients sustained even two weeks' abstinence (from drugs other than cannabis) and at the end of this period 15%[50] to 17%[49] were not using. Most of the 57% who had professed abstinence as their sole goal had yet to get there. It seems a fair bet that had those on methadone been taken at their words, and the assumption made that they

wanted to be quit of methadone sooner rather than later, some would have died in the attempt or blighted their health and prospects through continued unsafe drug use and crime.

Is abstinence the ultimate *goal?*

Together these studies suggest that stopping use of at least their problem drugs is a common ambition among treatment patients overall, and that in the indeterminate long-term, a fair proportion of methadone patients would like not to have to take medication in order to sustain their recovery. In this they are no different from patients with other long-term conditions, many of whom who feel uneasy about having to keep taking the pills even if this is clearly in their interests.[51] Their wishes must not be ignored, and in any event it is their choice, but neither would it be responsible for doctors simply to say, 'Go ahead, good for you'.

However, all this is to focus too narrowly on substance use. What drives most patients to resort to treatment is not substance use as such, but the mess this combined with the way society responds to it has made of their lives.[52] When asked effectively at the gates of a drug treatment centre why they have come there, not surprisingly their answers too are drug-focused. Had the same been asked of them when they were attending a welfare or benefits service, the answers would have been different.

Their goals in *life* and the reasons *why* they want to stop taking drugs are likely to be familiar to us all: health, a degree of happiness, a more fulfilling life, self-respect and the respect of others, stability. A cancer patient asked why they are going to a cancer clinic is likely to reply, 'To cure this disease', because this is the function of the service. But the *reason* they want this may be to live longer and see their grandchildren mature. If this could best be secured by control rather than cure, my guess is most would opt for it.

3% drug-free in Scotland, 25% in England?

This startling comparison derived from the DORIS research in Scotland. Professor McKeganey's results appalled some Scottish politicians and journalists – just 3% of methadone patients abstinent three years after starting treatment. Worse still for a nation newly emergent from Westminster's thumb, the English were doing better. There the corresponding figure was 25% after two years, complained the *Sunday Times*[20] and a news service for Scotland's top administrators and policymakers.[53]

It was a comparison they were invited to make by the researchers but one in which mistake was piled on mistake. As far as can be told, the 3% figure derived from a paper published in 2006 documenting the fate of 695 (all those who could be reinterviewed) out of 1033 drug users who had started treatment in 2001 in Scotland.[36] It is to date the most significant outcome report from the DORIS study.

Curious criterion

For the DORIS team, anything other than drinking or smoking in the three months preceding interviews conducted roughly three years after treatment entry meant the former patients were not abstinent. Unlike NTORS, they opted to deny abstinent status to anyone using cannabis or being prescribed legitimate substitute medication.

The upshot was that someone could be 'abstinent' if they were drinking morn till night, but not if they had smoked a single joint in the past three months. Nor could the criterion be made sense of as confining 'abstinence' to legal drug use, since it excluded legal opiate substitutes. These

decisions were justified by appeal to the abstinence objective endorsed by most of the sample, yet, as the researchers had admitted,[41] they had little idea what respondents meant when they ticked this option.

On this criterion, overall just 8%[54] of the sample qualified as abstinent. Elsewhere in the paper was the damning 3% figure, taken by press and politicians to mean that just 3% of patients who started methadone three years before had emerged abstinent. But in fact the 3%[55] related to "post-index-agency" treatment, in other words, to patients who had started methadone *after* leaving their first DORIS treatment. Nowhere does the paper tell us what happened to people who *started* the study on methadone.

Invalid comparison

Already this invalidates the comparison with the 25% figure from England. More properly rounded to 24%, this derives from the NTORS study and *does* relate to the initial treatment.[56] There were other major discrepancies. First, people who confined themselves to legally prescribed methadone were embraced by NTORS' abstinence outcomes. The DORIS researchers adjusted for that, raising their estimate for abstinent (ex)methadone patients in Scotland to 11%, a fact ignored by the press reports.

For the DORIS team, that evened the playing field.[57] Still the Scottish figures looked bad. But in fact the field remained tilted, not just because of the post-index treatment issue explained above, but because *NTORS ignored cannabis use.* Given that this is the most pervasive of the illegal drugs, it could have made a substantial difference, bringing the Scottish and English figures much closer.

Clues to how much can be extracted from an earlier DORIS paper in which, for example at the 16-month follow-up, another 7% of the sample would have been considered abstinent had cannabis been disregarded.[41] Last was the obvious point that the Scottish cohort had a year longer to overcome their problems. By neglecting these adjustments, the researchers lent their kudos to the distortions which found their way in to public and political domains.

Had the playing field actually been even, all these adjustments could have brought the Scottish figure up to near 20%,[58] within a few % of the English one. The scare that just 3% of Scottish methadone patients reached abstinence compared to 25% south of the border was based on error after error, and with it the panic that things must be badly wrong and something radical done to even out the discrepancy.

Divert to residential rehabilitation?

