



Frozen out

how not to treat drug users

If people with drug problems continue to be marginalised by the government and the drug treatment industry, society has no hope of reducing the harm caused by substance misuse. By **Sara McGrail**



It is well accepted that the problems of drug use are complex and people often need specialist services from drug treatment agencies to overcome them.

But we also know that enabling people to access real opportunities – to get back into work, to find and sustain a tenancy and to rebuild the relationship with their family, are the things that make a real difference to stability and long term recovery.

Drug treatment is not just healthcare, it's also about enabling someone to sustain their healthier status, using abstinence or maintenance, by accessing other services and supports. Those supports can be more important than medical interventions in preventing people who are using drugs – of whom there are many millions in the UK – from becoming people whose drug use is genuinely problematic for them or the community. Drug users do not exist in some netherworld – they are part of our communities. Their need for health and social care is not just – or even for a lot of people – primarily, about their drug use.

As soon as we admit that drugs affect a very broad group of individuals and that we need a broad range of interventions, not just medical ones, to deal with the harms drugs can cause an individual, we begin to make the case for mainstreaming.

EMBEDDED

Our drugs problems are not going to go away overnight, or even over 10 years. For many of our communities these are intractable, embedded problems that will only be mitigated through joined-up solutions: drug use is part of a range of social problems faced by the UK. We will deal with it most successfully when we deal with it alongside other issues. We will get best value for money when we bring drug treatment – and local drug strategy – into the mainstream.

It is a convention of the last 10 years that 'mainstreaming' refers to shifting funding from short term and programmatic to long term and embedded. But what if it were to mean something different? What if when we talked about mainstreaming the drugs agenda we meant mainstreaming how we address need rather than how we spend money?

How many drug users actually need specialist drug services? The interventions are not complex, the work is not particularly difficult, the pharmacology is not challenging. There are some individuals whose other health issues may make their care pathway more complex and more demanding of specialist input but by and large most drug problems can be managed adequately with support from regular health services.

EXCLUSION

The same is true for other public interventions – do problematic drug users really need different housing or education or employment support to other, albeit marginalized, people? If not, why do we seek to establish these services as part of specialist drug treatment? Is it because drug

services are so marginal to general health and social care that it is impossible for people to access them and access mainstream services? Is there something about the relationship we require people who use drugs to have with specialist services that reduces their social capital so far that they are unable to access mainstream services? Or is it simply that by separating off our health interventions from other health services we enable providers of mainstream public services to claim that drug users must be dealt with by specialists and therefore exclude them from support?

Whatever the reason – and it's probably a combination of all three – this exclusion from the mainstream clearly intensifies the problems people experience. A drug user evicted from their house or having their benefits suspended is far less likely to respond positively to treatment than the individual retaining this mainstream support. By locating drug services in specialist ghettos we prevent effective interaction between individuals and other helping services, rendering the drug user dependant on one entry point into public services, moderated solely by the fact they use drugs rather than the impact or extent of their drug use. How much this aids 'recovery' is questionable, though it is notable that this single care pathway – beginning in tier one and moving swiftly towards the specialists, cocooned within the security of the care plan – is at the heart of Models of Care, the government's treatment framework. Shouldn't we be asking ourselves if this journey into specialism is really necessary? And if it's not, what is it for?

There has been much debate over the past few years about whether the focus of drug treatment should be about public health, or whether it should be about crime. A view rarely expressed is that health and social interventions for drug users should be about getting mainstream services to meet the needs of people who use drugs. Why is this? What is it that makes us so comfortable with our clients not being the focus of our interventions?

CRIME AGENDA

Both the NTA and the Home Office in challenging accusations that too much emphasis was being placed on crime reduction in the National Drugs Strategy have been clear and honest in their affirmation that without the "treatment cuts crime" hypothesis, there would be no treatment – or at best drastically reduced funding for it. But what this means is that we are constantly required to push to the front of the voters mind that view of drug users as an infected, feral and criminal group on the margins of society. With the exception of forensic mental health, is there any other area of public health spending where investment is contingent on the reinforcement of prejudice?

