

Breaking the habit

Why the state should stop dealing drugs and start doing rehab

KATHY GYNGELL





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THE AUTHOR

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SUMMARY

- The Coalition has inherited a failing and costly drug policy. The priority was to prescribe methadone to drug addicts in the hope that that this would replace their use of street drugs, reduce street crime and cut criminal justice costs.
- This policy impeded and delayed addicts' recovery from addiction. There are as many addicts today as there were in 2004/05. Fewer than 4% of addicts emerge from treatment free from dependency. Drug deaths have continued to rise. In the last three years, the number of referrals to rehabilitation units has fallen to an all-time low of 3,914.
- It has been extremely expensive. The cost to the state of maintaining addicts on methadone has doubled since 2002/03 to £730 million a year. Drug users are estimated to receive £1.7 billion in benefits a year, while the welfare costs of looking after the children of drug addicts are estimated at a further £1.2 billion a year (the longer term inter-generational costs are unquantifiable but will probably be far higher).
- This brings the total social and economic burden for this population to over £3.6 billion.

- The Coalition has wisely recognised the scale of the problem it inherited. However, its proposed solution is flawed.
- In particular its 'Drugs Recovery Payment by Results (PbR)' approach will only reinforce the status quo.
- The PbR pilots will reward operators who can show that addicts have improved health and employment, who have not offended recently and who are not in treatment for drugs.
- This is seriously misguided. Solving the drug problem means recognising the problem for what it is: one of addiction. The solution lies in freeing people from it, not by measuring proxy outcomes (which are easy to manipulate).
- In addition, the tendering process is being managed by the National Treatment Agency – the organisation responsible for the previous policy. It clearly favours the current set-up. Independent small-scale rehabilitation operators have in effect been excluded from the PbR trials.
- PbR can work if:
 - the importance of abstinence-based rehabilitation is recognised and if bids from such operators are sought
 - there is one simple measure of success: that of six months abstinence from drugs
 - doctors, pharmacists and drug workers share in the rewards of getting addicts drugs-free.
- This approach would also be consistent with the Prime Minister's vision for the Big Society. It would involve a real transfer of power from large distant organisations to small innovative providers.

1. THE NATIONALISATION OF ADDICTION

“The last government became too target obsessed. It was all about how many addicts are in touch with treatment agencies, and this, in too many cases, really meant the addict was talking to someone and maybe getting some methadone, which is a government authorised form of opium, rather than heroin. It did not really address the problem – that [the addict] had a drug habit... I would like to... try to provide – difficult though it will be given the shortage of money we have been left – more residential treatment programmes. In the end, the way you get drug addicts clean is by getting them off drugs altogether, challenging their addiction rather than just replacing one opiate with another.”

David Cameron, *The Guardian*, 6 August 2010

In 1988, the Advisory Council on the Misuse of Drugs (ACMD) declared that the spread of HIV aids was a bigger threat to the public than drug misuse. The public health campaign that followed aimed to reduce the spread of HIV infection amongst injecting drug users. This involved prescribing methadone (a substitute drug that stops heroin addicts from experiencing the pain of drug withdrawals) and providing needle exchange as the default ‘harm reduction’ response to drug addiction.

If this approach to treatment could reduce HIV infection, New Labour was later advised, it could reduce drugs-related crime too.⁷ The ambition was to move as many heroin and crack cocaine users onto methadone as soon as possible. A special health authority, the National Treatment Agency (NTA), was set up with a target to get 200,000 problem drug users into treatment (but not rehabilitation) by 2008.

There was little public dissent. The number of drug addicts was going up, there was a crying need for drug treatment, courts were overrun with drug related offences – and who could argue with the desire to reduce harm? What is more, the investment promised to pay back three fold:⁸

For every extra £1 spent on drug misuse treatment, there (will be) a return of more than £3 in terms of cost savings associated with victim costs of crime, and reduced demands upon the criminal justice system.

Indeed, it was hoped that by selectively targeting the heroin and crack cocaine addicts, the true cost savings to society could 'be even greater.'

Following NICE guidelines, the NTA made methadone its standard front-line treatment for opiate dependency⁹ (whether clients were injecting heroin drug users or not).¹⁰ This was

⁷ Home Office, *Tackling Drugs to Build a Better Britain*, 1998.

⁸ M Gossop et al, *NTORS at one year: the National Treatment Outcome Research Study – Changes in substance use, health and criminal behaviours one year after intake*, Department of Health, 2003.

⁹ P Hayes, *DDN*, 12 January 2009.

¹⁰ Only 20,000 injecting drug users entered 'treatment' last year (NDTMS 2010).

deemed the appropriate ‘maintenance therapy in the management of opioid dependence’ justified by a series of randomised control trials.¹¹ It was expected to reduce the chance of HIV infection, and reduce overdoses (thereby saving lives) and criminal activity by retaining addicts in treatment and thus reducing their street drug dependency.

NICE’s ‘Psycho Social Support Guidance’ also recommended that psychological approaches to treatment should be supportive of, rather than alternative to, prescribing.¹³ It warned against “abstinence-based therapies” for, although “initially attractive (they) may be associated with subsequent increased risk of overdose death in the event of relapse after a period of abstinence during which drug tolerance is lost.”¹⁴ NICE only recommends such residential treatment for those with co-morbid mental health or housing problems or who have ‘relapsed’ into opioid use during treatment.¹⁵ NICE recently refused to review this guidance.¹⁶

But the studies which influenced NICE, those showing that patients who successfully completed In-Patient Detoxification (IPD) were more likely to die in a year than those who hadn’t, were studies of patients detoxed in NHS hospitals, not in abstinence-based residential treatment centres.¹⁷ Broadway

¹¹ See <http://guidance.nice.org.uk/nicemedia/live/11606/33832/33832.pdf>

¹³ See <http://www.nice.org.uk/nicemedia/pdf/CG51FullGuideline.pdf>

¹⁴ *ibid.*

¹⁵ *ibid.*

¹⁶ <http://guidance.nice.org.uk/cg51>

¹⁷ J Strang et al, “Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study,” *BMJ*, 2003.

Lodge, a charitable rehabilitation unit, recently reported that it has conducted 7,500 detoxifications since it opened 35 years ago with no deaths.¹⁸ There is also clear evidence that IPD is less likely to be completed and that users find it less satisfactory than detox in a residential setting.¹⁹

Where NICE led, the NTA has followed. This has ensured that pharmacology, not psychology, is the standard treatment for drug users. Formerly independent drug charities, who used to focus on abstinence-based rehabilitation, are now largely dependent on the state for generous multi-million pound methadone prescribing treatment and needle exchange contracts.

Many addicts want to be drug free

Of those coming into treatment, just 8% are referred from prison, with another 15% from arrest referral or through court-ordered Drug Rehabilitation Requirements (DRR). None are referred from the nationwide needle exchange services and a mere 1% from social services. The bulk, 40%, seek treatment of their own accord or are referred by their GP (7%).²⁰

When asked what they want, addicts overwhelmingly reply they want help to overcome their drug addiction.²¹ Becoming drug free was also the single goal expressed by 76% of drug users recruited to the Drug Outcome Research in Scotland study,

¹⁸ As reported by the Addiction Recovery Foundation.

¹⁹ D Best, *National Needs Assessment for Tier 4 Drugs Services*, NTA, 2005.

²⁰ NDTMS, NHS October, 2010.

²¹ This was the finding of a survey of over 12,000 addicts questioned on behalf of the National Treatment Agency. See NTA, *First Annual Service User Satisfaction Survey*, 2006.

compared with just 7.4% who wanted to stabilize their drug use, 7.1% who wanted to reduce it and 0.7% who wanted advice on safer drug use (i.e. safe injecting).²² Heroin users were the most unhappy with their level of drug use: the majority (81.2%), wanted to stop using heroin completely; only 6.8% to reduce their use. The majority (76.6%) of cocaine and crack users claimed they would like to stop using cocaine or crack completely; just 8.6% to reduce it.

But their wishes have not been respected.

Being 'in treatment'

"I went to the doctor's and he put me in touch with a drug agency. I went there, and they says 'we'll detox you, we'll start cutting you down a couple of mls a month'.

"I said, 'A month? I'm on 80mls, so how long is that going to take?' And it worked out it would probably take a couple of years... I actually thought death would be better than what I was going through. 'I can't do this anymore; I can't live the way I'm living.' I actually said that to myself."²³

Today the NTA manages 192,000 drug dependents and is 'in contact' with another 14,000.²⁴ Three quarters (150,000) are on regular doses of methadone or another opiate substitute (anything between 20mg and 200mg per day). Far fewer are in treatment for cocaine (11,000), cannabis (14,000) and amphetamines (4,000). In comparison, only 3,914 of all of those

²² N McKeganey et al, *Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study*, 2006.

²³ BBC, *The Report*, 10 August 2010.

²⁴ NDTMS, op cit.

contacting drug services in 2009 were referred to abstinence-based residential rehabilitation treatment.²⁵

Prescribing methadone is the default response of most drug services, even if the addict continues a cocaine or crack cocaine habit (for which methadone is inappropriate) or if his heroin habit is secondary. There are at least 50,000 people on prescription whose heroin problem is not their primary problem or not their only drug problem.²⁶ 'Service users', as the NTA and its drug workers call them, collect their prescriptions – or scripts – from pharmacies on a daily or weekly basis, after an initial two or three weeks of having their methadone consumption supervised.