Despite that, it seems likely that abstinence as the DORIS team defined it was indeed rare after methadone, since these programmes were among the bag of non-residential rehabilitation community services which ended in 6% abstinence. The contrast was stark with residential rehabilitation, where the figure was 25%. Rather than the comparison with England, for the researchers this was the key finding.[37] Since they could divine little difference between methadone and rehabilitation caseloads,[59] the impression was that diverting more patients in to residential rehabilitation would improve the nation's abstinence outcomes and with them social reintegration. Underlining this was a statistical test showing that even after taking in to account the other variables measured in DORIS, abstinence was significantly more common after residential rehabilitation.[36]

Some caution was to be expected here because, as the Scottish Executive itself was advised in one of its reports, internationally the evidence for residential rehabilitation is weak compared to

methadone maintenance.[9] After reviewing the evidence, England's National Institute for Health and Clinical Excellence could not be sure that residential rehabilitation led to any greater degree of abstinence or drug use reduction than non-residential treatments.[13] Wholesale diversion of current or would-be future methadone patients in to rehabs would be a leap in to the gloom (if not entirely in to the dark) with people's lives.

The view that diversion is warranted presumes that among the methadone-prescribed thousands are patients who, if only they were given the chance (or a big enough push), would do as well in rehabilitation as the few who currently make it through the doors. That may be true, but the very scarcity of rehabilitation entrants in Scotland gives rise to the suspicion that they are either very unusual or unusually well supported by local services.

There's another obvious reason why the caseloads might differ. Referral and funding systems are (or should be) geared to actually *creating* differences. The hoops aspirants have to go through to secure funding for and admission to residential care should screen out people on whom this investment is most likely to be wasted or who might undermine therapeutic peer relations in these closed communities, yet screen in the more badly affected applicants seen as in need of residential care. Community-based services are expected to be less choosy and have fewer mechanisms for exerting choice over their patients.

Whether surveys reveal caseload differences depends partly on which differences are looked for. An in-depth investigation carried out by a small-scale Scottish study found clear distinctions between patients in residential and non-residential (all taking methadone[60]) settings indicative of a more eclectic range of pre-treatment drug use and greater psychological problems among the residents.[61] Such findings bite both ways: more problems to overcome, but also more reasons to make drastic lifestyle changes to overcome them.

For all these reasons, it is unsafe to assume that patients who would otherwise have started on methadone would do well if diverted to residential care, or vice versa. Unlike the DORIS team, similar considerations led NTORS researchers to avoid comparing the performances of different treatment modalities. These would be invalid unless there was a level playing field in terms of caseload and that simply could not be assured.[62] The other complication, one also (see below) applicable to DORIS, was that over the years patients rarely confined themselves to a single treatment modality, complicating the assessment of just what it was which led to the final outcomes.

It's how you do it

Even if outcomes from methadone in Scotland are poor, is this a condemnation of the modality itself or of the way it is implemented there? We know that methadone services vary widely in their performances. Adequate, flexible dosing, procedures which minimise both drop-out and throw-out, caring and empathic staff committed to the welfare of patients even if that means indefinite maintenance, good organisation, all these make a difference. The more services take on the new abstentionists' agenda, the less effective they will be at retaining patients and safeguarding them and the communities they live in.

When in 2007 the Scottish Advisory Committee on Drug Misuse reviewed methadone services in Scotland they found patchy adherence to UK dosage guidelines, differing views on the desirability of long-term prescribing and long-term supervised consumption, and suspected that insufficient resources were devoted to rehabilitating patients.[128]

Scotland's performance is hugely affected by Glasgow's services which treat over 40% of the national methadone caseload.[128] A report on opiate injectors starting methadone treatment there in 1996 and whom the researchers managed to interview found that less than 40% were in

continuous treatment for six months and just a quarter for 12 months. These may be considerable overestimates since most of the patients starting treatment during that period failed to turn up for the initial interview. Many of the interruptions were due to imprisonment, but a third were initiated by the prescriber as a sanction for behaviour such as taking other drugs or misbehaving at the pharmacy, where at first all the patients were forced to consume their methadone.[130] It was these gaps in provision which seemed to lead to overdose incidents and fatalities.

Glasgow has since restructured and retention is reportedly much better, aided by a turning away from punitive policies and a greater focus on harm reduction.[133] This change of heart will almost certainly have saved lives yet contributed to the criticism of services as failing to send drug users out the other end as non-drug users. Glasgow's experience shows that methadone maintenance is not a unitary phenomenon. It can be and is done differently with widely differing results.

How and what you do is of course dependent on finance. In NTORS each episode of residential rehabilitation cost on average nearly three times as much as an episode of methadone maintenance yet achieved about the same reduction in crime.[134] With equivalent financing the rehabilitative power of methadone might be at least as apparent as that of residential rehabilitation.

It may be true that patients who want to exit opioid use altogether are denied the opportunity to try residential rehabilitation and fall back on methadone programmes. But that case has not been made as strongly as the raw figures suggest, nor can these tell us whether their goals in life (and their lives themselves) would have been better protected and advanced by alternative provision.

Plus ça change

The more pragmatic of today's advocates for rebalancing treatment towards residential rehabilitation argue that methadone's prominence is partly due to the inaccessibility of the resources needed to help patients live without drugs, legal or illegal. They acknowledge that substitute prescribing will still be needed, but needed for fewer people if more had access to the 24-hour, 360-degree, life-changing influences which can be provided in a residential setting.

