THE POLITICS OF NUMBERS

How target setting has blocked people's recovery from addiction.

By **David Best, Teodora Groshkova** & **Paul McTague**

There is a substantial evidence base, from a diverse range of studies conducted in a wide range of treatment settings across a number of countries, that would indicate that drug treatment 'works'. Yet there continues to be disquiet about how much of an over-simplification this is.

While the framework on which the English Treatment Effectiveness Initiative is based, the Treatment Process Model – set up in 2004 by US psychologist Dwayne Simpson – would recognise that only 'good treatment' works, further questions arise. Does it work the same for everyone? Are the benefits of treatment actually for the users of those services or simply an exercise in reducing the spread of crime and disease?

But at the heart of this article is a simple question. Has the growth of drug treatment generated hidden harms, as well as eliciting the gains so well-evidenced in treatment outcome research?

The growth of treatment in England is intrinsically bound to the government's two most recent 10 year drug strategies, *Tackling Drugs to Build a Better Britain*, launched in 1998 and *Tackling Problems: Changing Lives*, published a year ago.

The mantra of the NTA, central in implementing drug strategy, has been "more treatment, better treatment, fairer treatment". Yet this article will question whether 'more treatment' is always a desirable goal and whether this approach has had as a consequence for a generation of addicts who, without this unquestioning assumption of treatment benefit, may never have become 'problem drug users' in the first place. There is no question that treatment does not provide benefit, but we will challenge the perception that this is always the case and suggest that the machinery of treatment can create casualties.

The central hypothesis of this article is that there are two points at which adverse effects have arisen: via the rush to get people into treatment and subsequently in the relative lethargy around helping people to come out the other end. This, in part, results from a policy package which has three targets for providers and commissioners – to reduce waiting times, to get numbers into treatment and to keep them there for at least 12 weeks. Thus, the obstacles to treatment access have been reduced and removed – but at what cost?

THE MACHINERY OF TREATMENT CAN CREATE CASUALTIES

Increasing access to treatment, via criminal justice and accident and emergency liaison facilities, has meant that those who test positive for opiates in particular are rapidly delivered to a treatment system that assesses their need. However, this measure of need is biased in two ways: by the targets that need to be fed and by the limited range of options for what 'treatment' actually means. In other words, we rush users through the process to a methadone script because that is what is available and, as argued in our article 'Politics of Recovery', in the previous issue of *Druglink*, we offer little else in the way of psychosocial support.

Furthermore, as a requirement of the risk management requirements contained in the 'Orange Guidelines', those who are scripted are required to have 12 weeks of supervised daily consumption of methadone or buprenorphine. In other words, if people were not dependent at the start of this process they certainly will be by this point. This is accompanied by a social constructionist change in which heroin user becomes a 'problem drug user' and the labelling and stigma generates its own dynamics of identity change and a growing dependence on treatment – an argument clearly articulated in John Davies' key work *The Myth of Addiction*.

The system of drug treatment, if effective, has the collateral damage effect of institutionalising dependence in substance users who may have naturally matured out or recovered. From a developmental perspective, there are key transitions and turning points in addiction careers, but the structural forces that broaden the net of capture for drug treatment can overpower these natural career variations. And the growth of treatment industries can have the effect of reducing the healing powers of