There is no objective procedure by which prescribers assess the appropriateness of prescribing, the addict's severity of dependence or the dose level he requires.²⁷ Dosage can be as much a response to the addicts' demands of what they say they need 'to hold' them.

Around 50,000 of the NTA's service users are supposed to receive psychological help. However, it is unclear what this constitutes or what supplementary 'psycho-social' or 'structured' support amounts to. One study revealed that 'intensively supervised' arrestees on drugs intervention programmes only

²⁵ NDTMS, op cit. Note that the NTA does not offer abstinence structured day programmes as a 'treatment modality.'

²⁶ NDTMS, op cit.

²⁷ Although there are guidelines on methadone dose build up, there is no uniform assessment of dosage, duration of prescription, or severity of dependence against which such prescriptions are being provided. As a result there is enormous variation across practitioners in respect of each of these items.

received four hours of 'psycho social' counselling over the year. This included general conversations with drug workers (who are not psychotherapists or clinical psychologists).²⁸

*"It was very hard, if not impossible, to control my heroin use as my methadone went up... that's something every addict has in common. So I ended up on 80ml a day and still using the same amount of heroin. As for the support I was told I'd receive from my key worker, I was lucky if I spoke to them for 20 minutes a month. That isn't support."*²⁹

A day's snapshot in April 2009 of all the clients in one Drug and Alcohol Action Team (DAAT) area revealed that 90% of them, that day, got no other treatment at all other than their prescription.³⁰ A recent local area audit also described a wide range of drugs services in its area, none of which it said had anything to do with constructive rehabilitation. It commented that the drugs workers lacked the requisite skills to provide this anyway.³¹

The rare rehab experience

"It's a very unreal place to come to at first, you know, when you're fresh off the streets, or fresh from prison. You know, whatever life you've come from, you've come from a life of chaos, and you come into here and you're thinking, whooah – and then it's just full of people all asking after

²⁸ D Best et al, "What treatment means in practice: an analysis of the therapeutic activity provided in criminal justice drug treatment services in Birmingham," *Addiction Research and Theory*, 2009.

²⁹ The Report, op cit.

³⁰ Information given anonymously by a treatment provider.

³¹ *Drug Rehabilitation Scrutiny Review*, Northamptonshire County Council, August 2010.

you, and asking if you are all right, and supporting you, and you're thinking no, this isn't right, nobody has cared about me before".³²

Residential rehab provides a setting that mirrors 'right living' as Wendy Dawson, CEO of the Ley Community puts it. It is peer-driven, supports abstinence, encourages self help, guides resettlement and aftercare with national and locally based mutual aid and recovery groups.

But the best estimate is that there are only 1,872 beds now available (equating to 4,000 places per year) at 'affordable' levels of around £500 or £600 per week run by not-for-profit projects or charities.³³ There are no National Health Service rehabs. Award-winning centres have closed more beds as the number of statutory referrals has declined, leaving the sector in near terminal crisis.

"For most of last year half our 18 rehab beds... were empty and this year that pattern has continued. This is despite the continuing success of that programme in delivering drug free outcomes and the fact that in 2009 the NTA and Health Care Commission awarded us an 'excellent' rating following a review – one of only 11 rehab services in the country to be awarded this grade."³⁴

The NTA argues that it has no duty to provide funding for individuals to go into rehab; that it has no responsibility to

³² Author's interview with addict in an abstinence (medication free) therapeutic community.

³³ Addiction Today Treatment Directory.

³⁴ Peter Walker, CEO, Addiction Recovery Agency.

'subsidise' it, nor to ensure that rehab beds are filled; nor that the skilled rehabilitation workforce survives; that this is primarily the responsibility of community care services.³⁶ Their key defence is expense, that "rehab is about 13 times more expensive than methadone... So if we sent everybody to rehab, we could only serve one in 13 of the population that we've got."³⁷ But this greatly overstates the costs of the most effective rehab units and understates the costs of prescribing, as will be seen later.³⁸

One typical urban Drug Action Team recently estimated how it spent the £10 million allocated to it for drug treatment in 2010/11. Its spending priorities were roughly as follows:

- 30% on GP prescribing
- 22% on specialist prescribing
- 7% on Tier 2 harm reduction services (e.g. needle exchanges)
- 7% on day programmes (60% harm reduction day care and 40% abstinence day care)
- 6% on rehabilitation.

The balance of costs – 28% of the budget – was earmarked for DAAT administration and management services. In comparison, a total of only 9% was planned for abstinence services.³⁹

³⁶ Authors discussions with senior NTA executives regarding the precarious future of rehab.

³⁷ Annette Dale Perera, Director of Quality at the NTA between 2001 and 2009. BBC, *The Report*, op. cit.

³⁸ See Chapter 4.

³⁹ Author interview. The 9% comprises 6% on rehab plus the 40% of the 7% on abstinence day centres.

This according to Paul Hayes, CEO of the NTA, constitutes a “balanced treatment system”.⁴⁰ The NTA has yet to acknowledge the need to re-balance treatment funding towards abstinence based rehabilitation.

Yet the current inpatient detoxification and residential provision falls far short of the NTA’s own original needs assessment. This judged a requirement of 24,585 places for a 163,000 treatment population.⁴¹ Today, the treatment population is 210,000.

What it all costs

Drug treatment funding in England has doubled since 2002/03 to £734 million a year excluding prison treatment costs.⁴² It comprises:

- £380 million of NHS Pooled Treatment budget
- £205 million of local (community care) funds
- £110 million of Ministry of Justice Drugs Intervention Programme funding
- £25 million adolescent treatment funding
- £19 million for the National Treatment Agency’s operational and running costs.

⁴⁰ Paul Hayes, Drugscope conference on 4 November 2010.

⁴¹ NTA, *National Needs Assessment for Tier 4 Drugs Services in England*, Research paper 16, 2005.

⁴² See <http://www.nta.nhs.uk/funding.aspx>; and <http://www.homeoffice.gov.uk/publications/non-personal-data/drugs/dip-action-team's-grants>

That means that the cost of maintaining each addict in 'effective treatment' is over £3,800 a year each.⁴³ This is despite the fact that the annual cost of basic methadone dispensing and prescribing is no more than £300 a head.⁴⁴

What we get in return

Last year this expenditure bought:

- 2.5 million methadone prescriptions.⁴⁵
- 3,914 residential rehabilitation interventions of varying lengths.
- 9,392 inpatient detoxifications.
- 8,112 people (4% of PDUs) discharged, officially judged to be free of drug dependency.⁴⁶

⁴³ This is based on the in-treatment population of 206,000 of which 192,000 are judged to be in effective treatment. Dividing the £734 million cost by 192,000 comes to £3,823. Note that a Home Office analysis of the cost of Tier 3 prescribing and Tier 4 drug treatment services arrived at the larger sum of £6,064 per client per year. See *The Drug Treatment Outcomes Research study (DTORS): Cost-effectiveness analysis*, Home Office, 2009.

⁴⁴ Written Answer, 14 September 2010 to Andrew Griffiths MP.

⁴⁵ Written Answer, 28 October 2008 to Andrew Griffiths MP. This refers the number of items of methadone prescribed in each primary care trust in England, in the financial year 2009-10. Prescriptions for all uses of methadone are included in the figures given including those given as an opioid analgesic, a treatment in opioid dependence and as a cough suppressant.

⁴⁶ NDTMS 'treatment completion' categories are ill-defined and unsatisfactory. For example it is unclear what the words 'dependency and 'drugs' relate to – prescribed as well as illicit, opiate or all illicit drugs, or not?

Despite this considerable expense:

- One quarter of the NTA's prescribing clients have been on state sponsored methadone for four years or more; and one half of them for two years or more.⁴⁷ In the North West and Yorkshire and Humberside, 90% of 21,000 people on scripts have been on them for more than three years.⁴⁸
- Unknown numbers are returning to start 'a new treatment journey'.
- Supervised methadone consumption is limited to the first few weeks, by all but a few of the drug treatment providers.
- Methadone is prescribed regardless of the client's other drug and alcohol habits.⁴⁹
- The majority of those prescribed with methadone stay dependent on alcohol and street drugs, topping up on street heroin,⁵⁰ which is sometimes financed by selling their prescriptions.
- There are no expectations for getting 'clients' off methadone, few targets, no time limits set on prescribing and no reduction plans.⁵²

⁴⁷ PQ Written Answer Andrew Griffiths MP, 18 October 2010.

⁴⁸ PQ Written Answer, Andrew Griffiths MP, 19 January 2011.

⁴⁹ NDTMS, February 2010.

⁵⁰ NTA Lancet paper.

⁵² Some charity drug services contractors like CRI have begun to introduce their own methadone reduction plans in attempt to wean

- The numbers 'carried over' in treatment year-on-year far exceeds those leaving treatment.
- Problem drug use has not been dented – there is no statistically significant decrease in the most recent estimate made of problems drug user numbers.⁵³

The NTA claims that around 23,500 people leave the treatment system every year having overcome their dependency and that this figure has gone up by around 120% since 2005 proving the 'success' of treatment.⁵⁴ There is no abstinence requirement for successful discharge.⁵⁵ There are no follow-up checks. All the NTA analysis shows is that these people are no longer on the treatment register and have not come back.⁵⁶ They may also have given up, be back on street drugs or have died.

them off – notably their Eastbourne project. Author's interview with David Biddle of CRI.

⁵³ NTA Annual Report, 2010.

⁵⁴ Ibid.

⁵⁵ Ibid.

⁵⁶ Neil McKeganey, www.addictiontoday.org.