At its most defensible, the argument runs that if we had enough of the right kind of institutions, if they were attractive and easily and rapidly accessible, and if post-discharge anti-relapse supports were sufficiently prompt, accessible, attractive and robust, maintenance might wither to cater for the few who could not or would not take advantage of these offers.

Ironically, a very similar argument was put forward over 60 years ago by the Rolleston committee – but to justify opiate maintenance prescribing. Effectively, they argued that if only we had more accessible (in those days and effectively also today, that meant more affordable) rehabilitative institutions[63] we might be able to withdraw most people and maintain few – but we haven't, so needs must.[64]

In both eras the argument may have some validity but remains to be proven because the infrastructure has yet to be put in place to be able to test it. Highlighting that gap – the apparent retreat from residential rehabilitation not just in Scotland but elsewhere in the UK – is one useful thing to emerge from this episode.

We've tried moving away from maintenance

Another echo from the past[65] can be found in the pages of the influential *Treatment and Rehabilitation* report from the UK's Advisory Council on the Misuse of Drugs.[66] Published in 1982, it reflected on a period when the prescribing clinics set up in 1968 had tired of the 'keep out the dealers' heroin maintenance role they had initially been tasked with and moved towards the more

respected medical role of trying to effect cures.

Then as now "greater emphasis is … being placed on the ultimate objective of a drug-free existence." In pursuit of this objective, "Some clinics have introduced a strict no-opioid prescribing policy". And the consequence? "Our enquiries indicate that a policy of not prescribing drugs has deterred opioid misusers from seeking treatment." Then as now too, there was concern that the opposite approach – long term maintenance – "has not prevented a substantial growth in drug misuse and may be a factor in blocking the ready access of new patients to the clinics".

There is no reason to believe that the consequences today of curtailed prescribing in pursuit of drug-free patients will be any different – fewer dependent opiate users opting for treatment. The difference is that the mechanisms for forcing them to accept the alternatives via the criminal justice system are more fully developed.

Rehabs need methadone to mop up drop-outs and relapsers

Even if we had moved towards an ideal world where everyone had access to residential rehabilitation, that wouldn't necessarily eliminate the need for substitute prescribing. Internationally, the research record of residential facilities has been blighted by high drop-out rates, leaving 'uncured' former residents still in need of help. In Scotland's DORIS study it seems that most (perhaps 48) of the 85 residents who had the benefit of residential rehabilitation then had to be rescued from relapse by methadone treatment [36 67] and in England's NTORS study, perhaps a third. [68]

If in Scotland some of these then exited methadone drug-free, they could have accounted for a large proportion (after all, there were only 21) recorded as drug-free after having started DORIS in residential rehabilitation. Similarly, we don't know how many who emerged drug-free directly from rehab had previously been stabilised via methadone maintenance. Answers to these questions are needed before we can assume that the credit for the rehab's 'successes' was not also shared by methadone.

Maintenance is incompatible with a truly productive life?

Despite the risk (according to research, probability) of losing the stability gained on opiate substitutes and of relapse with all its consequences, maybe the potential prize in terms of a truly productive, stable and socially integrated life makes it worth trying to do without the drugs? Here we come across the clearest fallacy in the current debate, the place where black turns white and vice versa – the contention that being drug- and in particular opioid-free is required for this transformation.

Far from substitute prescribing impeding reintegration, depriving patients of this treatment is itself a very effective way to impede and reverse social reintegration.[69] Where before long-term retention was seen as a the main mechanism for ensuring patient stability and a sign of its success, now it is being devalued as a failure to become drug-free.

Turn back to the '60s and Dole and Nyswander's original methadone maintenance study, and reintegration was very much not just the objective, but the core outcome and the selling point focused on by its creators.[70] You don't have to believe, as Vincent Dole did, that addiction is a metabolic disease to accept that some patients need to continue to take opiate-type medications precisely *in order* to function in ways which to them and to us look every bit as productive as the lives of many teetotallers or social drinkers. To focus on whether they are taking prescribed drugs is to miss the point – it doesn't matter, what matters is the quality of their lives and their contributions to society.

In so far as such transformations *are* hampered by substitute prescribing, it could be because of the stigma we attach to it and the restrictions we place upon it which can obstruct family and working life. At its most basic, in English prescribing services, provision outside normal office hours is often poor,[71] and here and elsewhere the demands of supervised consumption and regular attendance, and the fear of being exposed as a patient, risk a self-fulfilling prophecy.[72 73 74 75 76] Some find the relatively normal, productive lives they seek more feasible on illicit opiates than when chained to the demands imposed by restrictive maintenance regimes.[77] When it comes to social reintegration through employment, even the drugs field is ambivalent about employing drug users still in treatment. From this point of view, hiding one's drug use and staying illegal may be a better option.

Tarnished silver bullet

But there may be more to it – a failure to realise the transformational potential of substitute prescribing due not just to counterproductive restrictions, but also to a poverty of ambition. Here the new abstentionists may have put their finger on something even if their pressure threatens to squeeze the baby out with the bath water.

