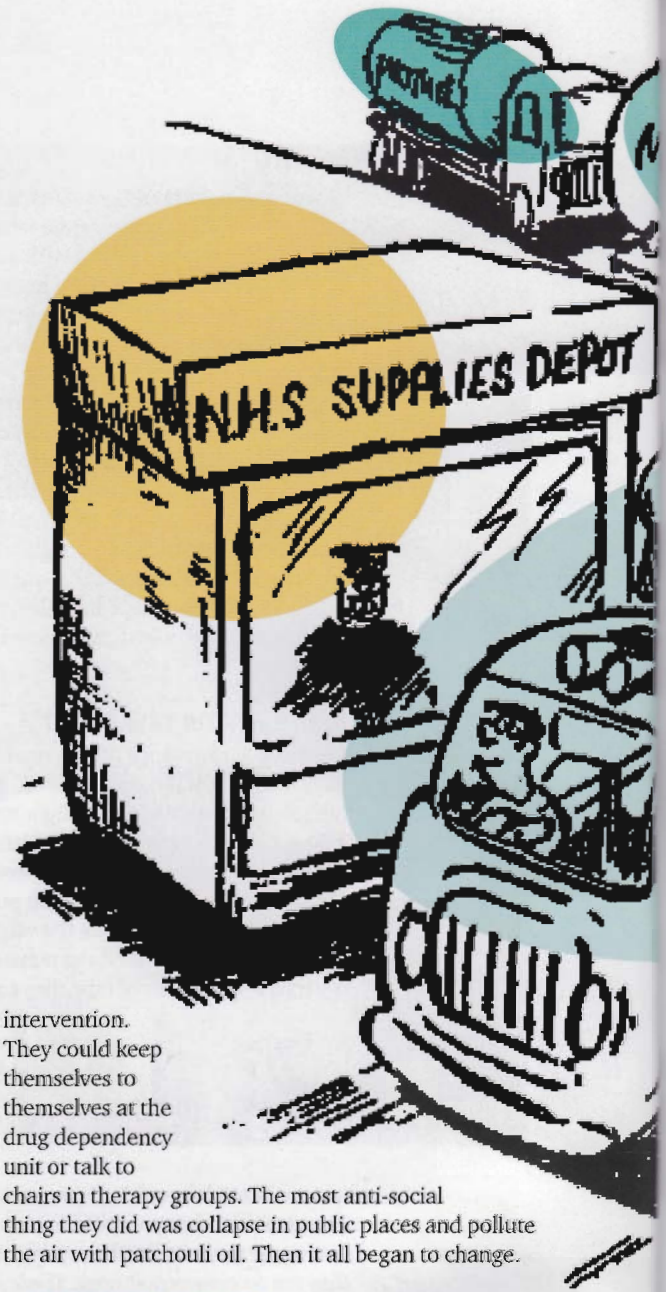
From cauliflower cheese to methadone

Treating problem drug users has become a multi-million pound, red-tape laden industry. This was not always so. **Mark Gilman** explains how treatment services have been forced to adapt to cope with dramatic changes in the causes and characteristics of drug misuse



IF you were one of a small number of problem drug users in need of treatment in England in 1974 you were at the mercy of geography, a handful of psychiatrists and the latest trend in psychobabble. In Manchester you could go to the drug dependency unit at the psychiatric hospital to have your addiction controlled by substitute drugs or you could reject all that in favour of encounter groups, musician Roy Harper and a free cauliflower cheese lunch courtesy of Lifeline's day centre. Thirty years on you have a much wider range of options to choose from. You can still opt for substitute prescribing. Or, you could have acupuncture, aromatherapy and an Indian head massage.

SHEER SCALE

The biggest difference between now and then is the sheer scale of the drug treatment sector. The main statutory NHS service in Manchester now provides substitute drug treatment to some 2,500 problem users. Needle exchanges provide a crucial service to another 1,000. There are probably another 500 who are 'smelling' to get well (aromatherapy) being pricked (acupuncture) or massaged back to health. In short, about 4,000 of Manchester's 6,000 problem users are in contact with the treatment system. All of these treatment interventions are supported by multi million pound budgets and monitored by a bureaucracy made up of local DAT officers, regional representatives of central government and us at the National Treatment Agency (NTA). It's a far cry from encounters with Roy Harper and cauliflower cheese.