The promotion of this prejudice, while bringing us an opportunity to binge on our own good fortune across the industry, is also exactly what has encouraged and enabled mainstream services to exclude drug users.

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❖ 21 20 years ago. Major investment – initially on the back of HIV and subsequently hanging on to the crime agenda has brought a huge increase in the scope and economic value of our industry. The field I joined as an HIV outreach worker in the late 80s has become a multi-million pound industry, with its own self-sustaining professionalising agenda. Neither the health nor the crime agenda, however, has brought this industry what it really craves: secure long-term mainstream funding for drug treatment and sustainability for itself.

To retain the funding we have, we need to emphasise the risk that drug users pose to the community. But if we are to achieve genuine, long-term sustainable solutions to drug-related harm, we need to change our analysis of not just our client group, but also our own work and the purpose of investment in treatment for drug users.

ONE OF US

Maybe the question we should be asking ourselves for the next strategy is not "what services can we set up to meet the needs of this discrete group of highly problematic substance users"? but "how can we ensure that the services we provide to communities can effectively meet the needs of people experiencing problems with drugs such that they can avoid the marginalisation and exclusion from the social contract which will result in them becoming part of a discrete group of highly problematic substance users."

When we ask the second question, we come back again and again to that idea that people who experience problems with substance use are not 'others' and do not as a rule require services to be provided in specialist settings. Moreover, if drugs are a social problem then the problems related to substance use are collectively owned. If we persistently refuse to make adequate provision for drug users within our social and healthcare services then who is to blame for increasing crime rates and poor public health?

It is uncertain what model of commissioning would serve to genuinely deliver services to meet the needs of drug users, but partial mainstreaming is unlikely to solve the problems we face. Section 17 of the Crime and Disorder Act 1998 and its amendments in 2002 may be helpful. But what may be more critical is to begin to reverse the government's promotion of drug users as mad, bad, dangerous and distant – a group to be singled out, dealt with, gripped, expelled and punished. Not because that approach is morally wrong (though it is) not because that approach is economically disastrous (though it is) but because it simply doesn't work and because if we carry on dealing with drugs in this fashion we will further exclude and alienate huge groups of people from our communities, and by doing that we will maximise rather than minimise the harms related to substance use.

So what would the role of the drug treatment industry be in a world where need was addressed in the mainstream? Long term we have to hope that



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the role of the drug treatment industry will diminish and fade away except for the small number of specialists who will be needed to work with people with highly complex need. However, in the short and medium term, there's a hell of a lot for us to do.

SHAKE UP

Efforts need to be made to train and educate our peers in other areas of healthcare to work respectfully and confidently with a client group that includes people who use drugs. We need to work to reinstate the human rights people are losing purely because they use drugs – legal or illegal.

Excluding someone from either a health service (such as a dentist or doctor), a social service (such as social housing or an educational establishment), or an economic opportunity (such as a job or a business) because of their drug or alcohol use should be made illegal. It should be possible to exclude someone from one of these opportunities because they behave in a way that is inappropriate or dangerous for that public space, but substance use in and of itself should not be the basis for exclusion.

By refusing health services the right to exclude people from their caseload because of their substance use, we begin to compel them to provide appropriate treatment. This begins to address the problem of primary care reluctance to work with people around issues relating to their substance use. It also starts to de-specialise medical treatment. Medical treatment for problems relating to substance use is complicated more by the marginalisation of the client group than by any inherent clinical issues. It's not rocket science. Let's keep specialist services for specialist need - like dual diagnosis or co-morbidity.

We need to educate people about the realities of drug use. To begin to encourage parents groups and communities not to exclude people who use drugs, but to positively include people and to hold accountable those mainstream public services that dismiss the problem as the remit of the specialists.