Opiate substitution is as close as we get to a silver bullet in addiction treatment. But in PR terms in Britain, and to a degree in practice, its potential has been squandered. First was the unique freedom British doctors had to prescribe injectables including injectable heroin, an option largely abandoned here only to be picked up and validated in continental Europe.[78]

The oral methadone services left in the wake of this retreat have allowed themselves to concede the reintegration ground to drug-free services – allowed themselves *not* to be seen as potentially an effective platform for non-residential rehabilitation. This is partly because in reality they *have* failed to realise this potential. Nationally the ambition has been titrated down to keeping patients off the streets and out of the courts.

In NTORS, despite being in regular contact with a medical service, methadone patients' improvements in physical and psychological health were disappointing.[68] Inputs to improve aspects of their lives other than those catered for by methadone itself seemed minimal – a weekly half-hour one-to-one counselling session in the first month (and for a quarter none at all) dropping to about fortnightly after three months, and for a few, group counselling.[79]

But more of the *kind* of counselling they received would not necessarily have improved things. How much they got in the first month was unrelated to substance use at six months, and those who were counselled did no better on this measure than those left to get their support in other ways.[80] Compared to primary care services, in the first month specialist clinics provided both nearly twice the number and the length of counselling sessions, and continued to provide more, yet (see below) if anything outcomes were better at the surgeries.[81]

Non-therapeutic relationships

Probably around the time the NTORS patients were being treated, interviews with staff and patients at London methadone services offered a rare glimpse of the dynamics behind these statistics.[82] Therapeutic relationships were undermined because patients saw counsellors primarily as gatekeepers to methadone, and by resource constraints which left time for little more than monitoring progress rather than counselling and support. Patients who feared that illegal drug use would meet with a disciplinary sanction and dose reduction reacted by withholding information, creating distrust and tension and impeding even the ability to monitor and adjust to progress.

If it's thought that the route forward is greater access to specialist treatment and greater adherence to good practice guidelines, findings from NTORS and elsewhere should give pause for thought. Despite their specialisation, hospital bases, psychiatrist leads and multi-disciplinary teams, drug dependence clinics have not been shown to perform better than experienced and supported GPs. In NTORS the GPs saw comparable patients but cut crime more rapidly and achieved greater improvements in psychological health and non-opiate drug use, and at each time point from one month to two years recorded slightly better retention (assuming that retention is good and black and white have not yet been reversed).[81 83]

In Liverpool in the mid '90s the health care contrast was in some respects stark. Primary care methadone patients were several times more likely to have been tested for hepatitis B or hepatitis C and to have been immunised[84] against hepatitis B than those at the specialist clinic, and retention at the primary care service seemed much better, though as in DORIS, the attempt to account for caseload differences may have been incomplete.[85]

At least society benefits from reduced crime?

Last of the shibboleths we'll shake just a little is the biggest one of all, the one into which the NTA poured nearly all its eggs and our money – the certainty that treatment saves us all money by cutting crime. This finding from NTORS led the government to embrace treatment as the single most effective tool within its grasp to cut national levels of acquisitive crime.

Though it did (deliberately past tense) the job in the sense of extracting money from the Treasury, this justification is now being publicly challenged as an inappropriate goal and insufficient outcome for treatment. Such ethical misgivings might be derided as failing to grasp the hard-nosed reality of what it takes to prise open the public purse, but if at all, the argument stands up only if it can be shown that crime really has been cut.

The queries aren't about whether their crime tallies fall when dependent heroin or cocaine users enter treatment – on average, they do – but about whether treatment is the cause and whether these changes cumulate in to something which noticeably dents national crime levels and creates economic savings.

At this level, the elephantine crime justification rests on what scientifically must be considered a pinhead of evidence – a degree of coincidence between trends in the crimes the government assumes are drug-related and the implementation of its treatment and criminal justice initiatives.[86] Knowledgeable commentators have pointed out that these crimes had been falling before the current strategy started and probably continued to fall for reasons unrelated to levels of dependent substance use – and, by extension, unrelated to the numbers curbing their use through treatment.[87] The crime most closely associated with addiction – shoplifting – has actually been rising throughout the life of the drug strategy.[88]

The same commentators questioned the foundations for the drugs-crime link which underpins the strategy, based as it is on data from less than a quarter of the offenders unlucky or inept enough to get arrested, a small fraction of all the active offenders in Britain.

Despite these doubts, some elements of Britain's crime rate *may* have fallen less steeply had there not been the investment in addiction treatment, but that's the best we can say. In any event, crime reduction only ever justified treatment for a minority of the people who seek it – the 1 in 10 patients in NTORS who were highly criminally active before treatment and among whom reductions in crime were concentrated.[89]

£3 crime cost savings for £1 treatment?

Still, it might be argued, a treatment net which captures these prolific offenders pays for itself even it also captures less troublesome patients. With its headline finding of £3 social cost savings (mainly due to reduced crime) for each £ spent on treatment, NTORS seemed to prove the case. But both sides of the equation rested on assumptions seemingly so convenient for everyone concerned that their fragility has been overlooked.

Most people assume the £ was the full cost of the treatments studied in NTORS, but in fact it was the *extra* amount spent on treatment in the year after entering the study compared to the year before. This stroke-of-the-pen cut the costs by nearly half, but conflicts with the way other studies have done similar calculations.[89] In some papers the NTORS team countenance the possibility that prior treatments received by 80% of the sample had cumulated in to the benefits harvested during the NTORS year,[68 90 91] suggesting that these costs too would have to be added.

