The reactionary radicals

Heavy-end drug services are being sliced in the name of progress

ONE OF THE MANY ironies of the '80s is the way 'radical' thought has provided cover for some of the great backward steps in social provision. Good examples are community care and the Children Act where the rhetoric of deinstitutionalisation (closing mental hospitals and childrens homes) has cloaked withdrawal of social and medical support. The tendency in the social care field to lurch from one 'big idea' to the next, and to rubbish everything else, has given a spurious legitimacy to cost-cutting and service dilution – policies inimical to the intention of progressive reformers but which carry the banner of radicalism. Purse-string holders can hide cheeseparing behind loud talk of applying up-to-the-minute theories to child abuse, crime, or whatever else is dominating the policy agenda.

We see a similar process in the drugs field as opinion formers switch from one 'progressive' idea to the next (maintenance, abstinence, harm reduction, outreach, community safety), and label those who don't share their nimble thinking as dinosaurs. The conceptual framework of the drugs field is being swept by a form of utilitarian social engineering less interested in whether prescribing large amounts of opiates (or other drugs) is helpful in the long term for the individual, than in how much methadone is needed to curb thefts from cars.

Individualised therapy at risk

Individualised therapy geared to promoting personal development risks being cast aside in the rush. It would be thought deeply reactionary to suggest doctors keep an injured burglar in traction for the public good; why should we accept the notion of elderly scriptees with zimmer frames queuing for their daily cup of methadone? Some who favour the coercion of smokers and rage against the overprescribing of tranquillisers fail to see that large opiate prescriptions can also lock people into a life of dulled senses, blunted emotions and constipation, as well as risking overdose.

Good prescribing practice has always mediated between the conflicting aims of relieving craving and withdrawal but leaving the door open to the impetus to move on. The real 'British system' uses the relationship between prescriber and scriptee to apply gentle but persistent pressure on the latter to move towards abstinence.

As with all negotiations, there are two parties. Drug users unable or unwilling to stop have tended to end up being prescribed over extended periods, even in agencies formally opposed to maintenance. This process is the basis for harm minimisation in NHS services – a holding operation, not an end in itself. Prescribing can be a way of attracting more drug users into services, protecting society from crime and disease by keeping them off the streets, but this is a side-effect of its main purpose – helping the problem drug user gain control of their life. Viewing prescribing as simply another facet of harm minimisation devalues a potentially valuable specialist resource.

Anxiety about the spread of HIV and other diseases has led to the welcome growth in harm-minimisation activity and low-threshold counselling and outreach services. Valuing these shouldn't mean devaluing what went before, but too often does. Cost-conscious purchasers can claim support from the field's most eminent thinkers as instead of adding a new layer of services to meet these new needs, they replace costly individual therapies with a mass approach, making 'society' the client rather than the drug user. Drug services which are complementary, serving different purposes and client needs, have become seen as interchangeable.

> Large scripts can lock people into a life of blunted emotions

Hungry purchasers, particularly in areas which used to be served by regional drug dependency units, are busily constructing a new model of services consisting of underfunded one-stop street agencies, a part-time psychiatrist, perhaps a CPN or two, and a couple of detox beds located (totally unsuitably) on an acute psychiatric ward. They then call these 'comprehensive drug services' and cheerfully cancel contracts with existing services. After all, a needle exchange-cum-outreach-cum-advice centre run by volunteers and poorly paid workers on one-year (pension-free) contracts is a great deal cheaper than a clinic staffed by career professionals.

Once you accept that all drug services do the same thing but in different ways, you open the door to this kind of cost-cutting, particularly as 'cost effectiveness' tends to be measured by numbers of people who turn up, not what happens to them afterwards. Complementary provider agencies should be fighting together to sustain the breadth of available help rather than acquiescing to this dilution of services, and then squabbling over the crumbs.

We must get past this notion that a drug service is a drug service is a drug service, and that all drug users are the same. Destigmatising drug users does not mean that they should be encouraged to stay drug users for ever. Many enjoy taking drugs, but will benefit from clean works, good information and advice, and support when things aren't going well. Others get into a mess and need detailed therapeutic interventions or at least a breathing space. They are in danger of losing this option. We need to put the utilitarian demon back in its box and recognise that the protection of society is a useful by-product of drug services – it is not an end in itself. Then perhaps the slaughter of heavy-end drug dependency resources will stop. ❍

from
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