2. THE HARMS OF HARM REDUCTION

“The medical profession and the addicted community have a complex, symbiotic, mutually dependent relationship that does none of us any good. Basically they pretend to be ill and we pretend to treat them. And thousands of public employees make a good living out of it. Prescribing for opiate addicts is like throwing petrol on a fire; pointless, counter productive, stupid, self-defeating. And yet we keep doing it.”

Dr Phil Peverley, *PULSE*, 22 June 2006

Treatment policy has not achieved what it set out to do. It has not saved lives. It has not reduced crime. It has not got people better. By sponsoring addiction, drug treatment has entrenched a costly dual dependency – on drugs and on welfare.

Lives saved or lost?

Methadone treatment has proved more risky than anticipated. Despite all the methadone, deaths involving heroin and morphine, 880 of them last year, have risen by 5% since 2005.⁵⁷

⁵⁷ ONS *Deaths related to drug poisoning in England and Wales, 2009.*

In the words of Professor Neil McKeganey:

“We are seeing a steady increase in the UK of the numbers of addicts who are dying alongside a massive explosion of the prescribing of methadone – more deaths than in any previous year. More addicts on methadone than in any previous year.”⁵⁸

Of even greater concern though is an exponential rise of deaths involving methadone since 2005. Up by 85%, to 408 in 2009, methadone deaths now constitute a quarter of all drugs poisoning deaths.⁵⁹ Advocates of methadone – such as Dr Roy Robertson – say that “people are much more likely to survive if they’re on a methadone treatment programme... we’ve no idea what would happen to deaths if we stopped prescribing methadone.”⁶⁰ But the rise in deaths as a result of, or relating to, the medical treatment received by addicts must call this complacency into question.

Public health or damaged health?

The incidence of reported HIV infection among injecting drug users has remained low in most European countries.⁶¹ In the UK, however, it has been rising over the last decade. One in 73 now carry HIV. In 2002, it was just one in 400. Hepatitis C infection amongst injecting drug users has also risen sharply: two-fifths are now infected.⁶² Both may be a reflection of poor Blood

⁵⁸ BBC Radio 4, *The Report*, 5 August 2010.

⁵⁹ Op. cit.

⁶⁰ Op. cit.

⁶¹ European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) *Annual report, The Drug Situation in Europe*, 2010.

⁶² *Shooting Up*, HPA 2009.

Borne Virus (BBV) testing and vaccination services, of more needles being distributed than exchanged, of a failure to recruit from needle exchange to methadone prescribing.

An NTA survey has found that half of all needle exchange services had no viral testing on site; 40% of them had no immunisation on site or testing for BBV's when they assessed new clients. One third did not discuss injecting hygiene and safer injecting techniques.⁶³ Yet, despite this evidence, some of the government's top drug advisers claim that "harm reduction has left us with one of the lowest rates of HIV amongst injecting drug users in Europe."⁶⁴

And does needle exchange work? A recent economic modelling and evaluation of needle exchange cost-effectiveness was unable to conclude that it did. It also pointed out that needle exchanges could lead to an *increase* of new injectors; that needle exchanges may encourage drug users to inject for longer (by making injecting safer and more socially acceptable), thereby diluting their benefits and even reversing them.⁶⁵

Lengthening drug dependency?

"(Methadone) sounds good but it keeps people actually where they are. In fact they are worse off because they

⁶³ D Abdulrahim, D Gordon, D Best, *Findings of a survey of needle exchanges in England*, NTA, May 2006.

⁶⁴ *The Times*, 12 July 2009.

⁶⁵ P Vickerman, A Miners, JI Williams, *Assessing the cost-effectiveness of interventions linked to needle and syringe programmes for injecting drug users: An economic modelling report* Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, October 2008.

go back on heroin because 'the methadone is not holding them', is their phrase. It is harder to come off and it is so sad. It is a very debilitating drug and memory loss is a big thing for the young people coming off it."

Maxie Richards, pioneering rehab worker, BBC, *The Report*

Methadone is viewed by its proponents as a necessary treatment. But its benefits diminish after the first eight months.⁶⁶ By prescribing methadone without an end in sight, the risk is that the individual feels less need to confront his or her behaviour. Methadone postpones the process of recovery.

Being on methadone prolongs the median duration of addicts' drug injecting careers from five to 20 years. This is the main finding of a recent Edinburgh study of 794 addicts followed over a 30 year period.⁶⁷ 55 deaths occurred from drug overdose while the addicts were on scripts. Other deaths from BBVs undermine the claim that methadone protects from overdose and death.⁶⁸ The study also revealed too that half the 'survivors' suffered from poor health, that injecting over the years, alongside their script, prolonged poor quality of life and high rates of physical and mental illness. 43% of the cohort had a history of problem drinking.

⁶⁶ N McKeganey et al, *Key Findings from the Drugs Outcome Research in Scotland Study*, University of Glasgow; 2008.

⁶⁷ Kimber et al *BMJ* 2010; 341:c3172. This studies 794 patients with a history of injecting drug use, presenting between 1980 and 2007. "Exposure to opiate substitution treatment was inversely related to the chances of achieving long term cessation" the study concluded.

⁶⁸ Dr Andrew Ashworth, *BMJ*, 2010.

The longer an individual is 'in treatment' the less likely too is his motivation or ability to become drug free. Recent research that methadone contributes to depressed cognitive functioning (higher dosage correlates to lower IQs)⁶⁹ raises serious questions about the medical ethics of this treatment.

Labour's opiate obsession

The Labour Government's treatment policy assumed that heroin and crack cocaine were the only sources of problem drug use. Yet among arrestees cannabis was found to be the most widely taken drug. 41% had taken it in the last month, followed by heroin (13%), powder cocaine (13%), and crack (11%).⁷⁰ It has also ignored the widespread alcohol abuse amongst drug users in outpatient or community prescribing services.⁷¹

Cocaine, for which there is no prescribed substitute, has become the fastest rising drug of abuse. By November 2008 the UK had the highest number of cocaine users in the EU for the fifth year running and one in eight Britons under 35 had taken cocaine. Opinion surveys showed that the large majority of 1.75 million young adults were using it thought it harmless.⁷² But since 1999, there has been:

⁶⁹ R King and D Best, "Cognitive functioning and cognitive style among drug users in maintenance substitution treatment", *Drugs Education and Prevention Policy*, 16 September 2010.

⁷⁰ R Boreham et al, *The Arrestee Survey 2003-6.*, Home Office Statistical Bulletin, 2007.

⁷¹ M Gossop et al, "Patterns of drinking and drinking outcomes among drug misusers. 1-year follow-up results", *Journal of Substance Abuse Treatment*, 2000.

⁷² *The Observer*, Drugs Poll, 16 November 2008.

- 130% increase in deaths in which cocaine was involved⁷³
- 152% rise in deaths where cocaine was the *only* drug mentioned on the death certificate
- 300% rise in poisoning by cocaine from 188 cases to 1033 in 2008/9
- 132% rise in cocaine related mental health disorders.⁷⁴

Also ignored has been the rise of deaths associated with other prescribed drugs of abuse. Benzodiazepines are routinely misprescribed alongside methadone. Death certificates mentioning them rose to 261 in 2009, an increase of 13%, in just one year, from 2008.⁷⁵ Since 1999 cannabis related mental health and behavioural disorders' have risen too, by 25%, despite cannabis use recorded as being on the decline.⁷⁶

Cutting crime, reducing re-offending?

Despite treatment availability, drug-related re-offending has continued at high rates, rising 2.9% between 2007 and 2008.⁷⁷ Prolific drug-using offenders still commit over two proven offences each per year.⁷⁸ This begs the question of what impact the policy

⁷³ Based on analysis of published data. See www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=214

⁷⁴ *ibid*

⁷⁵ *Op cit.*

⁷⁶ *Op cit.*

⁷⁷ *The 2009 Drug Misusing Offenders Cohort for England and Wales*, Home Office March 2010.

⁷⁸ *The 2009 Drug Misusing Offenders Cohort for England and Wales*, Home Office December 2010.

is having. The Public Accounts Select Committee reprimanded both the Home Office (the lead drug policy department) and the NTA for not knowing, 'the overall effect its expenditure on drugs treatment is having', specifically with regard to crime.⁷⁹

The latest Arrestee survey also reveals the limited impact of methadone treatment. Only 26% of those reporting having had treatment say they are no longer heroin dependent.⁸⁰ Nor are they necessarily free of other drugs.

Yet the NTA has said confidently that "all the research evidence states that drug treatment is effective in reducing drug use and cutting crime".⁸¹ But an analysis of the first tranche of Drug Treatment and Testing Orders suggested otherwise. It found an 80% reconviction rate within two years for those who could be traced.⁸²

It is true that giving an addict free opiates will reduce his need to steal for heroin. However, the addict's life is rarely that straightforward: the majority of those put on scripts have no illicit drug-free periods at all, even in first six months of treatment. Only 37% of a national treatment cohort reported to their drugs worker that they were illicit heroin free in the 28 days

⁷⁹ Public Accounts Select Committee, *Tackling Problem Drug Use*, 30th Report of Session, 2009/10, 24 March 2010.

⁸⁰ R Boreham, op. cit.

⁸¹ C Bradbury, 'Stop the TOP: NTA Response', *Addiction Today*, May 2010.

⁸² K Holloway et al, *The impact of Drug Treatment and Testing Orders on offending: two-year reconviction results*, Home Office Research Findings, 2005.

before their six month review.⁸³ This was claimed as evidence of treatment effectiveness and reduced criminality.