On the other side, the £3 consisted largely of costs to the victims of crime, which in turn consisted largely of the value of stolen property.[92] Effectively, the assumption was made that these were losses to society as a whole – yet some parts of society benefited in the form of cheap or free goods. Some economists treat these as 'transfer payments'[93] and cancel them out when it comes to calculating the net loss to society. Because these were the proceeds of crime, NTORS decided not to, inflating the cost-savings side of the equation.

What difference the alternative assumption would have made in NTORS we cannot know, but we do know that in California disregarding such losses cut the cost savings to a third of the previous estimate.[94] This seminal study made this calculation precisely to reach an estimate of the real costs to society *as a whole*, including its drug dependent citizens.

In Britain an economic analysis[95] of the costs of methadone and buprenorphine maintenance, on which the National Institute for Health and Clinical Excellence based its guidance,[96] tried excluding victim costs to provide an alternative accounting of the benefits to society. It revealed the "considerable impact that the inclusion of victim costs has on the results", an impact which eliminated the apparent advantage of treatment versus no treatment.

Add in the possibility that the crime careers of the NTORS patients had peaked before treatment entry and might have declined somewhat even without treatment, and it becomes highly questionable whether NTORS did demonstrate social cost savings from treatment. But a failure (if that's what it was) to *demonstrate* benefits is not the same as there being none. Benefits there almost certainly were in terms of saved and improved lives. These were not included in NTORS' economic estimates, leaving crime as the main component.

Treatment and in particular methadone treatment[134] substantially reduces the crimes committed by the patients and that along with other benefits is enough to justify its provision. To argue that in the process it saves the country money and noticeably dents national crime levels is both questionable and unnecessary.

Surely things are better now?

Some things[97] have got better since the NTORS patients started their treatments in the mid '90s, but in term of the abstinence and reintegration outcomes which came to the fore in October 2007, they may as easily have got worse.

Methadone services

A few indicators can be extrapolated from NTORS itself. Compared to the primary care services

run by GPs, in that study the specialist clinics adhered more closely to what was and still is being urged as good practice. Over the first six months, six of the eight clinics practised supervised consumption compared to one of the seven surgeries, daily dispensing was more common, and they almost exclusively prescribed oral methadone while GPs occasionally prescribed the deprecated methadone tablets or ampoules, which guidelines said should be reserved to specialists.[98] Yet (see above) the GPs did as well or better. Similarly, the GPs performed relatively well despite offering even less counselling than the clinics, and counselling quantity was unrelated to substance misuse outcomes.

Such findings raise a question mark over whether specialist staff and settings, counselling of the kind provided in the '90s (and for all we know, today), and guidelines promoted as good practice, really are indicators of quality treatment, and whether further progress in these directions will make things better or worse for the patients.

They also suggest a way forward. As the authors of the Liverpool study commented, "It may be that general practice provides a stable, more flexible and convenient setting, with the integration of other aspects of health care". [85] Recent specialist training initiatives for GPs and the expansion of shared care may be spreading these benefits, as long as increased standardisation and regulation is not at the same time eroding the personalised care which may lie at the heart of their successes.

Recent findings from London methadone clinics and GP shared care services are not encouraging. These revealed a "relatively poor response to treatment", a verdict delivered by authors which included staff of the services concerned.[99]

When the services took a census in March 2003, typically their patients had been in treatment for 14 months. According to information given to and recorded by their keyworkers, they were still using heroin two to three times a week compared to daily at intake. Even with respect to the drug targeted by the treatment, it did not look good. It looked worse when the less manipulable evidence of urine tests was available – as expected, 84% opiate positive at intake, but on average over a year in to treatment still 60% positive.

Evidence that the punitive expectations of London methadone patients in the '90s might not be misplaced today comes from an NTA survey published in 2007.[100] Mystifyingly, it was not uncommon for methadone services to 'reward' cessation of cocaine use by offering increased doses of opiate substitute medications or greater choice of the type of medication. The flip side must be that the unfortunates unable to curb their cocaine use were denied these aids to restraining their illicit opiate use.

Finally from 2004, a bleak account of the role of methadone from a bleak part of England, a northern sink estate distinguished locally by an unenviable set of indicators of community and family breakdown.[75] The report is based on in-situ interviews with 50 local problem drug users (on this estate, not hard to find), 31 of whom were in treatment, primarily methadone.

Most of the 50 had experienced school exclusion, three-quarters left without a formal qualification, marketable skills were rare, and a history of homelessness was the norm. All but six were unemployed even in the informal economy. Serious drug use had started early, for most following the example set by their parents. Six in ten had been in prison, though currently half were steering clear of crime.

Overwhelmingly their comments on methadone were negative. Though some myth-swallowing was evident, these are redolent of a treatment which most grudgingly tolerated for the partial relief it gave from criminality and the hard grind of sourcing drugs illegally. To the authors, the reason was obvious: "For many of our sample, the problem of methadone is in many ways that numbers of them actually do not wish to stop using heroin; hence the complaints about getting an extra addiction".