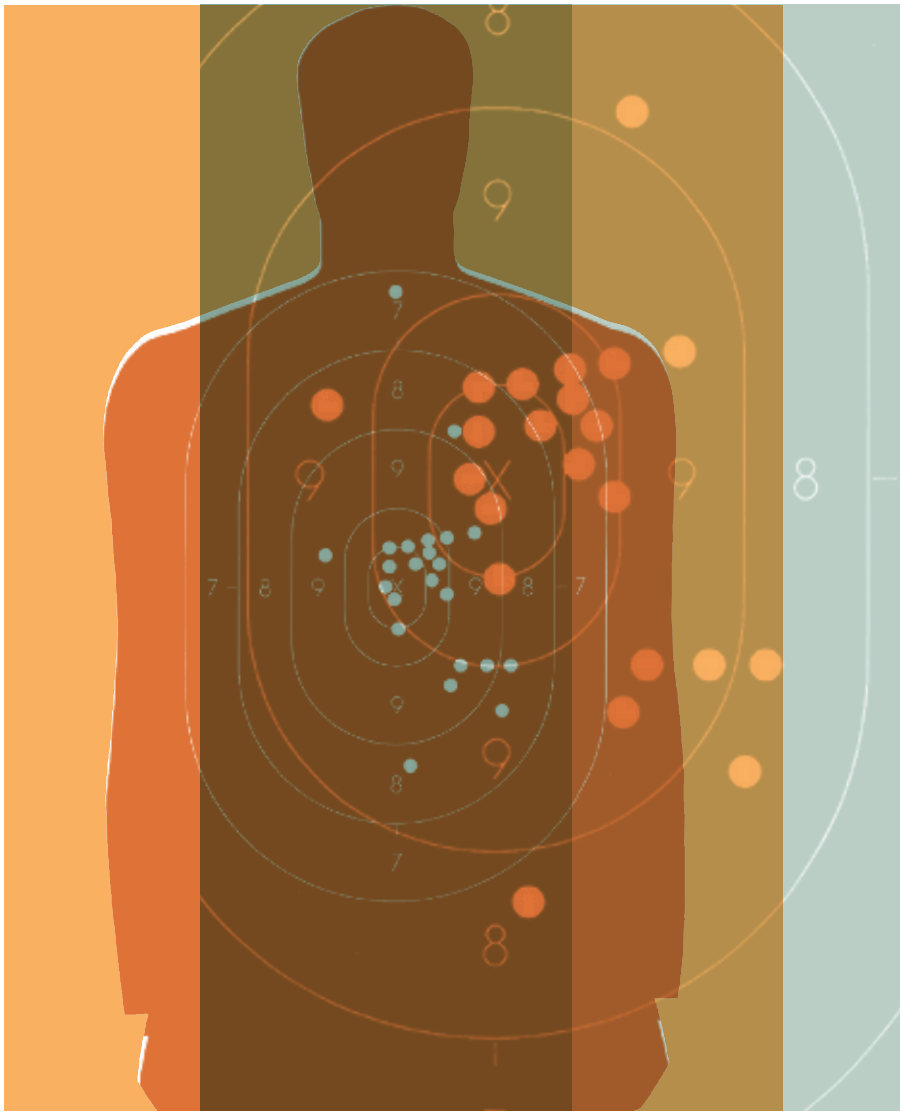
local communities and their groups.

Naturally, this does not happen to everyone. But there is a risk that we have not considered adequately the unquestioning belief in the virtue of structured drug treatment as the core response to substance problems (or even substance use in arrestees who test positive). By developing local systems that reward reduced waiting times, increased numbers and longer retention, we generate an enhanced risk of picking up non-addicts, labelling them as addicts and ensuring that they really are dependent within three months of them getting arrested or having an accident while exploring their drug use.

Our previous work has articulated the concerns we have about the paucity of options for clients once in treatment and the risks associated with the dominant maintenance prescribing model of 'scripting and chatting' (see last issue of *Druglink*). But for all the good that is done by this 'risk averse' model of treatment, it offers the real risk of medicating through windows of opportunity for change – so preventing long-term recovery and identity change.

What makes this more problematic is that there are good reasons for both client (loss of benefits, fear of withdrawal, concerns about life options and employment prospects) and worker (governance and risk fears about relapse, poor structures for delivering change interventions, lack of evidenced change models, as well as the numbers and targets relayed through their managers) to elongate the clinical relationship.

Even for clients who aspire to change, the system is often poorly articulated and structured to enable this process to succeed. Although the growth of community rehabilitation offers an exciting alternative, the long-established problems of community care assessments and rehab access are perpetuated by organisational cultures that often do not believe in recovery and which tend to be sceptical of clients' aims for abstinence. The NTA's Tier 4 Needs Assessment for England clearly demonstrated that clients do not think abstinence-oriented treatments were accessible or sufficiently integrated, while the huge inconsistencies in worker and commissioner attitudes helped to sustain these views. Paradoxically, those who achieve 'stability' within this treatment model are then, often based on economic decisions, 'parked' in shared care arrangements, where there is even less likelihood of intensive psychosocial interventions. In other words, the 'reward' for stability is neglect by the system, rather than using a genuinely developmental model to operationalise this as the opportunity for driving lasting change.



In sum, what the targeted treatment system has done is to create a Frankenstein's monster where opiate users are urged into a treatment monster almost as soon as their use comes to the attention of the machinery of the treatment industry. This system is predicated on a primary prescribing approach with little help with the psychological change processes necessary for recovery, no involvement in the structural changes (jobs, families and relationships) and little support for the client's own resolve to change, whenever this arises.

Whatever the recovery agenda achieves in the UK, one of its first objectives must be to provoke a fundamental challenge to this 'Procrustean bed'. Procrustes was a charitable man who invited all passing strangers to sleep in his 'magical' iron bed claiming it adjusted itself to just the right size. However, during the night Procrustes would either amputate limbs hanging off the end or use a rack to stretch those not tall enough. The big concern about our iron bed is that we have created a system that gets even those who do not want to sleep, to stay with Procrustes – and then we don't let them leave in the morning.

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