On reflection, the profile of problem drug use in 1974 was one of the most unsafe periods ever. Many people injected barbiturates and these were notoriously dangerous in overdose. But, there weren't that many problem drug users and they didn't pose much of a threat to the general public. They didn't tend to steal from people, shops, houses or cars nor did they have that much sexual contact with the non-problem drug using community. For the most part, they weren't stealing from us or infecting us with blood-borne viruses so they weren't seen as a priority for state intervention. They could keep themselves to themselves at the drug dependency unit or talk to chairs in therapy groups. The most anti-social thing they did was collapse in public places and pollute the air with patchouli oil. Then it all began to change.

1995
US drug offenders given doughnuts to stay clean

CHASING THE DRAGON

Brown powder heroin came to the UK from the 'golden crescent' of South West Asia in the early 1980s. Brown powder heroin is designed and produced to be smoked, not injected. When it arrived in the UK it was met by young working-class people who were used to smoking cannabis in all manner of ways. It was not a big cultural leap to make from "hot knifing" cannabis to smoking brown powder heroin off a piece of foil. This was not 'junkie' behaviour because junkies inject. Moreover it was available and relatively cheap. A £5 bag of 'brown' heroin could get a couple of novice users stoned for a day.

Unfortunately, the arrival of brown powder heroin and its take up by young working-class people happened in the context of mass unemployment. Soon we had young, unemployed working-class people waking up to realise that after smoking brown heroin for a few weeks or months they felt like they had a cold or flu. These flu like symptoms disappeared after they smoked some more heroin. Working-class estates all over the UK began to realise that they were home to unemployed heroin 'addicts'. Areas that were particularly badly affected were parts of the Wirral, Merseyside, Greater Manchester, south London and Glasgow. The realisation that you shared an estate with heroin addicts often happened as you came home to find that your house had been burgled and your TV

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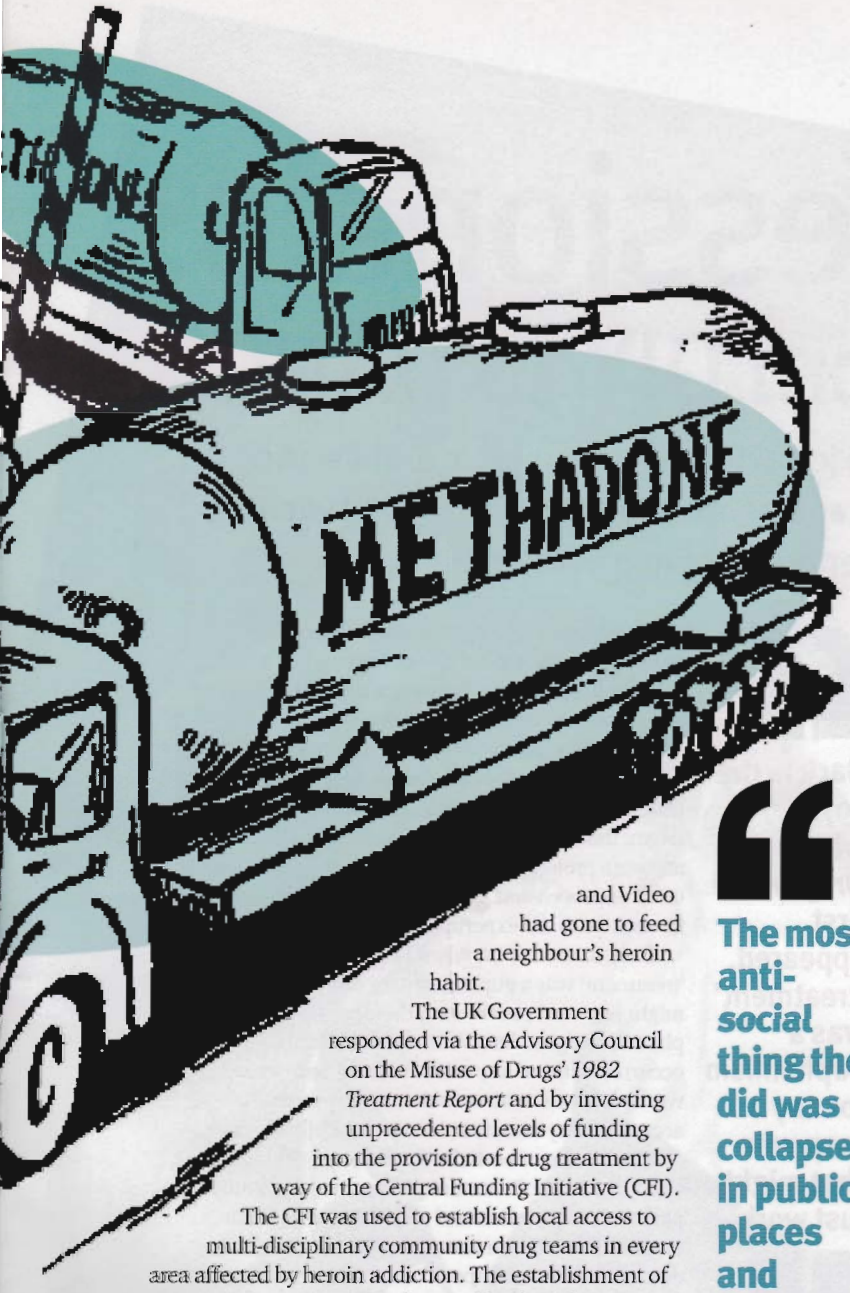