Multiple dependency – the welfare burden⁸⁴

Most of those on methadone script are, not surprisingly, out of work. Indeed, their employment rate is only marginally better than that of the whole PDU population (79%, compared with 81% of PDUs).⁸⁵ One charity estimates that 90% of its clients on prescription are not in any sort of employment and are fully welfare dependent.⁸⁶

Yet little attention has been paid to the actual and year on year welfare costs of problem drug users, the majority of whom are dependent on benefits, methadone treatment and street drugs. However, a response to a Parliamentary Question revealed that, in 2006 (the latest year when figures are available), problem drug users made 267,000 welfare claims for Job Seekers Allowance, Incapacity Benefit, Income Support, and Disability Allowance. The cost of these benefits added up to £1.14 billion a year.⁸⁷

⁸³ *The Lancet*, 10 October 2009.

⁸⁴ Estimates of the welfare costs of problem drug use, like previous estimates of the crime cost of problem drug use, need to recognise that drug dependency may be a correlate rather than a cause or a sole cause of economic dependency. However welfare dependency is unlikely to be overcome while drug dependency continues.

⁸⁵ UK Reitox, *Focal Point*, 2007.

⁸⁶ Author interview.

⁸⁷ Written Answer 20 July 2010, Mike Weatherley (from Chris Grayling) for the number of users on benefits. See Appendix One for computation. This calculation of the value of benefits uses median range estimates for each benefit and assumes single status of the claimants. Given that two thirds of those in treatment are over 30

Estimated welfare costs of problem drug users, England, 2006

	Number	Value of benefits
Jobseeker's Allowance	66,000	£201 million
Incapacity Benefit	87,000	£411 million
Income Support	146,000	£437 million
Disability Living Allowance	25,000	£91 million
Total in receipt of one or more of the above benefits	267,000	£1,141 million

Note that this £1.14 billion total excludes housing benefit (a locally claimed benefit). On the basis that the great majority of the 146,000 claimants for income support would also claim housing benefit, this can be estimated at an additional cost of £531 million – bringing the total cost to nearly £1.7 billion.⁸⁸

This calculation can be compared with an estimate of the current 'in treatment' population's welfare bill which is derived from the actual benefits claimed by the clients of two drug treatment centres.

The annual average benefits receipts of all the clients in one drug treatment centre in the East of England, including their housing benefit and child tax credit and child benefit worked

and nearly one third over 40 this is most likely to be an underestimate of the true figure.

⁸⁸ This assumes that an average housing benefit cost at a low to median level of £70 per week each. Note that the total calculations include neither child tax credit nor child benefit.

out at £6,921 a head.⁸⁹ Extrapolated to the 174,000 PDUs in treatment, this suggests a total welfare bill of £1.2 billion. Average annual benefits receipts of all the clients in a Midlands residential rehabilitation centre came to a higher figure of £9,155. Extrapolated to the whole PDU treatment population this would imply a welfare bill of £1.6 billion.

Of concern too is the duration of Incapacity Benefit. 60% of drug users on IB have been on it for over five years and of that subgroup, 41% have been on it for 10 years – a cumulative cost that makes rehab costs pale into insignificance.⁹⁰

The cost on children

Added to this welfare bill are the financial costs of helping the children of PDUs.

The number of children involved with drug-dependent adults is substantial. The most recent estimates suggest that:⁹²

- 2% (256,000) of all children live with a class A drug user
- 7.4% (approximately 862,000) with a class C drug user
- 72,000 children live with an injecting drug user or a user in drug treatment
- around 108,000 live with an adult who has overdosed

⁸⁹ See Appendix 2.

⁹⁰ DWP, *Duration of Incapacity Benefit to August 2010*, 2011.

⁹² V Manning, “New estimates of the number of children living with substance misusing parents: results from UK national household surveys”, *BMC Public Health* 2009.

- 2.8% (334,866) live with a drug dependent user
- 70% of all children of drug addict parents are not looked after by the parent. 12,500 of them are in the care system.⁹⁴

To illustrate the scale of the problem: 33 young female heroin addicts currently in treatment at just one centre have 79 children between them. 71 of these children have had or have social service involvement.⁹⁵ Children in care and care leavers report the highest drug use of all young people – 34% smoke cannabis daily, 10% use heroin and crack cocaine – adding to their already chronic disadvantage.⁹⁷

The financial cost is also significant: using an £39,000 average annual cost for foster or residential care per child,⁹⁸ the cost for these 12,500 looked after-children is roughly £487 million.

Overall the estimated expenditure on child and family work attributed to drug use is £1.2 billion.⁹⁹

The NTA's failure opposition to rehab

The NTA has asked, on the numerous occasions it has been challenged about its failure to get more people into rehab, why it should pay for someone's rehab programme when they could

⁹⁴ ACMD, *Hidden Harm: Responding to the needs of children of problem drug users*, Home Office 2003.

⁹⁵ B Hard, "Contraception use in female service users prescribed opioid substitute medication in Gwent", *Kaleidoscope*, November 2010.

⁹⁷ Home Office, *Drug Use Among Vulnerable Groups of Young People: findings from the 2003 Crime and Justice Survey*, 2005.

⁹⁸ The Information Centre for Health and Social Care, 2007.

⁹⁹ UK Reitox 2007 op cit.

pay much less for a prescribing programme and get more people into treatment.

The answer is that abstinence is more cost-effective than methadone treatment; and that treating fewer people properly is the better business plan. Thousands of people will recover from addiction without any formal intervention as recovered addicts' testimonies¹⁰⁰ and US epidemiological surveys and research show.¹⁰¹ The evidence suggests that continued dependency is not inevitable, that addiction is recoverable. This can take place in the context of 12 step programmes, in therapeutic communities and through peer support. Some people recover naturally; others through treatment and/or the assistance of self-help and mutual aid groups.¹⁰²

Recovered addicts themselves cite rehab as the most helpful formal 'intervention' offered.¹⁰³ And US research shows that longer stays predict better outcomes; that while this may be more expensive in the short term it brings far greater savings in the long run; that clients with the greatest problems who stayed at least three months gained the most.¹⁰⁴

¹⁰⁰ See Addict Recovery testimonies in Chapter 5.

¹⁰¹ See for example analysis of The Epidemiologic Catchment Area Study; The National Co-morbidity Survey; the NIAAA survey; The National Comorbidity Survey Replication in G Heyman, *Addiction – a disorder of choice*, Harvard University Press, 2009.

¹⁰² L Sobell et al, "Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions" *Addiction*, 2000.

¹⁰³ D Best, *Addiction Today*, 2009.

¹⁰⁴ C Franey and M Ashton, "The grand design: lessons from DATOS", *Drug and Alcohol Findings*, 2002.

Both of the two major UK (longitudinal cohort) drugs treatment surveys back up addicts' belief that going into rehab is more likely to result in abstinence. One pointed to the importance of abstinence for other aspects of recovery:¹⁰⁵

“Respondents who had been totally drug free for a period of at least 90 days were more likely (than methadone clients) to have been on an educational course or in employment; less likely to have attempted suicide or self-harmed; less likely to have been arrested; less likely to be drinking excessively; less likely to have committed a crime or an acquisitive crime; and more likely to rate their health as much better or somewhat better.

¹⁰⁵ N McKeganey, “Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study”, *Drugs: Education, Prevention and Policy*, 2006.

3. IS “PAYMENT BY RESULTS” THE ANSWER?

“Successful partnerships will be expected to test out new and innovative commissioning and delivery models, including developing their own approaches to payment by results, to deliver improved outcomes.”

The National Treatment Agency’s invitation to tender for
‘partnership’ pilots

“The change from managing the process to managing the outcome is a radical one.”

Professor Keith Humphreys, adviser to Coalition’s drug recovery steering group

To its great credit, the Coalition has recognised that the treatment system it inherited is not working. Its stated goal is to help individuals recover from their addiction; and to contribute to society instead of being a cost to society.

This, it believes, can be achieved not by a change in treatment priorities but by a change of governance. This is the background to the Payment by Results (PbR) trials currently being conducted.

The intention is to reward providers – whether they be drug charities, NH Trusts, private companies or not for profit agencies – who are successful in meeting nationally agreed outcomes for drug users. These outcomes are defined as improved health, crime reduction and employment as well as freedom from drug dependency. The idea is that risk will be transferred to the provider thus creating an incentive for treatment providers to find the best ways of getting addicts better. The Government hopes this will allow ‘what works’ to emerge through ‘market’ factors and not by government diktat.

It has also been decided that individual tariffs will be set for addicts; these will be weighted to reflect the severity of dependence and the complexity of social problems faced.

In theory, this all makes sense. The discipline of only paying when real recovery from addiction is achieved, yet acknowledging the various challenges posed, is a great improvement on the current system which incentivises retaining people in methadone treatment. As such, PbR should be an effective way:

- to incentivise recovery
- to free commissioners to draw on innovation from the private and third sector
- to recognise that ‘one size does not fit all’ and that there is more than one path to recovery
- to allow the best practice and innovation to emerge through a market mechanism rather than by government diktat.

Whether practice will live up to theory and whether PbR is guaranteed to ascertain ‘what works’ is another matter.

Problems with the PbR pilots

“I find it very hard to understand that when the government wants to focus on recovery, the Department of Health/NTA bring out a pilot for payment-by-results that excludes nearly all the smaller organisations with the most experience and proven success of delivering recovery.”

