Huseyin Djemil launches his first monthly column on the addiction-treatment field.

Raise our ambition

ADDICTED, TREATED + LIVING RECOVERY

Imagine that you have what a clinician describes as a "chronic relapsing condition". The best hope is to manage the symptoms and you are told there is no 'cure'. You get access to a drug that helps to manage your symptoms but over time you realise that you are not receiving much, if any, benefit from it; your symptoms flare up and you relapse. The clinician explains: "it's a chronic relapsing condition, let's increase your dose of the drug and this should help bring your symptoms back under control". You go through this cycle a number of times, eventually finding it hard to comply with the treatment regime. You are in full-blown relapse. Around this time, you find out about a treatment process that can help you and you want to try it. But you are told that this treatment is expensive, few people get access to it, so you have to prove your motivation before you can be considered.

You play the game because you are desperate and you 'prove' your motivation is high by jumping through whatever 'hoops' the system places in front of you, and you get access to the treatment that you are told can help you with your chronic relapsing condition. It's tough but as you progress through the treatment you realise that people going through it are getting better and you meet others that have been better for years and you realise that the diagnosis of a Chronic Relapsing Condition is not as solid a diagnosis as you were led to believe; people have been getting better from this condition and staying well for many years. Confusing – but this is the position with drug and alcohol services in the UK today.

People use drugs and alcohol for all sorts of reasons. When their use of these substances becomes problematic or life dominating, the primary response, particularly with opiates, is to call in the professionals, assess substance use disorder as a Chronic Relapsing Condition, then prescribe a substitute drug for that 'condition', usually methadone or buprenorphine.

The UK has built a treatment system around this medical model, with mass substitute-prescribing programmes across the UK maintaining 140,000-150,000 opiate users in treatment (on methadone, buprenorphine) from a total pool of about 279,000 people in treatment in 2016-17, according to NDTMS, the government's National Drug Treatment Monitoring System. We spend £millions annually and have spent £billions to date keeping otherwise-healthy people sick and dependent on the state. After a while, you realise that the so-called 'expensive' treatment, that leads to people getting better, is not as expensive as the current system which merely manages people's symptoms. For example, we prescribe methadone to about 61,000 people for between 2 and 5+ years

My comparison is between community services, based on a clinically dominant model and residential rehabilitation centres that provide a more social model of help that often starts with a clinically safe detox and quickly moves on to a life-learning process to help people put their lives and their relationships back together and move forward with a job, a home and positive social network, sometimes where they live but

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also, if they choose, to re-settle near the rehab that helped them get their lives back together.

Residential rehabilitation centres are dotted all over the UK but they are dwindling in number because they generally sit outside the funded treatment system, and most of the available state finances go into the medical model of treatment and into the treatment infrastructure needed to commission and monitor it. Local authorities advertise multi-year contracts to provide medically dominant services and have very little money left to buy residential rehabilitation services.

In my experience of working across community and residential services, most of the available resource (80%+) goes on community service contracts which are let for 3-5 years at a time, with typical contract values of between £2-£5million a year: for example a minimum £6million to approx. £25million per contract. In comparison, residential rehabilitation centres, if they want access to state funds have to tender for 'framework agreements' (think zero hours contracts), which can take just as long to tender for as the medically dominant community contracts, are subject to the same regulatory regime, but perversely have no guarantee of patient placements and so no guarantee of funding.

The average framework agreement for residential rehabilitation centres will have about £150,000-£400,000 per year available for placements, and the framework can accommodate 10-25 service providers at a time. In some cases, each placement also has to go through an additional mini-tender process before being confirmed. We need a way to rebalance the treatment system so that we can reflect the aspiration of the *National Drug Strategy 2017* and "raise our ambition for full recovery". One way of trying to achieve that rebalancing is to advocate for investment to move towards a more hybrid approach. Of course we need clinicians, we just don't need a medically dominant model that mass prescribes methadone for 10s x 1,000s of people. We need a system that enables people to become community assets who are able to help and support and inspire others into recovery. We want to create citizens, with freedoms and rights, not clients beholden to and trapped in the system that is meant to be helping them, but is instead robbing them of the cognitive ability to even imagine a life in recovery, far less realise it.

I wish we had more rehabs accessible locally, as part of a mixed treatment economy, enabling people to get well in the place they got sick (although for some it may still be necessary for a short time away from home). I recently spoke to a man who had been in prison for 21 years, with no community ties. He entered a rehab some miles away, got the help he needed, completed his programme and returned to live and work and build his life near to the place he was from. That man is a community asset, being sustained in mutual-aid meetings where he lives and will be sustaining others. Being visible in recovery is important and, when we can be seen, we challenge the stigma of addiction and make it possible for others to imagine themselves living a life in recovery, too.

About the author:

"I entered treatment for addiction to heroin and freebase cocaine in 1986. I was 23 years old and had been using daily for 7 years. I spent 2 years in rehab, then re-started my life without drugs. Today, I describe myself as being in long-term recovery from addiction. I have worked in the substance misuse treatment, criminal justice, and social care sector since 1993, have been a freelance consultant since 2007 – and have lived through radical policy change."