and Video had gone to feed a neighbour's heroin habit.

The UK Government responded via the Advisory Council on the Misuse of Drugs' *1982 Treatment Report* and by investing unprecedented levels of funding into the provision of drug treatment by way of the Central Funding Initiative (CFI). The CFI was used to establish local access to multi-disciplinary community drug teams in every area affected by heroin addiction. The establishment of these teams was heavily influenced by the Advisory Council on the Misuse of Drugs' (ACMD) definition of a problem drug taker. It did not simply say that problem drug users were bad and therefore required the attention of the law. Neither did it say they were simply mad and required the attention of psychiatrists. The ACMD's definition accepted that problem drug users could be bad, they could be mad and it soon became apparent that many were sad. However, the reason for their sadness was that heroin (as predicted by William Burroughs) won by default. Heroin had come into their lives at a time when they were unemployed. The heroin-using lifestyle filled the vacuum created by unemployment. Thousands of unemployed working-class people became heroin addicts almost without realising how it had happened..

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NO EASY CURE

In recognition that contemporary problem drug use was multi-faceted, community drug services were staffed on a multi-disciplinary basis. But we realised that we were dealing with a medical condition that was not easily cured by a quick physical detox and a few sessions of non-directive Rogerian counselling. It took some time before the newly expanded drugs treatment sector realised that heroin addiction is not something that is easily 'cured'. Looking back I think that one of the key reasons that GPs were so reluctant to take on the shared care of heroin addicts is that we tended to present heroin addiction as a condition that was amenable to quick cures. In time we realised that in fact we were dealing with heroin addicts who, however they had got into it, were suffering from a chronic and relapsing condition. Moreover this was a chronic and relapsing condition that was compounded by poverty, unemployment and poor mental health. Heroin addiction in this context is better understood alongside other chronic and relapsing conditions that are also compounded and made worse by poor psychosocial factors. Asthma and late onset diabetes are similar conditions that disproportionately afflict the socially excluded because of the lifestyle choices that are made from within limited social options. To make matters worse many, in some areas most, of the heroin addicts became injectors. So now we had a very large group of people with a chronic relapsing condition that could draw in and affect the general public by making them victims of crime and blood-borne viruses.

In 1984 it was very common to find addicts entering treatment who only used heroin. In 2004 this is very rare. Most people that make their way to drug treatment nowadays are poly-drug users. They will use heroin and other opiates in conjunction with benzodiazepines, alcohol and crack cocaine. We can treat their opiate dependency with methadone. This means that the addict has money that would have been spent on street heroin to spend on illicit benzodiazepines, alcohol, and crack cocaine.

GREENER PASTURES?

Methadone yields good results in the first few months of treatment. Once in receipt of a suitable dose of methadone the addict can have a break from the hustle and bustle of taking care of their addiction business. However, for some, over time the obvious benefits start to fall off. In 1998 Elliott Currie, author of *The Reckoning*, addressed a conference on social exclusion and drugs in Manchester. He wondered aloud whether or not it is really such a great achievement to take an impoverished, unemployed individual who is addicted to heroin and turn him or her into an impoverished, unemployed individual who is addicted to methadone, alcohol, benzodiazepines and crack.

There is no doubt that methadone maintenance as devised by Dr Dole and Dr Nyswander (1964) is a most valuable treatment for some heroin addicts. Members of the Methadone Alliance (now The Alliance) are quite rightly advocating for methadone maintenance to be made available to all those who need it for as long as they need it. However, we know that in order to properly treat addiction we need to address the psychological and social problems that make up the condition. Nowadays we call these the 'wrap around services'. They are wrapped around substitute prescriptions, detoxifications and residential placements.

The very best drug treatment agencies become a hybrid of a housing association, an employment service and a dating agency. To arrive at a long-term solution to a drug problem you need somewhere decent to live, something to do - a job perhaps - and someone to love. It is these common human desires that unite all of us with those seeking to exit problem drug use. Cauliflower cheese anyone? ■