Brian Dudley, CEO of Broadway Lodge, *Addiction Today*, March 2011

Drugs Recovery PBR is to be tested out through eight pilot areas to run for one year from 11 October 2011. The Government hopes that the ‘local area frameworks’ they have chosen will draw on innovation from a wide range of providers. The intention is that they build on and transform the current system. But problems are inherent from the start, in how they are being set up and in an absence of specific terms of engagement.¹⁰⁶

The “forces of conservatism” within Whitehall

Those who have led the failed methadone approach have now been given responsibility for implementing the new system. Those who provide drug services under the current failing system are now the successful pilot bidders.

The status quo is deeply entrenched. The denial of failure is endemic within the DoH. This is evident in the original invitation to tender and the pre-qualification process led by the Department of Health and the National Treatment Agency. It was premised on the idea that methadone was working:

¹⁰⁶ Department of Health, *Piloting Payment by Results for Drugs Recovery: Invitation to participate*, December 2010.

“Existing drug funding, commissioning and delivery systems have helped to deliver an unprecedented increase in drug treatment, supporting individuals on their recovery journey.”

The strength of negativity towards rehab driven abstinence based recovery is also shown by the example of NE Lincolnshire’s DAAT Strategy Manager. At an NTA round table discussion of the new strategy, he announced that he had no rehab within 50 miles and “in any case ‘service users’ show no wish to go”.¹⁰⁷

This false presumption underlies the decision to limit applications for the Drug Recovery pilots to the drug action team areas that command and drive the current system. The qualifying criterion of full local partnership back-up (DAT, PCT, DIP, Police, Probation Services and so on) has excluded all but the DATs. Smaller rehabs were ineligible from partnership participation on the specious grounds of a potential conflict of interest over future contracts. Yet a far greater conflict of interest was overlooked in the successful pilot bids,¹⁰⁸ where commissioners employed by the NHS or PCT currently buy drug services from the NHS.

Another problem with the tender process is that it does nothing to compensate for the fact that, as a direct result of government policy, rehabilitation organisations have been struggling over the last 10 years. The tender documents also show a lack of

¹⁰⁷ NTA Stakeholder roundtable meeting record, 27 January 2011.

¹⁰⁸ See DH, *Pilot Summaries* (undated). Available from www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@abouts/documents/digitalasset/dh126535.pdf

knowledge about the pros and cons of rehabilitation versus 'resettlement' programmes and approaches. They include the assumption that 'what works' is not known, a statement that all successful recovery providers would contest.

This leaves rehab providers unable to compete fairly with both the large drugs charities and the NH drug services contractors – unashamedly named in some of the pilots – where the methadone orthodoxy is prevalent.¹⁰⁹ Yet there is no requirement, under the terms for the pilots, for the large providers to finance their own risk up front.

An unlevel playing field

It is telling that none of the bidders approached or consulted any successful rehab operators in the course of preparing their bids. Rehabs who took the initiative themselves, including one in David Cameron's own constituency, were and continue to be cold shouldered, even though the co-design phase has begun. Yet few of the partnerships have any expertise in addiction, have even visited a rehab, have personal experience of recovery, or have ever attended an AA, NA or an Alanon meeting. By contrast, amongst the most successful of the rehabs many are run by people who are themselves in recovery.

Furthermore, several of the successful pilots have chosen to delimit the scope of treatment that PbR will be applied to. This further skews the playing field favour of the status quo. Although the requirement to recommitment services is implicit, most of the pilots are choosing to partition off significant elements of treatment, thus protecting themselves from the need to do this.

¹⁰⁹ NTA, *Piloting Payment by Results for Drugs Recovery: Invitation to participate*, DH, December 2010.

It is left to them to decide how much of their significant budgets will be given over to PbR, or not.

So Bracknell is not applying “Payment by Results to their Primary Care Prescribing, the Needle Exchange Scheme or the Supervised Consumption Scheme”. This begs two questions: what budgets will be left to be assigned to psycho-social or recovery interventions; and what chance will the area pilot have to work when a substantial proportion of clients will be retained on methadone prescribing because there are no incentives to get them off?

Enfield similarly is restricting the scope of PbR to its mentoring scheme, service user programme, and residential treatment components of delivery.

Wigan proposes to restrict PbR ‘eligibility’ to clients in ‘structured tier three drug treatment services only’ plus dependent alcohol users. Its aim for them appears to relate more to resettlement services – housing, education etc – than providing innovative recovery treatment.

Kent proposes to run “an integrated recovery system” through all the existing treatment tiers, but plans to divest the responsibility of how to do this to a ‘prime provider’ who is likely to be a major drug charity or NH provider.

The resistance to innovation is also demonstrated by the statement from Wakefield that they have been using an outcomes-focused system for the past two years that “can be quickly adapted to our proposed PbR model”. Oxford too looks to be reluctant to engage in any fundamental change or new and innovative commissioning since it has decided that all its current structured drug and alcohol interventions will simply be re-commissioned under a “Recovery Framework.” It plans also to

continue to commission needle exchanges (currently in approximately 40% of pharmacies across the county) on a payment by activity basis.

None of the pilots involve any change of commissioning personnel – leaving the old guard in charge of reform. Several of the pilots also propose to trigger what are effectively ‘process payments’ – payments at various stages to acknowledge initial engagement, 12 week retention, interim progress, as well as completed treatment and sustained recovery through the four specified national outcomes. This dilution minimises the risk to the provider and restricts real competition.

The TUPE ‘noose’

“One of the main impediments to date to an ‘abstinence recovery’ provider bidding for a contract are punitive TUPE laws which means if he wins he has to take on a demotivated, poorly trained workforce unskilled in anything but harm minimisation plus NHS terms and conditions and sick pay that he can’t afford.”

Tom Kirkwood, CEO, TTP

Yet it is questionable whether the PbR commissioners and the partnerships behind them have the necessary knowledge about different approaches to evaluate providers, programmes, bids; define measures and structure incentives appropriately.

Those with the rehabilitation expertise – often themselves former addicts – have not had the asset base, cash flow or clout to qualify for public sector treatment funding, or to take it over. They are involved because they care, not because they see getting addicts better as a route to more state funding. The risk is that PbR will favour large charities, and those NH and NH Mental Health Trusts who are responsible for the harm reduction approach.

And even if these smaller rehab providers did take over a contract, then they would face all the troubles expressed by Tom Kirkwood above.

Individual tariff setting by the Local Area Single Assessment and Referral System (LASARS)

Under PbR, an individual tariff will be allocated to each drug user, set according to nationally established criteria, by a Local Area Single Assessment and Referral System. This has been broadly welcomed, although there are questions over whether it can genuinely ensure that clients are directed to appropriate treatment programmes. But there are several challenges, including:

- Will tariffs be high enough to secure the appropriate treatment? How, for example, would the tariff be set for Tina (a real case), who has been on methadone for 29 years and on benzodiazepines for 13 years? She was physically ill and enfeebled on entry to rehab. But after six months of residential rehabilitation (cost £12,000) her health is largely restored, she is drug-free and is attending college. Yet she still needs help with a rent deposit to secure 'safe' social or private housing.
- Will the LASAR genuinely act as the 'travel agency' for recovery services that it needs to be? Will it spell out what is available, the range of choice of treatment and services, while setting out what the client can and cannot do?
- Will LASAR decisions, which neither client nor provider can challenge, be as prescriptive and limiting as the current system?
- Will it be possible to resist the temptation to cherry pick or 'cream off' easy clients?

The last concern is pressing. As a manager of a rehab unit has pointed out:

“Realistically it would mean that centres would ‘cherry pick’ and not take in the clients who need treatment the most. Wouldn’t we all settle for the ‘easy’ cases? For example those with a history of long-term employment who already have stable accommodation? Anyone ‘troublesome’ would probably be discharged within a few days in order to bring in a ‘higher class’ of addict.”

There is also the reverse risk of inflating clients’ problems to secure the highest tariff, even though his needs may be, or turn out to be, less complex to resolve.

For all the above reasons, PbR is weighted against small providers who tend to have the expertise but not the cash flow or funding advantage of either NH drug services or of those charities co-opted by the state to provide them. As one successful rehabilitation centre manager pointed out:

“How many addicts need more than one course of treatment before they turn their lives around? Each course contributes something but only the last one would get paid! I can see that more people would be put on maintenance programmes as long as they got some voluntary work or, if they were seen to be working they could continue to get their script. Or to get a script they would need to find work of some sort. I also see how people will continue to falsify or engineer ways to show false outcomes.”

Proxy outcomes

But there is another problem with PbR as currently set up: they are using the wrong measurement of success. Instead of abstinence, four ‘equal’ indicators of success lie at the heart of PbR:

- crime reduction – measured by 12 month non-appearance on the Police National Computer (PNC)
- employment – measured by 12 month non-appearance on welfare claims data
- freedom from clinical dependency – measured by non-appearance on the national drug treatment data base
- health and well-being (an interim outcome).

This is all far too complex. They are blunt instruments. Non-appearance on the PNC, for example, means little when crime detection rates remain one in five. And such multiple outcomes also risk a system that knows the cost of everything and the value of nothing.

Yes, the outcomes are all desirable: who would argue against crime reduction, stable housing, employment and so on? But to be lasting, they should flow from the resolution of the original drug problem – freedom from drugs. As one Rehab director put it:

“We are not employment agencies. However as a direct result of people getting well they then become employable. I see it as an extremely condescending view that we have to do everything for the poor addict. They are very capable survivors who, given the opportunity to get clean, are capable of great things.”