Methadone is partly what you want to and, given all your other life circumstances, are able to make of it. On the Trees estate it became sucked in to a polydrug repertoire which now cost less as a result, but otherwise seems to have diminished not a jot .

Several years on, these it seemed were some of the faces of the "poor response" group in NTORS, the 1 in 6 methadone patients who a year after starting treatment continued with high-rate use of heroin and other illicit drugs.[91] The other 5 in 6 (if that's what it remains) either do not live in such places or have better things to do than to associate with other drug users or hang around the estate, the individuals most available to the researchers. Rather than being typical of methadone patients, they exemplify what the treatment's role *can* become when the routes via which it could be used to construct a better life (which on the Trees, many wanted) seem closed off.

Criminal justice referrals

NTORS also supplied a finding which suggests that the recent influx of patients via the criminal justice system might be making it harder to get good outcomes. This time the finding emerged from the residential services, mainly residential rehabilitation. After leaving, residents who relapsed to regular heroin use were exactly twice as likely (56% versus 28%) to have entered under some form of criminal justice supervision or awaiting trial or sentence, the only pre-entry feature distinguishing lapsers and relapsers from abstainers.[101]

A similar impression was gained in the north west of England in 2002 from patients entering ten specialist opiate prescribing services.[102] Six months later fewer than half were still there though another 5% were said to have completed their treatments. Patients referred from the criminal justice system were nearly three times as likely to have prematurely terminated. In methadone services, drop-out or throw-out usually means resumption of dependent opiate use.

Apparently contrary evidence comes from Kent where in 2003/04 structured day care services offered similar treatments to court-ordered and 'voluntary' clients, and both did equally well.[103] But in this study only patients who stuck around long enough for the first interview (on average three weeks[104] after treatment entry) could be included, and many didn't. With other attritions, the upshot was that less than half were recruited to the study and under 4 in 10 were interviewed at the first follow-up point. The authors acknowledge that recruitment problems may have been one reason why their study gave a different impression to that obtained in the north west.

Among the minority followed up there were the familiar reductions in crime and substance use but only "modest" improvements in physical or psychological health and none in access to training or employment, though housing and relationships had improved.

Residential rehabilitation

The most expensive and intensive way to try to transform dependent drug users in to sustainably drug-free former users is residential rehabilitation, the modality which UK drugs field leaders say is most suited to abstinence outcomes.[24] In NTORS, one year after starting these programmes[105] a further 34% of drug users had achieved abstinence from stimulants, benzodiazepines and illegal opiate-type drugs over the past three months.

However, 20% were once again in residential care. Despite the investment made in their rehabilitation, perhaps just 1 in 7 were enabled to sustain abstinence out in the real world[106] and some (conceivably, every single one) of these will have had to enter methadone or other community-based treatment programmes to avoid continued relapse.[107] Of the heroin users among them, within a fortnight of leaving residential care half had returned to the drug.[101]

If the drugs field leaders who signed their recent joint statement are right, there is little if any reason to believe things have improved and several reasons to believe they may have got worse. Financial screws have been tightened and staff time has been diverted to institutional survival, while ill-informed commissioning and inadequate inspection regimes have been unable to safeguard quality.

Apart from the Scottish DORIS study mentioned above, research which could confirm whether performance has suffered is almost completely lacking. One study of interest for this and for its criminal justice connections assessed how three DTTO teams in England in 2003 and 2004 handled their crack using caseloads.[108] Two of the three sites could not even provide basic records. The third, in London, was able to provide records for 70 relevant offenders, 48 of whom had undergone residential rehabilitation.

At most five of the 70 offenders may (we don't know – we only know the rest did *not*) have completed their court orders and remained free of crack or heroin use or heavy drinking. For the rest, the inflexibility of the order and of the treatment providers had combined with poor inter-agency working and administration to comprehensively fail the offenders enmeshed in their systems. We know that the early DTTO schemes suffered similarly;[109] if these were teething troubles, at these sites they persisted to maturity.

Hear no evil, see no evil

Counterproductive restrictions, lack of ambition, coerced referrals and administrative incompetence may have been compounded by a simpler failing – just not asking patients what they need. Holistic, individualised care which addresses the debt, housing, relationship, vocational, educational, legal and physical and mental health issues facing drug dependent patients is predicated on holistic, individualised assessment and care planning. If you don't know what someone needs and wants, it's hard to facilitate it.

When in 2005/06 the Healthcare Commission and the NTA investigated prescribing services in England, this was one of the weakest areas.[71] Half the local drug partnerships (drug action teams or the equivalent) and 4 in 10 services were "weak" in this respect. When it came to assessing and planning for the risks facing the patients and their associates, the corresponding figures were 70% and 52%.

Some of the biggest gaps were extraordinary: a fifth of services not assessing overdose history, half not assessing for alcohol dependence, the same proportion for abscesses, another half not enquiring who else shared the home, and the biggest gap of all – 6 in 10 failing to assess risks of transmission of blood borne viruses. With basic gaps like these, the chances of a holistic social as well as medical assessment and care plan seem remote.