Action should be taken to openly address the human rights of people who use drugs - to empower them to engage with and campaign for decent public services. Key to this is working with communities to demonstrate that inclusion, not ghetto-building and marginalisation, are the ways to solve problems related to substance use. We need to lobby for drug services to be included in the public participation agenda for local health services through Improving Patient Choice and Healthcare outside Hospitals – not, as was stated by Department of Health official Ken Anderson in an address to professionals in January 2006, exclude them from these opportunities because they are not able or fit to take advantage of them.

The drugs field has a clear decision to make. Are we here to help people who use drugs and other substances experience and cause less harm, or are we here to reinforce the problems that keep us in our jobs? ●

Sara McGrail is the author of The National Drug Strategy, a guide for local partnerships

Opinion

The public punishment of Dr Colin Brewer at the end of what became known as the Stapleford Case was a sad, expensive and embarrassing debacle which highlighted serious rifts in drug treatment, says **Tom Carnwath**

DR Colin Brewer, founder of private drug treatment clinic the Stapleford Centre, was struck off the medical register in November for serious professional misconduct in November after a two year General Medical Council (GMC) investigation into allegations of inappropriate drug prescribing. But his methods were also commended by the very panel which struck him off.

The Stapleford Case, the most prolonged and expensive review in the GMC's history, is the latest in a long line of GMC reviews of private doctors going back to that of Anne Dally in 1987. Ironically Colin Brewer was asked by the Home Office to take over Dr Dally's patients when she was herself struck off, in effect acknowledging that there was a group of patients who were not well served by the standard treatment then available in London.

Many of these patients, and their later successors, gave evidence to the GMC that they had been greatly helped by Dr Brewer's treatment, when they had not been able to achieve stability elsewhere. Almost uniquely the panel went out of its way to praise Dr Brewer before striking him off, pointing to his significant contributions to addiction medicine, his clinical concern, his lack of mercenary motivation and his willingness "rightly in some instances" to practice outside established guidelines in the best interests of his patients.

This has been a sad outcome for those of us who have learnt a lot from Colin over the years, particularly from his experience as an early adopter of procedures such as naltrexone implants, which may well become standard practice in the future. Nonetheless, he was inclined to very eccentric treatment which sometimes led to unsatisfactory outcome, including death on one occasion. Some private doctors in previous cases were much more clearly out of order, and were rightly erased. In others cases erasure seemed an unjust overreaction. Particularly sad and unnecessary was the case of Dr Adrian Garfoot. It was not clear that any patient suffered harm at his hands, and many benefited enormously. He had always been a dedicated and conscientious doctor, and with the

right support and education he could have continued to be so.

We must ask why private clinics such as the Stapleford have been able to thrive in London. At the time that Dr Brewer took over Dr Dally's patients, there was a major division between addiction specialists about the best way to treat opiate addicts. Many were in favour of abstinence-based treatment, whereas others clearly saw the advantages of harm reduction, including maintenance prescribing, particularly after the arrival of HIV infection. The ACMD report Aids and Drug Misuse (1988) strongly advocated this latter approach, but not all were persuaded. For many years subsequently there were districts where it was still impossible to access adequate doses of methadone. Against this background the private clinics provided a vital, often life-saving, alternative for those not helped by NHS treatment.

The Home Office has understandable concerns when high doses of controlled drugs are prescribed. But why does the GMC save its fire for these occasions? Equally culpable clinically are those who under-treat their patients, thereby increasing their risk of infection and death. Had pressure been applied to these as well, the private addiction doctor would probably have disappeared long ago.

In a field of practice where moral opinion often weighs as heavily as clinical evidence, the GMC relies on clinical consensus to assess those who transgress. Unfortunately mainstream consensus is not always correct. Back in 1987, and for some years after, the views of certain private doctors about adequate maintenance prescribing were more justified by evidence than that of many NHS specialists and GPs - even though their actual practice was often questionable. The NHS has moved forward since that time. Had the private doctors been equally flexible about improving their practice, addiction medicine could have avoided this expensive and embarrassing debacle. ●

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Tom Carnwath is a consultant psychiatrist working with substance misuse services in County Durham