These measures are also open to interpretation and abuse. For example, employability also needs to be demonstrated while jobs need to ‘proved’ (the job might not be ‘real’ nor the client capable).

Unfair priority

PbR runs the risk of attempting to tackle a whole range of social issues which may or may not have anything to do with drug dependency. This could be seen to be giving unfair priority to those people who happen to take drugs over those in similar adverse circumstances who don't take drugs. In fact, it could be seen as a state-sponsored incentive to take drugs if your problems are going to be paid for and fast-tracked. Want help with new housing? Then become an addict and the state will step in.

The Diamond Initiative

Why the solution does not lie in joined-up services

The Diamond Initiative was a 'multi agency' resettlement programme set up by the London Criminal Justice Partnership. It aimed to offer high levels of help to released offenders, including conventional drugs services, advice on housing, training and employment, on a group, 59.4% of whom had serious drug problems.

Its principal finding is that the known re-offending rates in the experimental group were *higher* than that in a matched control group: of the evaluation cohort of 368 offenders, 156 (42.4%) re-offended within 12 months of release from prison. From the control group (similar offenders from similar localities), 136 out of 327 offenders (41.6%) re-offended within 12 months.

According to Tim Godwin, Assistant Deputy Commissioner of the Met:

"The main reason for its lack of success was continued drug abuse by many of the offenders, one third of whom had a history of using class A substances... too many prolific offenders are being 'maintained' on class A substances after being convicted, and most returned to crime as a result... All I know is we haven't got it right at the moment. Current treatment programmes are about maintenance, as opposed to stopping offenders using class A drugs."

4. GETTING FREE: THE ADDICTS' TESTIMONY

Carl's story

Carl was one of five children of a single mum. He was 12 when he started smoking pot, taking acid trips and eating magic mushrooms, first without giving it a thought, he said. Soon he found that he needed to. He says he was probably a robber first. By 13 he was out of his mum's control and had started to smoke heroin. At 14 he was using heroin daily:

"I cannot honestly say I was under pressure from dealers. I put pressure on myself. First it was minor offences then I started to get arrested. I can't even think what my crime cost was to the local police force and probation service. I created chaos.

I was up before the juvenile court at least ten times. Initially I was bound over to keep the peace. Then it was community service, then probation and a borstal, Stoke Heath for 6 months then finally at 16 I was sent down to a YOI at Aylesbury. My drug taking continued in gaol – it did nothing to stop me. I didn't take any exams. I had a day and night heavy drug using occupation – I was always looking to get my next score. From then on I was

on 6, 9 or 12 month prison sentences. I stole from shops, warehouses and cars. The stays in gaol got longer, the crimes got bigger. I was in gaol for my 21st birthday. I thought when I stopped drugs I'd be OK. I did not understand the implications of what I was doing. I was in another world.

When I was 'out' I was living with my mum. I'd been on benefits since I was 16 onwards – on unemployment and income support. By this time I was on a doctor's methadone script too but there was no drug treatment programme. I felt like an outcast. I was being prescribed 4 or 5 different types of medication and I was seeing my friends start to die. I overdosed a couple of times in hospital. There was no offer of a detox – ever.

My girlfriend had become a drug user too. We had a son and the social services were in contact. Mum intervened and took our son to look after him. For the next 15 years my girlfriend and I were both drug taking, prescribed and illegal and living together – on various benefits. She got child benefit but this didn't get given to my mum – it got exchanged there and then for drugs.

We always managed to collect housing benefit x 2, social benefit x 2 and child benefit x 1. When I was in prison I used to leave my benefits book with my girlfriend and she kept cashing it. For 15 years we lived like this until a national newspaper came back to do a follow up on a 1980s report of drug use in Birkenhead. I turned out to be one of the few still alive from an original photo. The journalist told me there was a place I could go to and get better in Bournemouth. I thought he was lying but he came back and put me on a train. I was 37 and apart from prison had never left Liverpool in my life – I ended up in Brighton by mistake.

But the Providence Project came to get me. I went into a 12 step treatment programme at the Providence Project. My first day

clean and sober was on 29 August 2004. It took me three months to detox but much longer to learn how to communicate. I had shut down. But I listened to other people. I didn't run away.

Walking through the park one day I had to stop. I had an overwhelming feeling that I could do it. I moved from second stage treatment after 6 months into one of the Providence's 3rd stage houses, onto their aftercare programme and began college. I did voluntary work for NACRO and for Providence to pay my way, accompanying new clients to hospital for their appointments – making sure they got there and back etc and doing housing support work. I had to go to three fellowship (Narcotics Anonymous) meetings a week. I was 15 months in all in aftercare. I made friends who were further down the road to recovery. I had a chance to find out what I could do and what I wanted to do. I began to work three days a week for Providence, then they offered me full employment.

I have been a fully salaried worker now for three years, renting my own private accommodation, paying tax, putting back and not benefit dependent at all”

Carl had been on methadone and valium prescriptions for 22 years. 14 of those 22 years were in prison. He never worked one day – he sold drugs and stole. Treatment was never mentioned to him. Now he has been clean for five years, in a full-time job and pays taxes.

Clinton's story

Clinton was born in Glasgow, brought up in Corby from 11 years old after his parents split up, was the second oldest of six sisters and two brothers. His mother had a mental illness and his father was an alcoholic. He began using solvents at 11 years

old, beginning a progression of drug use. He was sent away to care, at 11, because in his words “I was uncontrollable”.

For the glue sniffing we chipped in or stole a pot of glue – the group of us that was truanting. I didn't go to school much because in care I was always being moved around – I was taken from Corby to Brackley in Oxfordshire. At 13 I was taken to another children's home at Tiffield where I didn't do any schoolwork at all. By this stage I was doing some alcohol and had had the odd joint and was taking acid. We always ran away from the children's home and the police always brought us back. I stayed in care until I was 15 when I was sent to an all boy's approved school where there was physical abuse.

I had a problem with alcohol by that time and was committing various offences. I got involved with an armed robbery and was caught. On my 16th birthday I was charged and sent away first for four months to a detention centre and then to Aylesbury Young Offenders Institute for four years, run by some ex military and with some brutality. This was in 1985. I will hold a resentment against those warders for the rest of my life. The day after I got out I met my old friends who were into amphetamines, I got drunk and injected speed. It became a daily habit virtually.

I still managed to get a job with British Steel. I also got a girlfriend and we had a baby but we lost it. I was 22. We split up a year later. Throughout I was on amphetamines. I was selling them, committing crime to pay for them – mainly fraudulent use of cheque cards. I had also started using heroin and contracted chronic Hep C. I was lucky not to get aids. What I did was to buy valium, temazepan and mogodon from old ladies – and although they were sedatives, injected they gave you a rush. The old ladies wanted to make some money.

I was still working and I met another girl. I had a beautiful baby daughter with her. But by 1993 I was back in prison – I was only 23 years old – because I hadn't paid a fine on a fraud charge. It was a short four month sentence. From then on I was in and out of prison – I can't count how many times. – I would say it has been for two thirds of my adult life – basically charges from burglary, theft, fraud and assault, six month, nine, 12 and 15 month sentences, ten years in total. My last sentence was in 2003 and I was 34 years old.

Over all this period I was on income support – that came automatically once you registered as an addict with a doctor – that was £63 to £80 a week for years. I had a book and I would always get someone else to cash it for me when I was in prison. I got housing benefits too. You'd get council cheques for living somewhere even if you weren't – then we would divvy it up.

I used prison to detox and I would go to the prison gym to get fit. I enjoyed the fact that I could get clean. I would think when I came out that I needed to get straight into rehab because I knew that I couldn't stop using on my own. The last time I got out of prison in 2000 I did get into a rehab in Bournemouth – it was called Allington House – and I managed then to be clean for a year. But I was still fundamentally dishonest about everything. I hung around Bournemouth after that, still using. But I had tasted sobriety and this was the hardest time of my using career. I was on the Prolific Offender list and Bournemouth police told me that they would hassle and harass me unless I went into treatment.

Finally I went to Dr Turnbull for help through an agency called the Foundation Programme. He gave me a subutex script. In the end the police funded my treatment at the Providence Project. They cared and they gave me their trust and they gave me the

chance, even though the night before I was due to go to treatment I got drunk and was in a scuffle – but they still took me. The police who supported me came to my graduation.

The fact is once I went into the Providence Project I never looked back. It was all about the way it was done there. It worked – not just because of the counselling and workshops – it was about the responsibility I was given and the trust that was placed in me.

My detox at the Providence Project lasted 12 days, then I was six months in treatment (three months primary and three months secondary) and another three months in aftercare. In the aftercare period I went to college and did a maths and English course. When I was one year clean I started an introductory course in counselling – this was all at Dorchester College of Further Education. I also did voluntary work as well as going to regular NA meetings. I rented a one bedroom flat. I was still benefit dependent 18 months after getting clean. I wanted to do the advanced diploma in counselling and for that I had to find the money myself. I wrote away to various charities and was successful. I also started working as a trainee counsellor in Weymouth.

I am now a fully qualified therapist, a salaried taxpayer, paying my own rent without any state support. That is how it has been for two and half years now. My daughter is 16 and I have been clean for six years. Before I was busy dying. Now I am busy living.”

There are only handful of projects around the country that achieve what The Providence Project, the innovatory rehabilitation centre founded by former addict Steve Spiegel, achieved for Carl and Clinton and for many others too. The Providence Projects’ annual ‘graduate’ reunions where hundreds

come back and add up their combined hundreds of years of clean time are a testament to the high success rates that 12 step abstinence programmes with built in aftercare can achieve.