These figures were reached solely by looking at the services' forms and documented procedures. Conceivably, experienced and thorough practitioners actually did investigate all these issues and more. Even then the failure to systematically prompt and document such assessments begs questions. Perhaps more conceivably, even when there were appropriate forms and procedures, assessments and plans were in practice sometimes missed or short-cut – as in US drug services where state-of-the-art patient profiling measures mandated by the state were completed so those boxes could be ticked, but the results sat on shelves rather than informing service delivery.[110]

What the NTA took from the prescribing side of the data was that "There is a need to move away from standard policies, which prescribe the same amount for each service user and for prescribing to be linked more closely to individual need".[111] If services are failing even in that core form of individualisation, the same seems at least as true in respect of the 'ancillary' wrap-around services.

Even when patients take the initiative and ask for help, they don't always feel they get it at the most basic level of a referral. In a survey of English drug service patients conducted in 2005, this applied to about 4 in 10 each of those seeking housing or employment or training assistance and over half seeking financial support.[46] The respondents in this study were not a random sample – they were recruited by the services themselves – opening up the possibility that these were the patients most engaged with (and therefore most approachable and available to) the service.

McDonaldisation lives on

What does this add up to? In the small parts where the veil has been lifted, a treatment 'system' in respect of offenders sometimes hardly worthy of that term and across the board still struggling to move beyond crime and substance use reductions to effect the kinds of changes in people's lives which could sustain their recovery. Despite questionable interpretations and prescriptions for change, here is the unpalatable lump of truth in the BBC's accusations and the new abstinence lobby's charge that too little is being done to turn around the increasing numbers of lives touched by Britain's addiction treatment services.

It's not necessarily the fault of the providers. They have to follow where the targets and brownie point tallies lead them or lose contracts, and they just don't lead far beyond, 'Get 'em in and get 'em out, treatment completed'. As long as 31 December intervenes, a return in short order counts as just another successful patient recruitment.

In Germany, the self-defeating consequences of the drive for standardisation and efficiency in order to produce the required numbers has been analysed in a paper teasingly titled, "What do hamburgers and drug care have in common: some unorthodox remarks on the McDonaldization and rationality of drug care".[112] The reader is challenged to read it and see if 'Germany' could not be replaced by 'Britain' without invalidating the text.

More with less

That brings us to the final problem – money. Per patient, resources for addiction treatment have been cut and will probably continue to be cut.[113] Getting more patients more quickly out the back door of treatment is how the NTA hopes to square the circle of getting more in the front with proportionately fewer resources.[114]

The problem is that keeping people on methadone is relatively cheap. To bring them to the point where they can safely and sustainably do without it will not be. Turning round lives often blighted by severe psychological problems and a disastrous history stretching back to childhood, reversing the deficits accrued during a decade or more devoted to dependent drug use, transforming environments which are more addiction- than recovery-friendly, and getting the rest of society to cooperate – that costs.

The risk is that this difficult and expensive work will be short-changed. To meet new expectations about 'successful' treatment completion, people may be led to exit treatment only to come back sooner rather than later because their lives have not fundamentally altered for the better, or exit more finally via overdose and disease. Already some services have assumed that their mission now is to keep people for 12 weeks then get them out as soon as possible as a treatment completion or referral on, the criteria for success they think is being set from the centre.

Lives *are* being turned round, but to make this the norm will take special people who can forge and stick with relationships which instil optimism and confidence, and a preparedness to go well beyond treatment to (among other things) low caseload, intensive case management, supported housing and supported employment, intensive and assertive outreach teams, persistent and active

aftercare, and reconstruction of family relationships.

Another way to square the more-for-less circle is to provide these inputs from generic welfare, housing and reintegration resources.[115] In a resistant or resource-starved environment, this hasn't always been shown to produce dividends.[116] It takes a leap of faith to believe that the services the most disadvantaged patients need will be provided through partnerships with other agencies, yet still be accessed by and effectively delivered to drug users whose lives are in a mess and who constitute unappealing fodder for the average housing department or apprenticeship scheme. Assuming this is at worst unrealistic, at best a long-term solution to the cash squeeze. Equity and economy demand that the attempt be made, and it certainly *can* succeed, but making these attempts is itself a costly business requiring investment.

First stop making things worse

Arguably the most important things we can do cost little or nothing and may actually save money, yet are the hardest to achieve. Rather than spending money to make things better, we can stop acting and spending in ways which make things worse, the link Dawn Primarolo failed to make. Stigma and discrimination attached to drug use contribute to poor health and psychological damage and make people unwilling to come out and seek help until things are so bad they can't carry on.[75 117 118] At this point the route back may be so steep that maintenance and harm reduction are the only feasible options. Others avoid treatment altogether or drop out early because of the 'junkie' stigma and the humiliating requirements which contaminate the help on offer.[119] Even the prisoners in our jails feel the added stigma of being known as an 'addict', the main reason in one sample why they did not seek help.[77]

Criminalisation, imprisonment and stigma sever the family and social ties, and destroy the opportunities for decent housing and employment,[115] which could be clung to as anchors to help people haul themselves out of a bad patch with drugs. The few recovery resources dependent drug users may have started with are systematically dismantled by the same state which then tries to mitigate the damage. As Italian addiction psychiatrist Umberto Nizzoli put it, 'the doors are closed behind them',[120] blocking the way back to conventional social ties and rewards and helping to create the 'chronic relapsing' condition we find so hard to reverse.[35]

Can *we* change?

