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## Recovery through contradiction?

*Alex Stevens examines the tensions between rhetoric and action in the government's new approach to drug treatment.*

With this new drug strategy, the circle has turned. It was a Conservative government that introduced the first drug strategy, *Tackling Drugs Together*, in 1995. This aimed to reduce drug related crime, protect young people and reduce health harms by discouraging drug use. It was criticised at the time for having unrealistic, intangible aims and for not providing the necessary funding. New Labour's strategies introduced increasingly specific targets and massively expanded the funding of treatment. This new Coalition strategy has no targets and provides no new funding.

Some of its diagnoses of the ills of British drug policy are welcome. It usefully brings together analysis of harms related to alcohol and illicit drugs (although it fails to draw the conclusion that alcohol and other drugs should be regulated in similar ways). It mentions the importance of polysubstance use and mental health problems. And it argues that 'treatment success has been eroded by the failure to gain stable accommodation or employment'. Too often, people who have had drug problems have made progress through treatment in reducing their drug use, and then slipped back into relapse when they have been excluded from decent housing and work. About 91% of drug users are unemployed when they enter treatment, a percentage which only falls to about 84% a year later (Jones et al., 2009). However, the strategy's diagnoses are rarely followed by proposals that offer real hope for success. This is because, in common with all its predecessors, the strategy fails to resolve some fundamental contradictions in British drug policy.

The first contradiction is between evidence and ideology. On page 9 it states that '[t]his government is committed to an evidence-based approach'. The last Conservative government did use some evidence in its drug policy. It introduced effective harm reduction measures such as needle exchange. Margaret Thatcher was persuaded that drug-related harms could be reduced, even while people continued to use. In contrast, on page 18, the new strategy defines 'full recovery' as total abstinence from drugs and alcohol. It claims that it 'is only through this permanent change that individuals will cease offending, stop harming themselves and their communities and successfully contribute to society'. According to the available evidence on various forms of drug treatment, this is simply not true. Take the most extreme opposite example to the abstinent vision of recovery. In Switzerland, Germany, the Netherlands, Spain, Belgium and the UK, there are special clinics where dependent users are prescribed heroin. This has been shown to successfully reduce offending, reduce harms to health, and encourage patients into employment (Uchtenhagen, 2008).

The strategy grudgingly accepts the validity of heroin assisted treatment, but spends its rhetorical energy in advocating the untested idea that an 'outcome-focused', 'whole systems', 'locally owned' approach can deliver significant reductions in the number of people using drugs. This is not based on evidence, but on guesswork. No

research is referred to in justification of this approach. And no data is presented – or even considered - in the strategy’s rejection of alternatives. In her foreword, Home Secretary Theresa May writes, ‘this Government does not believe that liberalisation and legalisation are the answer’. Her belief ignores evidence from countries - including the Netherlands, Australia and Portugal - which suggests that decriminalisation (at least in these countries) can reduce the harms of criminalising drug users, without leading to increases in other drug-related harms. The strength of her belief is perhaps explained by the strategy impact assessment’s discussion of the options that were considered by the government. Only two options are mentioned. Option two is the strategy. Option one is ‘do nothing’. If you refuse to consider options other than those that you have ideologically chosen, then your belief will remain intact.

Faith in criminalisation as an appropriate response to drug use brings us to the second of the fundamental contradictions that run through this and previous strategies. All have used expansive claims on the costs that drug use imposes on society. None have acknowledged that a large portion of these costs are self-inflicted. In England and Wales, for example, we spend about £2 billion each year on imprisoning people who have been convicted of drug offences. This government and the last have repeatedly refused to analyse whether this presents value for money, or whether the harm that it does to prisoners and their families is proportionate to any effect in reducing drug harms. The strategy lists crime in local neighbourhoods, family separation and ‘the corrupting effect of international organised crime’ as ‘the profound and negative effect’ of drugs. But by inflating drug prices, by sending people to prison and by leaving the supply of drugs in the hands of criminal networks, the current approach contributes to these harms. We are still spending more money on unevidenced attempts to restrict supply than we do on effective drug treatment.

The strategy does not have much to say about public expenditure. The impact assessment claims that ‘there are no new economic or financial costs incurred by Government as a result of the shift in emphasis in this policy’. So recovery to abstinence must be achieved for no more than is currently being used to maintain large numbers of dependent opiate users on methadone. The Centre for Social Justice, a Conservative think tank, previously argued that methadone maintenance should be replaced by residential abstinence treatment. It estimated the annual cost of the former at about £2,020 per person, compared to £26,000 for the latter. It did not explain how the gap between these costs would be bridged. And neither does the strategy. It tries to square this circle with a ‘Big Society’ solution. It does not demand an increase in residential treatment. It devolves commissioning decisions to local Directors of Public Health, who are supposed to recruit networks of ‘recovery champions’. These are ‘envisaged’ to include people already in recovery, who will be encouraged to mentor their peers. Peer led recovery works for some, but is not generally effective on its own. The strategy is for abstinence to be somehow achieved on the cheap.

This leads us to a new contradiction in this strategy. Labour’s drug strategies backed up their aims to expand treatment with increased funding; both of treatment services and of ancillary, preventive services. The new strategy spills fine words on the idea that social, physical and human capital are necessary for recovery. It includes cash, employment and skills in these concepts. But the government is simultaneously limiting treated drug users’ access to benefits, cutting jobs and to the schemes that

support people into employment. Even early family intervention and Supporting People (funding for housing of vulnerable groups) - which are both glowingly referred to in the strategy - are not safe. The document refers to Community Budgets as the mechanism for investment in early intervention. These will enable local areas to pool money from a variety of funding streams to work with vulnerable families. But they do not provide new money and these funding streams are being cut.

Early intervention may survive for some families, but the services on which all vulnerable families rely will struggle to meet the need. Changes to housing benefit, for example, will lead to dislocation and upheaval as families are forced to move into cheaper areas and smaller dwellings. The central funding for Supporting People has been cut by 12% in real terms and is no longer ringfenced. Faced with massive cuts to their other grants, local authorities are raiding Supporting People in order to mitigate cuts elsewhere. A 'snapshot survey' by Homeless Link has estimated the scale of these cuts at between 26% and 37% across councils. This will severely reduce the ability of people recovering from drug use to get sustainable housing. The imposition of massive cuts on the welfare state is simply incompatible with the strategy's aim of developing 'recovery capital'.

So we have a strategy that is both nostalgic and oxymoronic. It harks back to an imaginary era when people knew that they 'should not start taking drugs and those who do should stop'. It reminds us of the 1995 effort to reduce harmful drug use without investing more in the services that are likely to do this. It recalls consistent governmental refusal to accept that drug use is a universal feature of human life that can be regulated, but cannot be wished away. It repeats the mistake of picking out a few drugs and a relatively small group of users for attention, while leaving untouched the broader social processes that create drug harms (including the commercial promotion of alcohol and the political creation of unemployment). It advocates a focus on recovery while removing the welfare systems that support it.

We could do better. We could focus treatment on protecting people's health as well as offering them the support they need to put dependence behind them. We could avoid harming people with ineffective criminalisation. We could escape this cycle of drug strategies which call for big steps forward, while their blindness to the effects of prohibition and of social policy on drug-related harms keeps taking us two steps back.

## References

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