Park View

Another example is Park View in Liverpool whose success goes beyond “the cessation of drug taking and the (control of) associated harms in the first instance” whether this be for a chaotic drug using sex worker or a prolific drug using offender.

Most of Park View’s clients are PDUs and many are rough sleepers and street drinkers.

“The vast majority of our clients have criminal histories and approximately 70% of them have served prison sentences,” Carl Edwards, Park View’s founder and Director says. “We take approximately 145 per year; approximately 25% to 30% of our clients are PPOs and 75% to 80% have no fixed abode. We offer a first, second and third stage abstinence programme, depending on need, that can last from three months to a year. We see shocking deficits right across the socio-economic spectrum: employment histories, education and training, housing, family circumstances etc, but we also see people with strengths and assets.

“We get women reunited with children and men no longer at risk of committing serious offences. This is common; it is what we do. Recovery happens all the time here and the more people that get it, the more other people “catch” it. It’s contagious. In terms of our graduates, we are watching them do more for themselves and each other in the community than we could ever have done for them or they could do for themselves when they first came into our service. They have become autonomous, fully self-supporting through their own

contributions to their own lives. We see people change all this around, by a combination of ourselves, their peers in support, 12 step/ mutual aid, continued abstinence, and critically, meaningful occupation in the community.”

Modern Rehab

Treatment outcomes of the sort that Park View and the Providence Project deliver are not collected or measured by the NTA.¹¹³ Nor are they adequately measured by non appearance on national data bases. Park View’s own ‘new graduate’ data base so far contains detailed information on 131 people who are clean and sober (many for several years) working and living in their own or rented accommodation. 29 of them are working in the drug and alcohol field completing a virtuous circle of recovery by putting back what they benefited from.¹¹⁴ Since 2006 Park View has recorded 80% positive outcomes, by these measures, in total. Only 20% have walked away or discharged themselves before their abstinence based programme was complete.

Most go from a primary phase of 12 to 19 weeks into a secondary phase for another six months. Both phases are in accommodation which is staffed 24/7. The third stage, for which Park View is only recompensed through housing benefit, involves putting the clients

¹¹³ For a comprehensive report of what ‘rehab’ means, achieves and costs see *Addiction Today*, ‘Residential Rehab Briefing’, Concordat of Recovery Providers, 2011.

¹¹⁴ This does not mean that there are not others too from Park View who are clean and sober or in work. This data base is of those who have stayed in touch and settled locally about whom it has been easy to collect information.

into self-running houses for up to one year. This is the time and commitment that it takes to rebuild a broken person.

One after another former addicts' personal testimonies stress the efficacy of '12 step' and therapeutic community programmes for recovery. As one addict commented:¹¹⁵

"I thought, when I first came here, I thought 'I need to get off drugs', and that was it. But then I learnt as I went on, that it was about learning life skills which I never learnt from being on heroin for like 22 years. You know, I just turned 40, and I'm thinking, 'there's stuff that I don't even know, what I haven't even learned that I'm supposed to,' like, normal people have learnt it and get on with it every day, and I am just sort of like cramming it into a year, you know. And it's hard... it's a very hard programme, intense. But it's good."

60% to 80% positive rehabilitation rates are now routinely achieved by a group of modern rehabs currently operating in the UK. The Addiction Recovery Agency in Bristol, TTP, The Ley in Oxfordshire, Park View in Liverpool, the Burton Addiction Centre and The Providence Project in Bournemouth, are just some of them. The key to their success is an abstinence and 'personal change' approach to treating addiction – helping them to help themselves.

Full freedom from drug dependency and from welfare dependency can be achieved with even the hardest of cases. Of 39 men who started a 12 month programme between 2008/9 at the Ley Community in Oxfordshire, 24 are already in employment – 61%. "They have become part of the recovery

¹¹⁵ Author Interview.

community in and around Oxfordshire – they are abstinent, in full-time employment and independent living, paying their taxes, not on benefits, not committing crime or in treatment!”¹¹⁶ Yet, as with Park View, many were sent to the Ley as a last resort, “entrenched addicts who have been failed by tier 2 & 3 services, sometimes placed in inappropriate rehabs for too short a time and have failed as a consequence”.

The Ley also runs a relapse prevention project (ARA in Bristol also runs temporary relapse accommodation from which clients can return so they do not have to start all over again) and a dry house for those people who have left the treatment programme and relapsed but are still in work and need support. The Ley gets clients onto their feet in the community offering them a six months short hold tenancy in a house attached to the community. Other rehabs like Providence are developing rent deposit schemes to help clients make the difficult move to independent living.

Six months in the rehab described here followed by aftercare routinely costs £12,000 – equivalent to the cost of two years of prescribing treatment.¹¹⁷ At some rehabs the clients’ benefits are used to reduce costs further. At ARA and at two centres runs by ADS in Manchester and Preston, for example, Employment Support Allowance, Incapacity Benefit and Pension credit are all counted towards the ‘home fees’ bringing down costs to the referrer, by £100 per client per week and still leaving the resident with a personal allowance of £22.50 a week.

¹¹⁶ Wendy Dawson CEO The Ley Community – author interview.

¹¹⁷ Home Office, *DTORS Research Report 25*, 2009.

5. HOW TO MAKE PbR WORK

The Coalition plans for PbR are well intentioned. But leaving its implementation to the Department of Health and the NTA is wrong. They accept that they are entering “relatively uncharted territory”.¹²² But, on top of that, the Coalition decision to ignore the clear benefits of a rehab-based approach is, as one expert says, “palpably absurd”.¹²⁴ That is why the modern rehabilitation units must be allowed to demonstrate this expertise, and be invited to participate fully in the pilots.

For if addiction is the problem, being free of addiction surely is the solution. Nothing else – crime, welfare dependency, neglect – is resolved until addiction is overcome. And for that to happen abstinence-based rehabilitation skills are fundamental.

The following reforms to PbR are needed.

¹²² NTA, *Building Recovery in Communities: a consultation for developing a recovery oriented framework to replace Models of Care*, Undated.

¹²⁴ Nick Barton, CEO Action on Addiction, *Addiction Recovery Today* February 2011.

Reform 1: simplify

i) a single payment criterion

One simple payment measure – freedom from all drugs (including methadone and alcohol) – should replace the current four proxy measures. A first payment should be triggered once the addict has achieved a period of 90 days abstinence and a final payment after six months abstinence.

How this is achieved is up to the provider. (It could include planned methadone reduction, community support, structured day or residential care, education, training, cognitive behaviour therapy, peer mentoring, mutual aid groups, family counselling or any combination of the above).

Other positive outcomes – such as education, training, employment, crime free living, restoration of parental responsibility – could be included but only as a bonus scheme.

ii) a simple tariff scale

The proposed scheme is far too complex. It would be far better to assign clients to one of three tariff groups: moderate, difficult or challenging. This would ensure the ‘upfront’ cost of rehab where necessary. It should be open to discussion between client, and the advocate or family member. Rehab recovery practitioners must be consulted on how tariffs are formulated.

Reform 2: engage doctors

- i) give doctors a positive incentive to refer to rehab
- ii) set restrictions on methadone prescribing and dispensing

Reform 3: use harm reduction services as the first step to rehab

Harm reduction services – such as needle exchanges, bbv testing and vaccination – need to be encouraged to provide a gateway into recovery treatment and rehabilitation.

Reform 4: facilitate the inclusion of good modern rehab expertise at every level of the pilot development

“People do recover from addiction/dependency and have been achieving recovery for a long time. But we have not been very good at either acknowledging this fact nor in documenting how and when recovery occurs, not utilising this knowledge to shape our endeavours in treatment”.

David Best, *Addiction Today* July/August 2010

This is the crucial test of PbR: can it harness the energy and the expertise of the successful modern rehab models?

Some have argued that rehab and abstinence projects are not affordable, that there is no up-front money available for the trials. But this is not accurate. Drugs treatment funding is already generous: a large DAT will receive between £10 million and £15 million a year. Surely 20% or so of this could be made available to rehab providers in some of the pilot areas?

The above reforms would concentrate minds on the best way to achieve abstinence, and would reward only the most successful and cost-effective programmes. They would help addicts to become drug free and reduce the tendency to manage every aspect of their existence. Methadone has entrenched long-term state and welfare dependency. Recovery depends on the ability of individuals to take responsibility for themselves. The Coalition must decide which of these two options it prefers.

APPENDIX 1 CALCULATION OF THE BENEFITS BILL

1. Estimated number of Problem Drug Users claiming benefits

	Number
Jobseeker's Allowance	66,000
Incapacity Benefit	87,000
Income Support	146,000
Disability Living Allowance	25,000
Total in receipt of one or more of the above benefits	267,000

1. Data are for England, 2006.
2. The figures are derived from estimates of the number of problem drug users (PDUs) on each benefit. They do not record if problem drug use is the reason for the benefit claim.
3. Figures are rounded to the nearest 1,000.
4. The sum of the component benefits is greater than the total because claimants can be in receipt of one or more benefits at the same time.
5. PDUs are defined as those who use opiates (e.g. heroin) and/or crack cocaine and include those who are in treatment for their dependency.
6. Disability living allowance can be claimed by people who are both in and out of work.

Source: G Hay and L Bauld, *Population estimates of problematic drug users in England who access Department for Work and Pensions benefits: A feasibility study*, Working Paper No. 46, DWP, 2008.