One way to make sense of all this is to see addiction not as something inside the sufferer's head, but as a relationship between them and the world around them, a two-way process as much in our heads and hearts as theirs. The implication is that we can overcome their dependence by changing the world around them sufficiently radically and persistently and in the right ways – and that includes ourselves.

Their social world is a large part of that environment and the most formative, and the one over which we all have some degree of control. Rather than messing in *their* heads with chemicals and reprogramming neural links through cognitive-behavioural strategies or Skinnerian contingencies, we can mess within our own, reprogram how we and the world we control relates to them, and get similar and perhaps more lasting results. When the world as a whole is recalcitrant, we can do this by sectioning off a bit in the form a residential centre and radically altering the environment within, but the results are vulnerable on return.

Though their promoters may not realise or articulate it, this is the basis for the new found enthusiasm for residential care and wrap-around services as vehicles for more comprehensively altering how the world around them relates to the patients and residents.

It seems to be a lesson never learnt once and for all but continually rediscovered. One inspiring tutorial was played out in the late 1950s at the alcohol clinic of the Massachusetts General Hospital, then run by Morris Chafetz, later to become founding director of the US National Institute on Alcohol Abuse and Alcoholism.[121]

Recovery-friendly environments

He suspected that pessimism about whether alcoholics would accept and benefit from treatment derived partly from the dismissive and hostile attitudes of the broader society, including the very staff supposed to be helping them. If these attitudes were replaced by optimism and respect, patients might embrace the help they needed, and the grounds for pessimism might evaporate. He was right. Dr Chafetz showed that not only can a service's performance be improved, it can be transformed by the simple application of empathy and organisation.

It seems simple but in fact it's difficult because it requires people who in the first place care enough to try, have the imagination and empathy to put themselves in the seemingly alien shoes of the 'the addict', organisations supportive of their visions, and the clout and drive to beat steeply stacked odds to make these a reality.

In my experience Britain has an abundance of just such people working in its drug treatment sector. Many have come across from or still occupy the other side of the treatment table. Over the past 30 years I've been struck by the creativity, groundedness, and practical compassion of people doing a job most of us couldn't get to the starting blocks with. Those were and still are the kind of people drawn to working with the multiply excluded and widely despised. Give them the right systems and the right environment to work with, and they will help create transformations, just as Morris Chafetz did.

Around them they need a society accommodating enough to embrace dependent drug users not just within its ghettoised addiction treatment centres, but in the rest of its service provision and social life – and this when some of the makings of a recovery-friendly environment are in short supply, not just for drug users, but for everyone.

Top among them in Britain are decent affordable housing and economically and psychologically rewarding work as routes for people to emerge from welfare dependency despite extensive and intensive disadvantage, and just about the worst stigma anyone can accrue this side of paedophilia. Many need and will continue to need methadone, but as much or more they need housing where not everyone uses drugs, and jobs which give a modicum of self-respect and pay enough to make it worth jeopardising unemployed or disabled statuses.[75]

Three quarters of a change is better than none

When we just can't manage to change in all these ways, we can at least radically alter one aspect of the drug user's social environment – we can give them the drugs they previously had to source by relating to criminals and devote their lives to finding by hook or by crook, offering them a socially accepted role as patient rather than junkie criminal.

The transformational power of this kind of environmental change was visible in the '60s when nearly 90 opiate dependent Canadians migrated to Britain. Forced in to criminality to maintain their habits in their homeland, most sought the non-criminal normality promised by a 'British system' which at the time permitted any doctor to prescribe heroin long-term for the treatment of addiction.[122]

Missing their families or unable to adjust to British life, many returned and some were deported. By the end of the '60s, 23 of the 39 who had remained were still being prescribed heroin and five

were opiate-free. Data was available on 25, all but one of whom was interviewed.[123] Where in Canada only one had worked regularly, now 17 were. After a string of convictions while addicted in Canada, 12 had avoided conviction in Britain and others had cut their offending. Instead of spending a quarter of their lives in jail, in Britain it was just 2%. Two-thirds had found (in their own words) the "normal lives" they sought.

It hadn't worked for everyone. Some craved the buzz of the street life and some, especially those whose criminal careers had predated their addiction, continued to offend.[124] But for most, coming to Britain had enabled them to get straight when on average for well over a decade they had been unable to do so in Canada. Had the transatlantic trip transformed them in to 'productive' citizens, or was it the change in how the rest of the world related to them?

As this story shows, becoming legally maintained is in itself a massive environmental change but sometimes an incomplete one because patients remain stigmatised, excluded from the mainstream and hampered by the obligations placed upon them. But at least we can do it and do it and do it en masse. And some (we should help to make it more) grasp this and create lives which contribute to society in ways those of us who get by on a drip feed of alcohol or nicotine or nothing at all should envy.

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23 They were careful not to in any way condemn methadone maintenance or to fail to acknowledge the benefits and continuing need for such services.

24 *Residential Rehabilitation and the national drug strategy*. 19 October 2007. http://www.phoenix-futures.org.uk/Filestore/Downloads/Residential_Rehabilitation_and_national_drug_strategy.pdf

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31 *Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2004–31 March 2005*. National Treatment Agency for Substance Misuse, 2006.

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49 The proportion of the followed up sample.

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