2. Methodology of calculating costs¹²⁵

There are many variables in play with each of the allowances. However, taking the median value of each benefit for the purpose of calculation arrives at a conservative estimate of the amount being claimed.¹²⁶

3. Jobseeker's Allowance:

There are two types of Jobseekers Allowance:

- **Contribution-based Jobseeker's Allowance (JSA(C))** entitlement is based on Class 1 National Insurance contributions in the two complete tax years preceeding the calendar year of claim. This allowance is paid regardless of assets.
- **Income-based Jobseeker's Allowance (JSA (IB))** is payable to those not eligible for JSA(C). This is means-tested for each individual claimant and/or their dependents. People who are eligible for JSA(C) may also claim JSA (IB) for any additional payments due under that benefit (for family dependents, for example). JSA (IB) is payable only if the claimant has less than £16,000 in savings (correct as of July 2006). Payments are reduced when the person has savings between £6,000 and £16,000.

¹²⁵ Note that in the following calculations, the PDU figures are taken from 2006, but the current rates of benefit are used. Thus the figures are based on the premise that the numbers of working-age claimants who are problem drug users have remained steady between 2006 and 2010.

¹²⁶ Since two thirds of those in treatment are over 30 and nearly one third over 40 (NDTMS, op. cit.) the 'median' figures adopted are probably underestimate the true figure.

Jobseeker's Allowance payments

The maximum weekly rates for JSA(C) are:

Age	Amount
Aged 16 to 24	£51.85
Aged 25 or over	£65.45

For JSA(IB), the maximum weekly rates are:

Type of person	Amount
Single people, aged under 25	£51.85
Single people, aged 25 or over	£65.45
Couples and civil partnerships (both aged 18+)	£102.75
Lone parent (aged under 18)	£51.85
Lone parent (aged 18 or over)	£65.45

Calculation of

If all 66,000 PDUs claiming JSA were under 24 and in receipt of the full JSA for their age range, the total is calculated as: 66,000 x £2,696.20 (yearly total):

Total per annum: £177,949,200

A higher rate of JSA is paid to those aged 25 and over. This age group receives £65.45 per week. If all 66,000 claimants are over 25 and in receipt of the full amount of JSA, the total is calculated as: 66,000 x £3,403.40 (yearly total):

Total per annum: £224,624,400

The median total is therefore £201,286,800. This figure needs to be taken cautiously, because unknown numbers of claimants will be receiving reduced JSA because of part-time work; or because they hold savings of over £6,000. Others will be using the JSA as a 'gateway' into more easily accessing other benefits, such as Housing Benefit and National Insurance

contribution credits – for example, if they work part time and earn more than £65.45 per week, they will receive no JSA payment, but may still be eligible for other assistance because they are on a low wage.

4. Incapacity Benefit

Incapacity Benefit (IB) is paid to those below the State Pension age who cannot work because of illness or disability and have made National Insurance contributions. It is administered by Jobcentre Plus.

The DWP estimates that in 2006 there were 87,000 PDUs claiming IB. Statistics for the same year also show that approximately 49,000 people were in receipt of Incapacity Benefit with the main disabling condition being their drug abuse. Therefore, in 2006, there were approximately 38,000 PDUs who were in receipt of Incapacity Benefit for a primary reason other than their drug abuse.

The lowest payment for a single person in receipt of IB is £3,889 per person, per annum – ie £3,889 x 87,000.

Total per annum: £338,343,000

The highest possible payment for a single person in receipt of Incapacity benefit is £5,566.60 per person per annum.

Total per annum: £484,294,200

The median total is therefore £411,318,600. Again, this estimate must be treated with caution, as there is no way of knowing precisely how many claimants are on which tier of Incapacity Benefit.

5. Income Support (IS)

IS is an income-related benefit for people on a low income. IS claimants may be entitled to certain other benefits (eg Housing Benefit etc). From 6 April 2009, the weekly rates of IS were:

Single

£50.95	aged 16 - 24
£64.30	aged 25 or over

Couple

£100.95	both aged 18 or over
£100.95	with responsibility for a child – one aged under 18

Lone Parent

£50.95	aged under 18
£64.30	aged 18 or over

Dependent Children

£56.11	birth to day before 20th birthday
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Premiums

£17.30	Family
£17.30	Family (lone parent rate)
£65.70	Pensioner - single
£97.50	Pensioner - couple
£97.50	Pensioner (enhanced) - couple
£97.50	Pensioner (higher) - couple
£27.50	Disability - single
£39.15	Disability - couple
£52.85	Severe Disability - single
£52.85	Severe Disability - couple (one qualifies)
£105.70	Severe Disability - couple (both qualify)
£13.40	Enhanced Disability - single
£19.30	Enhanced Disability - couple
£51.24	Disabled child
£20.65	Enhanced Disability Child
£29.50	Carer

People are paid an amount from the first three sections, depending on whether they are single, a couple, lone parent. This is the basic amount. Then they receive money for dependent children, and then a premium on top of this, should they qualify for anything from the list. Only the highest value premium is taken into account though.

Because there are so many variables, all we can do is look at an estimated cost of the IS component in isolation:

The figures from 2006 showed 146,000 problem drug users in receipt of income support. If all were under 25 and single, using current benefit rates, the total cost per person problem drug user, per year is: **£2,649.40**

The minimum cost per year is therefore:

$$£2649.40 \times 146,000 = £386,812,400$$

If all users in the 2006 list were over 25, then the cost per person problem drug user, per year is: **£3343.60**

The maximum cost per year is therefore:

$$£3343.60 \times 146,000 = £488,165,600.$$

The median of these two figures is: £437,489,000

6. Disability Living Allowance (DLA)

DLA is a non-means-tested, non-contributory benefit which can be claimed by a UK resident aged under 65 years who has care and/or mobility needs as a result of a mental or physical disability. It is tax-free. DLA is made up of a care component for people who need help with personal care needs and a mobility component for people who need help with walking difficulties. Individuals can qualify for DLA whether or not they are working. Earnings do not affect the amount of DLA received. Disability Living Allowance is in two parts – the care component and the mobility component.

Care component	Weekly rate
Highest rate	£71.40
Middle rate	£47.80
Lowest rate	£18.95
Mobility component	Weekly rate
Higher rate	£49.85
Lower rate	£18.95

In 2006, there were 25,000 PDUs in receipt of DLA. The lowest possible amount of DLA (using 2009 benefit rates) would be **£985.40 per person per annum**. Thus the lowest possible total cost of DLA per year would be:

$$£985.40 \times 25,000 = \mathbf{£24,635,000}$$

The highest possible amount of DLA (using 2009 benefit rates) would be **£6,305 per person per annum**. Therefore the highest possible cost of DLA per year would be:

$$£6,305 \times 25,000 = \mathbf{£157,625,000}$$

This gives a median figure of £91,130,000 per year.

APPENDIX 2

WELFARE CLAIMS DATA FROM TWO TREATMENT CENTRES

The following tables show the benefits being claimed by individuals at two rehab centres in 2010.

East of England

Client	AGE	ESA	JSA	Incapacity	Housing Benefit	Child Tax Credit	Child Benefit	Weekly Benefit	Monthly Benefit	Annual Benefit
Male	41	£65.00	£0.00	£0.00	£0.00	£0.00	£0.00	£65.00	£260.00	£3,120.00
Female	41	£0.00	£0.00	£107.00	£106.00	£0.00	£0.00	£213.00	£852.00	£10,224.00
Male	47	£0.00	£0.00	£60.00	£112.00	£0.00	£0.00	£172.00	£688.00	£8,256.00
Male	31	£0.00	£65.00	£0.00	£0.00	£0.00	£0.00	£65.00	£260.00	£3,120.00
Female	43	£64.00	£0.00	£0.00	£85.50	£0.00	£0.00	£149.50	£598.00	£7,176.00
Male	29	£65.00	£0.00	£0.00	£110.00	£0.00	£0.00	£175.00	£700.00	£8,400.00
Female	36	£94.00	£0.00	£0.00	£65.00	£0.00	£0.00	£159.00	£636.00	£7,632.00
Male	44	£65.00	£0.00	£0.00	£141.00	£0.00	£0.00	£206.00	£824.00	£9,888.00
Male	34	£60.00	£0.00	£0.00	£100.00	£0.00	£0.00	£160.00	£640.00	£7,680.00
Female	46	£0.00	£0.00	£0.00	£0.00	£40.00	£37.50	£77.50	£310.00	£3,720.00

Average benefits claimed £6,921

Midlands

In this rehab centre, 37 people were on various benefits, from incapacity to income support and ESA. Only one was employed.

The total level of benefits was £2,814.21 per week; or £146,000 a year; or £3,955 per person.

37 people were on Housing Benefit at an average of £1,00.00 per week for a one bed flat.

The total level of housing benefit claimed was £3,700 per week; or £192,400 a year; or £ 5,200 per person.

The average benefits claimed per person was therefore £9,155.



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The Coalition has inherited a failing and costly drug policy which prescribed methadone to drug addicts in the hope that that this would replace their use of street drugs and cut criminal justice costs.

This has been counter-productive. It impeded and delayed addicts' recovery from addiction. It has also been expensive: maintaining treatment and paying benefits to addicts costs over £3.6 billion a year.

The Coalition's new pilot schemes are flawed, not least because they discriminate against smaller rehabilitation units while favouring the quango, the NH services and large charities who were themselves responsible for the current shambles.

Abstinence-based rehabilitation is by far the best and in the long run, the cheapest method of helping addicts to recover: the Coalition must give smaller rehab units a chance to compete against the status quo.

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